Commissioning Operational Plan
2017-2019

“We care, innovate and deliver...”
Foreword

by Ian Stidston, Accountable Officer
NHS Castle Point and Rochford CCG

The NHS is facing the great challenge of improving the quality of care provided to patients in an equally challenging financial environment. This plan outlines how Castle Point and Rochford CCG plans to rise to this challenge in 2017/19 and beyond. Our vision is to enable the people of Castle Point and Rochford to live longer, healthier and happier lives by commissioning high quality, cost-effective, caring and compassionate services in partnership with our fellow health and social care commissioners. There are several components to this plan. Our priorities for 2017/19 focus on: some of the most vulnerable in our society (the elderly), ‘home not hospital’ as being preferred place of care, and; moving to a more personalised and preventative approach to healthcare.

Working with our partners at Essex County Council and Southend CCG, we will support our GPs to work more closely together and with community services and social care to better manage long term conditions, support the frail elderly and reduce A&E attendances and admissions into hospitals and nursing homes.

We will also work with other organisations in Essex, supported by the Success Regime to help local hospitals work more closely together to provide centres of excellence. Underpinning our Operational Plan is our desire to help patients and the public have greater control and responsibilities for maintaining and improving their own health.
Our Corporate Objectives
2017-19

1. Ensure quality services with a valued workforce.

2. Involve and listen to those affected by decisions.

3. Deliver constitutional standards and manage the delivery of health services within our available budget.

4. Work better, together as a health system to ensure sustainability.
Our Values

Value 1
We listen to patients, members, staff and partners

By listening … Together with our partners/patients, we want to build a local NHS that ensures patients get the standards of care they have the right to expect, care that is sustainable for future generations.

Value 2
We are prepared to do things differently to improve care

Being prepared to do things differently … Exploring new ways of delivering a simpler, better local health and care system that enables people to access seamless care to help them live the lives they want.

Value 3
We are committed to working with our partners

Working with our partners … Retaining and developing valuable relationships in order to resolve challenges on a whole systems level.

Value 4
We are ambitious and innovative

Being ambitious and innovative … Leading the way in delivering better services, empowering service users, putting them at the centre of care.

Value 5
We are compassionate

Showing compassion … Listening and caring about what’s going wrong and trying to help to make it better for patients or our partners. We are also passionate about recognising what’s working well.

Value 6
We are committed to making our plans happen

Making plans happen … Identifying the priority areas for improving health and care and creating goals that are meaningful and action-driven.
1. Introduction: About us

Did you know?

Our older population is expected to rise by 21% over the next 5 years

About half of our over 60s have multiple health and care needs

Almost two thirds of all emergency hospital admissions in 2013/14 were for over 75s

The number of people needing social care could quadruple in the next 20 years

Who we are

Castle Point and Rochford CCG has responsibility for commissioning NHS services in your area, everything from hospital care to your GP. Essex County Council commissions social care services – things like care and support people might need in their own home.

Vision and Transformation

Our vision for 2017/18 is ‘Planned, not Unplanned’ care delivered through the following three priority areas:

“Home not Hospital” through integrated care

Sustainable acute care

Strong resilient urgent and emergency care
1.1 Joint Strategic Needs Assessment

As set out in the JSNA [http://www.essexinsight.org.uk/Resource.aspx?ResourceID=299](http://www.essexinsight.org.uk/Resource.aspx?ResourceID=299) the number of people in the CCG is expected to rise but the elderly are expected to rise disproportionately. In the next five years the population of the CCG is expected to rise by 2% but the numbers of those 70 years and older is expected to rise by 21% (form 28,500 to 34,500).

As we age we tend to accumulate a health burden and have a greater need for health services. The projected increase in the elderly population will put a greater demand on health and social care than a proportionate increase in all age groups.

These changes in the population demographics mean that in the next 5 years the number of hospital admission would be expected to increase by 4% above what would be expected if all age groups increased by the same amount. In the same period costs would increase by an additional 6%. This means that even if the CCG received the same per capita budget it could still expect an annual £4 million overspend by 2020.
1.2 Health Needs of our Population

Public health analysis has identified the following 5 key health problems as priorities for the CCG:

- Cardiovascular disease
- Cancer
- Respiratory disease (chronic obstructive pulmonary disease (COPD) in particular)
- Mental health disease (depression / anxiety in those with chronic physical illness and physical health in those this severe chronic mental illness)
- Health inequity

Goals for Prevention - The following are aspirational goals for prevention (process and outcome)

- A meaningful reduction in prevalence of smoking in patients with COPD and in those on the general practice mental health register.
- A meaningful reduction in gradient of smoking prevalence by deprivation / occupational group.
- A significant reduction after two years, in emergency admissions for ischaemic heart disease and for COPD.
- Making every contact count (outlined below) training widely taken up across general practice, community providers and the two acute hospitals and social care partners.
- Social prescribing available from practices in the CCG.
- A reduction in the percentage of predicted undiagnosed hypertensive patients.
- At least maintain the current percentage of patients with hypertension with blood pressure recorded as within the target range.

Reducing Health Inequalities

In the period 2011 to 2013 in males the difference in life expectancy at birth between the most and least deprived individuals was 8.5 years in Castle Point and Rochford. In females the difference was nearly 6 years in Castle Point. The areas of increased deprivation within Castle Point and Rochford are shown in the map below taken from the local JSHNA.
1.3 High Impact Preventative Interventions

The following interventions have been selected to improve prevention of the identified health problems.

**Smoking cessation services and tobacco control:** the CCG will continue and deepen its working relationship with the smoking cessation services commissioned by Essex County Council (ECC). Particular focus will be given to supporting smokers with COPD, mental health illness or living in areas of deprivation to stop smoking. The CCG encourage the tobacco control activity of other agencies including the police and trading standards.

**Making every contact count (MECC):** Training material has been developed by ECC to train front line staff to provide brief interventions for health improvement such as smoking cessation, sensible drinking, weight loss, activity and a healthy diet. The CCG will promote these training materials across all practices, community providers and both acute trusts.

**Social prescribing:** Social Prescribing is often referred to as a means of enabling primary care services to refer a patient with social, emotional or practical needs relating to their overall health and wellbeing to a range of local, non-clinical services. In partnership with Essex County Council (ECC) the CCG has developed a social prescribing and early interventions project that covers all residents in the Castle Point and Rochford localities who are over the age of 18 which is provided by Castle Point Association of Voluntary Services (CAVS). The social navigators offer one to one discussions to explore an individual’s social support needs and act as a single point of access for community and voluntary services. Various different support may include, community transport, local exercise classes, benefits advice, housing, connections to legal advice, social clubs, volunteering, and be-friending.

**Hypertension:** ECC is supporting the increase detection of patients with hypertension through increase surveillance of the population not know to be hypertensive. The CCG will support this work. The CCG will also work with practices to increase the quality of hypertensive care of those diagnosed.

**Depression:** the CCG will support the programme commissioned by ECC to increase the detection of depression in patients with other long term conditions. In addition the CCG will support improvements in quality of the management of depression through psychological therapies, medication and ‘social prescriptions’.

**Physical activity:** as a member of the local (district/borough) health and well-being board the CCG will work with strategic partners including the voluntary sector, health care providers, local authority and other public bodies to set the strategic direction for supporting greater physical activity in the population.

**Falls:** in addition to the direct impact on health through problems such as hip fracture, falls have a major impact on mental health, confidence and general wellbeing. The CCG will support the falls prevention service commissioned by ECC by seeking ways to link other community services to it, scrutinising the performance of the service and support improvements when needed.
### The Model

NHS CP&R CCG will recognise the neighbourhood and not the hospital as the main location where healthcare takes place. The new model will establish the home accessing services within neighbourhoods as a more efficient location for quality and value focused healthcare.

### The Approach

**Long term conditions (LTC) care.** The main site for the provision of health and social care for patients with multiple LTCs should not be the hospital. Co-production and self-management, facilitated by technology, will be at the heart of the new model for CP&R CCG, enabling neighbourhoods to safely be the location for higher acuity healthcare.

**Workforce, relationships and culture.** The development of neighbourhood ‘hubs’ will see greater integration of primary care and community services, alongside opportunities to develop centres (hubs) and to develop and train workforce.

**Encouraging ‘integration’.** Our organisations will be incentivised to integrate services from multiple providers and will need skills from across the health and social care supply chain rather than in one form of provider. Contractual tools such as CQUINs will be used to enable incentivisation.

**Reforming specialist care.** Specialist providers will become expert not only in the delivery of specialist, episodic care but also in the delivery of community level social and health care across a wide set of geographies in CP&R CCG.

### Improved outcomes

The holistic care system is designed to ensure proactive prevention and early intervention, breaking the cycle of reactive care provision. Robust risk stratification / predictive modelling identifies patients at risk of decline for enrolment into the programme before their health deteriorates.

Each patient has a care plan tailored to their individual needs, with different programmes designed for different needs e.g. diabetic programme, chronic heart failure programme. There may also be more than one care plan in operation for an individual if more than one co-morbidity exists which can be brought together into one document.

Care takes place at convenient locations for the patient, with significant neighbourhood based care with support for transportation to ensure high levels of compliance with treatment programmes.

Breaking down barriers between organisations and removing silo working will deliver improvements in the care patients receive, increasing quality and patient experience.

Full authority over care decisions, and full clinical and financial accountability to ensure incentives are aligned to drive better outcomes for patients.

By delivering enhanced quality outcomes for patients by ensuring that those delivering care have the appropriate skills and competency to do so.

### Sustainable

- Reduced unplanned attendances at Accident and Emergency
- Decreased inpatient admissions and re-admissions and specialist utilisation (including reduced outpatient appointments)
- Shortened inpatient length of stay (enhanced recuperation and rehabilitation care in appropriate settings)
- Reduced proportion of deaths in hospital / increased provision of end-of-life care at home/ in hospices, aligned with patient choice)
- Release of GP time to address other patient groups
- Improved access and quality of care for patients
- Reducing reliance on residential care
## Sustainable Acute Care

### The Model
To deliver sustainable acute care the CCG is working in partnership with providers and across the Mid and South Essex STP to transform services, remove duplication and re-design services around the community model to enable acute providers to focus on the delivery of high quality, specialist care.

### The Approach
As part of the STP, the CCG is actively working to address the clinical and financial sustainability of local hospitals. This will be delivered through increased collaboration and shared functions to deliver the In Hospital model of care.

Throughout 2017-19, the CCG will continue to focus on key priority areas, driven by clinically led service reviews and pathway redesign. Using Commissioning for Value and NHS Atlas data, the CCG will strive to deliver the objective for ‘Right Care’ to maximise outcomes and value for our patients.

The In Hospital model of care intends to achieve three goals:
- Redesignation of emergency centres
- Separate elective and non-elective
- Consolidate services

### Improved outcomes
- Improvement in quality and safety through greater specialisation of clinical staff and equipment and increasing focus to provide senior medical cover.
- Improved capability to deliver seven day services.
- Delivery of access standards including RTT, cancer and diagnostics.

### Sustainable
- Reduction in out patient referrals, optimising alternative pathways and services outside of acute hospitals.
- Increase in shared care pathways across the system.
- Reduced length of stay post procedure through innovative and integrated rehabilitation.
- Increased use of non face to face contacts through use of modern technology.
- Shortened inpatient length of stay (enhanced recuperation and rehab care in appropriate settings).
- Reduction in back office and clinical support service costs through collaborative working.
- Implementation of a common offer to reduce variation of provision and procedures of limited clinical effectiveness.
- Development of workforce strategy across providers to create a flexible specialist workforce.
## The Model

The CCG recognises the need to radically transform urgent and emergency care services throughout the local health and social care system. The new model aims to provide responsive early intervention and ensure patients receive the right care, in the right setting at the right time, reducing the complexity of the current model. The In Hospital model of care intends to achieve three goals: 1) Redesignation of emergency centres 2) Separate elective and non-elective 3) Consolidate services.

## The Approach

### Integrated Urgent Care

- A key focus within the STP is strengthening capacity in the Urgent and Emergency Care pathway, increasing ‘hear and treat’ and ‘see and treat’ via NHS 111 and 999. The CCG are leading on the pan STP project to redesign and procure an Integrated Urgent Care (IUC) service, which will increase the number of callers to NHS 111 receiving a secondary clinical assessment prior to reaching a ‘Green’ ambulance or Emergency Department (ED) disposition.

### 999 – Services will be delivered through a new operational model with initial triage prior to dispatch, and further integrated with local clinical services.

### Urgent Care Pathway

- We will continue to build on the new Urgent Care pathway within ED, identifying those patients through clinical triage who are appropriate to be redirected out of an acute setting into primary, community or self care.

### Primary Care Early Intervention

- The CCG will continue to support General Practice in delivering new innovative initiatives aimed to identify patients at risk ensuring early intervention, both within the community and care home settings.

### Better Care Funds

- The CCG will support the delivery of Better Care Fund initiatives to reduce demand on urgent and emergency care services, ensuring early intervention to minimise patient deterioration and requiring acute emergency care. Our ambitious 2016/17 work programme identifies the impact on A&E attendance and Non-elective admissions. The work streams detail (inc activity reductions) are captured within our CCG QIPP work programme with schemes that focus on: Care Coordination Model (integrated risk stratification, assessment, care planning and case management); Community Geriatrician provision; improved End of Life Care; improved access to falls Prevention; remodelled Reablement services, and; improved access to community beds (including ‘discharge to assess’ models).

### System Resilience

- The CCG will continue to work in partnership with all local stakeholders by engaging with the System Resilience Group to deliver urgent and emergency care improvement / recovery plans ensuring resilient systems are maintained. Now we have recruited to the system resilience team we will be in a position to actively engage with the south west Essex SRG, working more closely with our partners to support this additional system accessed by our population. The CCG has implemented all QIPP schemes identified last year to reduce demand on the system and these have now been made mainstream programmes of work. Public Education and Appropriate use of services. Targeted communications will be used to ensure all patients and the public are aware of the services available and how to access if required to do so.

## Improved outcomes

- Ensuring patients receive timely appropriate care and redirected to the most appropriate services at the right time, reducing the impact on the emergency department. Treating patients in the comfort of their homes / place of residence to prevent the attendance / admission into an acute setting.
- Delivery of improved urgent and emergency care services as a result of the success regime and delivery of local system resilience group work programmes, leading to improve constitutional standards performance.
- Greater awareness of the public of service availability and which services are to be accessed at which times.

## Sustainable

- Reduced unplanned attendances at Accident and Emergency
- Decreased emergency inpatient admissions and re-admissions
- Shortened inpatient length of stay and bed occupancy (enhanced recuperation and rehabilitation care in appropriate settings)
- Reduction in 999 ambulance dispatches for minor conditions
Commissioning in the evolving system

• The CCG is continuing its journey to create the infrastructure required for the NHS of the future. The program of work is looking at both developments required within the provider landscape, as well as the necessary changes within the commissioning architecture.

• The CCG is working with Essex County Council, and has recently created a Strategic Commissioning Partnership Board for aligning commissioning decisions and discussions through a whole system approach. This will in time ensure that commissioners across the system are working in partnership and for the good of the system, and not just with their own organisational scope in mind. This will build on the principles of the BCF.

• The local area is on a journey to developing an MCP approach to contracting, provision and accountability. This is in line with the local CCG’s stated intent of developing integrated new models of care, and the wider STP intention to build strong, resilient out of hospital models.

• During 2016/17 we have built a Cross System Delivery Board, made up of executive managers from the CCG, local authority and significant incumbent providers including primary care, to progress new ways of working.

• It is expected that this forum becomes the engine room of the emerging MCP partnership arrangements and takes additional responsibility on during 2017/18 and beyond, including realigning traditional commissioner functions – such as pathway design and change management – to the most appropriate organisation in the local system.

• This approach is intended to be underpinned by a set of core principles signed up to by providers and commissioners to encourage new ways of working in line with NHS England issued Alliance Contracting guidance and MCP frameworks.
## 2017/18 and 2018/19 ‘Must Dos’

<table>
<thead>
<tr>
<th>No.</th>
<th>Must Do’s</th>
<th>Specifics (in brief)</th>
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| 1   | Strategic Transformation Plans (STP)    | • Implement agreed STP milestones  
• Achieve agreed STP trajectories                                                                 |
| 2   | Finance                                 | • Deliver control totals and financial balance  
• Implement STP plans and local targets  
• Meet demand reduction measures  
• Meet provider efficiency measures                                                                 |
| 3   | Primary Care                            | • Deliver sustainability plans within general practice  
• Ensure local investment meets or exceeds minimum requirement levels  
• Tackle workforce and workload issues  
• Extend and improve access to Primary Care  
• Support general practice at scale                                                                 |
| 4   | Urgent and Emergency Care               | • Deliver four hour A&E standard and standards for ambulance response  
• Meet priority standards for seven day hospital services  
• Implement the Urgent and Emergency Care Review  
• Deliver a reduction in ambulance 999 calls  
• Prepare for forthcoming waiting time standard for urgent care                                                                 |
| 5   | Referral to treatment times and elective care | • Deliver standard – 92% of patients on non-emergency pathways wait no more than 18 weeks  
• Deliver and achieve 100% of use of e-referrals  
• Streamline elective care pathways  
• Implement national maternity services review                                                                 |
| 6   | Cancer                                  | • Implement the Cancer taskforce report  
• Deliver NHS Constitution 62 day cancer standard  
• Progress on improving one-year survival rates  
• Roll out follow up pathways for breast cancer patients  
• Ensure all elements of the Recovery Package are commissioned.                                                                 |
| 7   | Mental Health                           | • Deliver, in full, the implementation plan for the Mental Health Five Year Forward View  
• Ensure delivery of mental access and quality standards including 24/7 access to community crisis resolution  
• Increase baseline spend on Mental Health  
• Maintain dementia diagnosis rate  
• Eliminate out of area placements by 2020/21                                                                 |
| 8   | People with learning disabilities       | • Deliver Transforming Care Partnership plan  
• Reduce inpatient bed capacity  
• Improve access to healthcare  
• Reduce premature mortality                                                                 |
| 9   | Improving quality in organisations      | • Implement plans to improve quality of care  
• Measure and improve efficient use of staffing resources  
• Participate in annual publication from reviews of deaths, avoidable death rates etc.                                                                 |
Must Do 1: Local Health System Sustainability and Transformation Plans (STP)

• The CCG’s STP planning footprint mirrors that of the ‘Success Regime’ area which covers mid and south Essex CCG locality areas.

• The Essex Success Regime is currently one of three such programmes in the country. It is overseen jointly by a tripartite of national organisations – NHS England, NHS Trust Development Authority and NHS Improvement, which looks after NHS Foundation Trusts. The tripartite works closely with the CQC.

• The Success Regime is part of the NHS Five Year Forward View, which is a blueprint for the NHS to take decisive steps to secure high quality, joined-up care. It sets out the challenges facing health and care nationally and how radical change is needed to sustain services into the future and improve care for patients.

• The Success Regime is concentrating on certain areas in the country where there are deep-rooted, systemic pressures. The overall aim is to improve health and care where these systems are managing financial deficits or issues of service quality or both. The Success Regime brings management and financial support to local delivery and will help to unblock any barriers to change. As for all parts of the NHS, the priority is to go faster and further with transformation. Every local health and care system must have a Sustainability and Transformation Plan, and this is what the Essex Success Regime will facilitate.

• The Mid and south Essex Success Regime is currently working together to develop the Sustainability and Transformation Plan and the following key objectives have been agreed and are reflected within this plan:

  ▪ Reduce the clinical and financial disadvantages for our local hospitals
  ▪ Accelerate plans for changes in urgent and emergency care
  ▪ More data and sharing
  ▪ Simplify commission, reduce workload and duplication
  ▪ Development of flexible working
  ▪ Joined up services in primary, community and social care
# STP Performance Targets

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<th>2016/17 YTD</th>
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| We are developing an STP MH oversight group that will monitor progress against the following mental health areas: children and young people; perinatal; adult (common and community); acute; health and justice and suicide prevention
| **Progress vs MH 5YFV Implementation Plan**     |             |                |                |                |                |                  |
| (Localities at each level of primary care working) |             |                |                |                |                |                  |
| Level 1                                         | 100%        | 88%            | 81%            | 73%            | 15%            | 100%             |
| Level 2                                         | 12%         | 88%            | 81%            | 73%            | 15%            | 100%             |
| Level 3                                         | 23%         | 88%            | 81%            | 73%            | 15%            | 100%             |
| Level 4                                         | 85%         | 88%            | 81%            | 73%            | 15%            | 100%             |
Key Challenges for 2017-19

The Challenge

Primary care is under pressure: rising workload...

- 81% of GPs report rise in complexity; move to 7 day working;
  need for same day appointments to relieve urgent care pathway (2 out of 5 CCGs have chronic ACSC2 emergency admissions above the national average)

...with significant workforce challenges

- Amongst worst in country for staff due to retire in next 5-10 years e.g., 20% of practices have all of their GPs aged over 54 years

Urgent and emergency care pathway also under strain

- Rising demand for A&E (above national average growth at c. 4% for past two years) and ambulance services (18% increase y-on-y)
- Complex system with little coordination or PC capacity for emergency appointments.

GP and 5YFV encourage move towards a larger footprint with greater integration between practices...

- Fragmented care: ~180 GP practices operating across M&SE

...and to provide a wider, more integrated array of services

- Changed GP role: concentrate on the highest risk and oversee multidisciplinary team to reduce avoidable hospitalisations

...supported by additional £48m funding over 5 years in line with £2.4b national investment to take forward GP5YFV programmes

Focus of this update

Two objectives to address the challenge

1. Manage demand for healthcare across primary, community and acute settings, by:
   - Delivering a step change in Prevention, Early Intervention and Self Care
   - Developing integrated pathways for Frail and End of Life patients that put individuals and their families at the centre
   - Strengthening capacity in the UEC pathway to be able to 'hear and treat', 'see and treat'
   - Integrating with social care, joined services

2. Build capacity outside the hospital to support more complex care needs, by:
   - Releasing General Practitioner Capacity through the use of other health and care professionals and technology
   - Organising care around natural communities (“localities) – delivering more services at a local level
   - Delivering care using a population segmented management approach
The CCG has a clear plan to deliver the five mandated Urgent Care interventions as defined nationally by NHS England. This plan will support the delivery of the Urgent & Emergency Care Transformation agenda supporting the recovery and sustainability of the constitutional standards, including the ‘A&E 4 hour waiting time standard’, leading to improved patient care and experience. The 5 key areas of focus are:

- Improved streaming within the Emergency Department and directing to the most appropriate service
- Improved call handling and decision making within our 111 service
- Improved ambulance response and provision of care outside of hospital
- Improved patient flow within our commissioned providers
- Improved whole system discharge ensuring patients on-going care needs are met

The CCG continues to work with its partners both locally through the South East A&E Delivery Board ensuring whole system governance and assurance, as well as supporting the wider system urgent care transformation underway through the STP and Essex Success Regime footprint.

Working relationship across the STP footprint to deliver better quality and standards.

The CCG is fully engaged in the work streams underway to support whole system transformation across the Mid & South Essex STP footprint. We are actively leading the delivery of a fully Integrated Urgent Care service across the STP footprint, ensuring patients receive timely and accessible care via our 111 service provider. This new service will support the delivery and sustainability of our constitutional standards by ensuring patients are treated at point of entry into the NHS as well as redirecting patients to services out of hospital, closer to home.
RTT – Recovery Plan (Appendix 3)
The CCG, in partnership with Southend Hospital has an agreed recovery plan to deliver the 18-week constitutional standards. Patient choice remains a key priority and where possible the CCG has commissioned local services for local people to meet these needs. A comprehensive outsourcing program has been delivered during 16/17 to support the delivery of the constitutional standards. There are continued pressures on acute hospitals in the delivery of this constitutional standard due to the rise in emergency medicine demands. The CCG meets regularly with its providers to ensure these demands are being managed and patients receive the most appropriate and timely treatment available to them. Patients on an 18-week pathway are reviewed weekly to ensure their care needs are being met and the CCG continues to engage with providers to seek this assurance.

The CCG has developed a comprehensive demand management plan, in support with its local system partners, to ensure early patient review, reduction in demand on the acute hospitals and our General Practice colleagues. The CCG is continuing to deliver improvements in services being available through the Electronic Referral System (ERS), improving patient choice and access to commissioned services. The demand management plan is based on delivering the NHS England published 8 best practice demand management principles which are:

Peer review of referrals – ensuring referrals are timely, appropriate and services are commissioned to meet these needs
Shared decision making – ensuring patients and their clinicians engage and make decisions together to agree the patients on-going care needs
Patient choice – ensuring patients are aware of treatment options available to them and make informed choices
Advice & guidance – ensuring all referrals are considered by clinicians improving the quality or referrals, reducing errors and delays
Alternatives to outpatients – ensuring patients receive care in the most appropriate care setting
Management & monitoring of follow up appointments – increasing post care advice guidance and care in the community closer to home
Consultant to consultant referrals – ensuring internal referrals are appropriate and do not delay the patient pathway and on-going treatment.
Direct access to diagnostics – ensuring patients journeys are streamlined so as to not delay their on-going care needs

Cancer – Recovery Plan (Appendix 3)
The CCG continues to work in partnership with its local and STP footprint partners to ensure patients receive timely care when referred onto a cancer pathway. There has been a significant rise in demand of cancer referrals in recent years due to increased awareness and monitoring of patients. Recovery action plans at both local and STP system levels have been developed to support the delivery of the 62 day (treatment from the point of referral) constitutional standard, which is supported by Specialist Cancer Network partners. The CCG fully supports the Mid & South Essex locality ‘Cancer Assurance Group’ meeting regularly to seek assurance of delivery of recovery plans.

There are on-going challenges in the sustainability of the cancer standards due to rise in demand, both in terms of referrals and treatments, a national workforce shortage and physical capacity within acute provider organisations to meet these needs. The local provider and STP wide cancer recovery plans aim to mitigate against the impacts of these on-going challenges.
IAPT (Recovery Plan – Appendix 3)
South Essex Partnership University NHS Foundation Trust, provider of the CCG’s IAPT service is now subject to two contract performance notices for the failure to meet both the IAPT access target (entering treatment) and the recovery rate target. Both contract performance notices have recovery action plans (RAPs), which are enforceable with financial penalties for continued failure to meet agreed recovery trajectories.

Dementia (Recovery Plan and trajectories – Appendix 3)
The NHS Digital (formerly HSCIC) data released September 2016, dementia diagnosis rates for over 65 years shows the CCG actual as 57.9%, work continues towards the delivery of the 67% trajectory and every effort is being made to meet the standard.

Ambulance Services (Recovery Plan – Appendix 3)
The Ambulance R2 standard continues to be a challenge. It is expected that initiatives recently implemented (Care Coordination) and schemes coming on line in coming months (care home interventions) will have a positive impact on conveyances. In addition NHS England have been asked to engage with the NHS Improvement with regards to exploring opportunities to increase see and treat rates minimising conveyances.

Mitigations to recover the position have been included within the A&E system recovery plan and will be regularly monitored by the SRG. The Ambulance 9 high impact interventions continue to be implemented through the EEAST Consortia Contract forum.

Contract sanctions are being applied as appropriate.
The CCG is working across the system to improve performance against a number of the Constitutional Standards and recovery plans are attached in Appendix 3 to this plan.

A key aspect of improving performance is through managing demand on acute services and the Demand Management plan is also attached in Appendix 3. The CCG is working across the STP footprint to identify innovative ways to reduce the pressures across the system.
Our Local Approach

- CCG’s approach to transforming care in our area is through the development of integrated Neighbourhoods Teams, (also referred to locally as Hubs). These will provide comprehensive proactive and responsive integrated (physical and mental health plus primary care, public health and social care) out of hospital care including population segmentation/risk stratification, case finding, care, co-ordination and signposting as well as build community and personal resilience.
Must Do 2: Finance

• NHS Castle Point and Rochford CCG has produced a draft financial plan for 2017/18, supporting the delivery of the key financial metrics under which we are measured and enabling the delivery of the strategic direction agreed by the Governing Body.
• These financial plans include a detailed annual plan by service type, coupled with details of annual QIPP schemes and investments.
• The plans enable the CCG to deliver on all of its targets, and the underpinning activity assumptions are being triangulated with Southend CCG for the CCG’s main acute contract, along with the Trust itself. Good progress is being made on agreeing the contract for the forthcoming financial year, with an aim to have a signed contract in place by 23rd December 2016.
• The CCG’s draft financial plan meets the requirements of the recently published planning guidance and complies with NHS England’s “business rules”, under which the CCG is obliged to operate. Furthermore, the plans meet the requirements of the Midlands and East published control totals.

Current Position and Key Issues

Resource Allocation:

• Movements in the CCG’s allocation from 2016/17 to 2017/18 are included within the table below;

<table>
<thead>
<tr>
<th>Nature of Spend</th>
<th>Allocation Type</th>
<th>Category</th>
<th>16/17</th>
<th>17/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent</td>
<td>Programme</td>
<td>Published CCG Programme Allocation</td>
<td>227,460</td>
<td>232,340</td>
</tr>
<tr>
<td>Recurrent</td>
<td>Running Costs</td>
<td>Published CCG Running Cost Allocation</td>
<td>3,901</td>
<td>3,891</td>
</tr>
<tr>
<td>Recurrent</td>
<td>Co-Comm</td>
<td>Co-Commissioning Funds</td>
<td>21,942</td>
<td>22,871</td>
</tr>
<tr>
<td>Recurrent</td>
<td>Programme</td>
<td>South Essex L&amp;D resources</td>
<td>(97)</td>
<td>(97)</td>
</tr>
<tr>
<td>Non-Recurent</td>
<td>Programme</td>
<td>Return of Surplus/(Deficit)</td>
<td>2,221</td>
<td>2,555</td>
</tr>
<tr>
<td>Non-Recurent</td>
<td>Programme</td>
<td>Control Total Adjustment</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Non-Recurent</td>
<td>Programme</td>
<td>IR Changes</td>
<td>(3,372)</td>
<td></td>
</tr>
<tr>
<td>Non-Recurent</td>
<td>Programme</td>
<td>HRG4 Changes</td>
<td>(2,303)</td>
<td></td>
</tr>
<tr>
<td>Non-Recurent</td>
<td>Programme</td>
<td>Q1 Eating Disorder Service</td>
<td>95</td>
<td></td>
</tr>
<tr>
<td>Non-Recurent</td>
<td>Programme</td>
<td>GP Development Programme - reception and clerical training</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Non-Recurent</td>
<td>Programme</td>
<td>Learning Disability Transformation funding to TCPs</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Non-Recurent</td>
<td>Programme</td>
<td>CAMHS Waiting List Monies</td>
<td>40</td>
<td></td>
</tr>
</tbody>
</table>

**TOTALS** | 255,638 | 255,985 |

• The CCG’s overall movements in relation to it’s 2017/18 allocation as follows;
• Programme growth of 2.1%
• Primary Care growth of 4.2%
• Running costs reduction of 0.3%
Must Do 2: Finance

Reserves Utilisation
The CCG has established reserves, in line with national guidance to mitigate any in-year financial risk. The following reserves have been established:

1.0% Non-recurrent reserve (uncommitted)
0.5% Contingency reserve

Expenditure can only be authorised from reserves with express agreement of the Chief Finance Officer and must demonstrate value for money.

Release of funding from the 1% non-recurrent reserve should be incurred in-year only, and whilst 0.5% is available to spend upon the CCG’s transformation programme, the remaining 0.5% is expected to continue to need express NHS England approval for release in 2017/18.

Mental Health Parity of Esteem
The CCG has set aside a sum for investment in the Mental Health Parity of Esteem agenda, equating to a real terms increase in Mental Health spend, which is in line with the CCG’s overall real terms funding increase.

---

**Table: Expenditure Category**

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>With 15/16 FFO</th>
<th>Less NR Exp</th>
<th>16/17 Recurrent FFO</th>
<th>Add Growth</th>
<th>Add FFO of 16/17 investments</th>
<th>Add Inflation</th>
<th>Year of Offset</th>
<th>CHST uplift</th>
<th>Net Traffic Inflator</th>
<th>Year OPF</th>
<th>Other Changes</th>
<th>Draft 17/18 Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Services</td>
<td>23,972</td>
<td>2,123</td>
<td>25,687</td>
<td>5,129</td>
<td>2,582</td>
<td>2,840</td>
<td>0</td>
<td>242</td>
<td>(6,710)</td>
<td>(5,675)</td>
<td>129,771</td>
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<tr>
<td>Mental Health Services</td>
<td>21,342</td>
<td>(60)</td>
<td>21,060</td>
<td>355</td>
<td>0</td>
<td>408</td>
<td>(488)</td>
<td>0</td>
<td>20</td>
<td>(1,684)</td>
<td>76</td>
<td>20,017</td>
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<td>Community Health Services</td>
<td>6,621</td>
<td>6</td>
<td>6,627</td>
<td>34</td>
<td>0</td>
<td>140</td>
<td>(138)</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>6,688</td>
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<tr>
<td>Continuing Care Services</td>
<td>14,363</td>
<td>(218)</td>
<td>14,145</td>
<td>1,134</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>300</td>
<td>0</td>
<td>14,869</td>
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<tr>
<td>Prescribing</td>
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<td>13</td>
<td>28,996</td>
<td>1,498</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>30,541</td>
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</tr>
<tr>
<td>Other Primary Care</td>
<td>2,393</td>
<td>(39)</td>
<td>2,354</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2,340</td>
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</tr>
<tr>
<td>Other Programme Services</td>
<td>5,249</td>
<td>(338)</td>
<td>4,911</td>
<td>96</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>986</td>
<td>400</td>
<td>6,394</td>
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<tr>
<td>R&amp;P</td>
<td>11,534</td>
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<td>11,534</td>
<td>268</td>
<td>0</td>
<td>268</td>
<td>(268)</td>
<td>0</td>
<td>11</td>
<td>0</td>
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<tr>
<td>Primary Care Co-Commissioning</td>
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<td>0</td>
<td>21,942</td>
<td>929</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>22,871</td>
<td></td>
</tr>
<tr>
<td>Other In-Year &amp; NR Adjustments</td>
<td>267</td>
<td>(251)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>562</td>
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<tr>
<td>CCG Risk Share Contribution</td>
<td>429</td>
<td>(429)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Running costs</td>
<td>3,801</td>
<td>0</td>
<td>3,801</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>110</td>
<td>3,881</td>
<td></td>
</tr>
<tr>
<td>Contingency (0.5%)</td>
<td>1,278</td>
<td>(1,278)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Non Recurrent Reserve (1%)</td>
<td>2,494</td>
<td>(2,494)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>SR Non Rec Reserve available for Transformation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ES/Head Requirement</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>554</td>
<td>554</td>
<td></td>
</tr>
<tr>
<td>Undistributed OPF</td>
<td>(1,059)</td>
<td>1,056</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

**Grand Totals**

- 253,083 [1,185]
- 251,898
- 10,276
- 96
- 3,792 [3,612]
- 852
- 1,033 [8,718]
- 1,156
- 253,430
NHS England is supporting and funding a rapid launch and expansion of the RightCare approach to all CCGs over the next two years. The CCG is participating in wave two of the RightCare programme and confirmed the name leads as: Robert Shaw (Executive Lead) / Mark Lim (Operational Lead) / Dr Mike Saad (Clinical Lead) and additional support is being provided through our Public Health leads.

We are aware of the effectiveness of the RightCare approach through reviewing the evidence and case studies to prove it at www.rightcare.nhs.uk/resourcecentre/

We will maximise this opportunity to learn more about the RightCare approach and the practical steps our CCG can take now to ensure successful implementation in the future. It will also be an opportunity to network with our peers and understand their plans for adopting RightCare.

Actions to be undertaken in January 2017:

• Undertake a diagnostic that covers:
  – CCGs prioritisation and business case approval processes.
  – Review of Where to look information and comparison with operational plans.
  – Agreement on areas of focus
  – Agreement of timescales for implementation.
  – Links with STP approach

• Establish an implementation working group in January 2017 to include:
  – Dr Mike Saad, Clinical Lead
  – Mark Lim, Operational lead
  – Debbie Vick, Finance Lead
  – Mark Durham, BI Lead
  – Dr Danny Showell, Public health Lead

• Working Group to agree an implementation plan for the CCG that embraces the opportunities within the RC approach and satisfies the initial requirements for the national programme. February 2017

• The RightCare Programme includes the Commissioning for Value Packs and tools which the CCG has found extremely useful in terms of identifying further areas of opportunity to transform services as outlined in the slide below.
In prioritising areas to focus efforts on prevention and service efficiency, a good place to start are the conditions causing the greatest hospital spend. Even small improvements in these areas can release resources that can be reinvested in patient care elsewhere. The chart below shows the conditions greatest hospital spend.

The CCG has commenced the implementation of ‘Getting it Right First Time’ programme, by developing clinical pathways that begin in primary care, but that involve a seamless transition across the secondary care sector, ensuring best value, high quality outcomes for patients. We are undertaking a full review of musculoskeletal (MSK) services supported by the south east Essex MSK Clinical Network. This work programme focusses on right care, right place, first time, and improving outcomes and patient experience. We are also embarking on a new programme of work looking at Cardiac conditions. Our QIPP programme includes specific projects for Respiratory and Ophthalmology. Respiratory is an increasing area of activity and spend across both elective and non-elective pathways.
QIPP Challenge and Impact

- The CCG has an £10.2 million funding gap /QIPP challenge for 2017/18. The table below details the QIPP schemes for 2017/18. We are confident of meeting our 2017/18 QIPP challenge and we have identified the work streams and services line savings that we will be aggressively pursue to ensure we deliver our financial statutory obligations. The summary table below sets out the current level of identified QIPP by contract/service area and also our overarching aim is to focus on these large areas rather than several small schemes, in conjunction with our wider system partners to ensure maximum impact as we continue to build.

- Further QIPP ideas identified through the Success Regime STP plans developed have not yet been included in the CCG’s identified QIPP position. The CCG is currently reviewing which can schemes can be taken forward and this will be included in due course.

Summary of QIPP Schemes

<table>
<thead>
<tr>
<th>Budget Area</th>
<th>2017/18 (Gross)</th>
<th>2017/18 (Investment)</th>
<th>2017/18 (Net Value)</th>
<th>% of Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>6,073,219</td>
<td>(1,676,945)</td>
<td>4,396,274</td>
<td>48%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>940,000</td>
<td>0</td>
<td>940,000</td>
<td>10%</td>
</tr>
<tr>
<td>Continuing Healthcare</td>
<td>500,000</td>
<td>0</td>
<td>500,000</td>
<td>5%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>1,494,417</td>
<td>0</td>
<td>1,494,417</td>
<td>16%</td>
</tr>
<tr>
<td>Other Programme</td>
<td>560,476</td>
<td>750,833</td>
<td>1,311,309</td>
<td>14%</td>
</tr>
<tr>
<td>Ambulance</td>
<td>491,000</td>
<td>0</td>
<td>491,000</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Total 2017/18 QIPP Identified by the CCG</strong></td>
<td><strong>10,059,112</strong></td>
<td><strong>(926,112)</strong></td>
<td><strong>9,133,000</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2017/18 QIPP Target</th>
<th>10,153,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unidentified QIPP</td>
<td>1,020,000</td>
</tr>
</tbody>
</table>
**Aim:** To redesign services to enable “Home, not Hospital” through Integrated Care.

- These projects will increase the number of patients cared for within their own homes, or community settings, reducing the reliance on traditional models of Acute care by implementing new pathways and commissioning integrated services.

**Community Geriatrician**

- The Community Geriatrician service will ensure consultant level clinical leadership for frail and vulnerable people within our population who are at risk of hospital admission and require a consultant led comprehensive assessment. The assessment will lead to an individualised plan of care that will enhance patient experience through interventions appropriate to their care needs. The service will be supported through 4 GPs who are training at Keele university to qualify as GP with a specialist interest in frailty. **Implementation date: November 2016**

**End of Life (QIPP Value: £500k)**

- Through CCG leadership and facilitation of South East Essex (End Of Life) network we will deliver a comprehensive work plan that has a range of initiatives aimed at identifying increasing numbers of patients who are 'end of life' and delivering services that ensure they are enabled to die in their preferred place of care. This includes CQUIN initiative, enhancing MDTs, crisis line for last hours of life, strengthening hospice at home, Macmillan GP supporting practice with GSF, and; providing GSF in Care Homes. The plan articulated aligns with the emerging thinking across the success regime. **Implementation date: Implemented**

**Care Home Programme (inc Primary Care Enhanced Service for Care Homes)**

- The CCG will develop comprehensive programme of targeted innovation and improvements within care homes that will aim to reduce number of 999 calls, A&E attendances and NEL admissions. A local enhanced service has been developed and % of care homes have their residents registered with a single GP providing proactive care. **Implementation date: October 2016 – December 2016**

**LTC Management**

- Key areas of focus for self-management for the CCG are: - tailoring interventions to the LTC; for conditions such as diabetes structured patient education may be beneficial, while conditions such as depression may require behavioural interventions; - involving patients in co-creating a personalised self-management action plan, which could include education programmes, medicines management advice and support, telecare and telehealth for self monitoring, psychological interventions and patient access to their own records; - telephone health coaching; - behavioural change programmes to encourage patient lifestyle change; - as the number of people who are unpaid carers for older people is expected to rise, providing support for informal caregiving. **Implementation date: April 2017**

**Falls Prevention Services**

- Identifying those at risk of falls and providing fracture prevention services for older people have been found to reduce hospital admissions and the need for social care such as admission to a care home. This service was slow to establish and become embedded however it has seen an increase in referrals to within 30% of predicted activity & the CCG will ensure we continue to maintain & improve throughput on the commissioned falls prevention service.

- In addition to the schemes the listed above the following ideas are also in scoping to support the delivery of the “home not hospital agenda”. **Implementation date: March 2016.**

**Frailty without complexity:**

- There is a significant cohort of older age patients that are frail and a small change in their circumstances can tip them into complexity. We will develop an integrated approach across statutory and third sector providers to develop a model that facilitates early identification and intervention for this cohort of patients. The model will bring together Police, Fire, befriending, social prescribing, and community services.

**Primary Care Support to Carers:**

- Those caring for others often do so in difficult circumstances and to the detriment of their own health & wellbeing. The Primary Care Support to Carers service will provide a dedicated provision in GP practices to encourage more carers to come forward as carers and therefore able to access appropriate health and care services to support them in their caring role. Implementation Date: Pilot Implemented, Evaluation March 2017.
In February 2015, the Governing Body approved a commissioning case for a care co-ordination service. The service was mobilised as a 12 month pilot commencing on 1 September 2015. The Care Co-ordination service brings together a single fully integrated multi-disciplinary team. It is clinically led (GP lead in each locality) and aims to improve both the delivery & case management of (health and social care) to the most vulnerable population in our population. Core aim is to identify frail patients at risk of decline and assess and plan their care and support to ensure he/she remains healthy and independent (and out of hospital and residential care) for as long as possible.

There service was commissioned with SEPT as lead provider and includes a range of other collaborative providers:

- South Essex Partnership Trust providing the leadership and core Care Co-ordination team;
- GP Healthcare Alliance providing the expert GP leadership including chair of weekly neighbourhood MDTs;
- Dedicated community pharmacy support secured through Medicines Management team, and;
- Age UK providing access to voluntary sector support.
- Social care input has subsequently been included into service model from Essex County Council.
- Mental Health locality leads and now working directly with team.

The service went live on 1 September 2015 and operates within each of the four defined localities within CP&R CCG boundaries, funding locality based MDTs to discuss the most complex cases.

The Care Co-ordination work stream is core to CP&R CCG’s QIPP work programme for 2016/17 with an estimated £1.5m gross QIPP saving attached related to a reduction Non-elective activity.

The Care Co-ordination scheme is seen as fundamental and crucial to our service transformation, forming the foundation for cultural and service change and remaining central to building integrated services in CP&R CCG and the achievement of the CCG’s vision and objectives.

This scheme forms the cornerstone of our aspiration to develop a Multi Community Specialist Provider (MCP) Model across all 4 localities. Project work is underway with lead provider (SEPT) to build this model. 2017/18 will focus on agreeing contractual form, informed by national guidance, with earliest anticipated local MCP contract in place by October 2018/19 at earliest.
Sustainable Acute Care

In 2017/18, CPR CCG, Southend CCG and Southend University Hospital NHS Foundation Trust will focus on three large scale Joint QIPP and Transformation programmes:

• Outpatient Reduction; Diabetes and Ophthalmology.

Outpatient Reduction - Led by Emily Hughes, with speciality clinical and commissioning leads (as noted below) (QIPP VALUE: £876k)

• This overarching project includes focus on demand management, patient pathways into and out of acute care, the use of e-referral (including advice and guidance), reduction in follow up activity and access to diagnostics.

Urology Pathway Review – led by Vicki Maloney with Dr Sunil Gupta (CP&R CCG)

• Implement the new 2 week wait Prostate Cancer pathway - all referrals will have a Specialist Nurse contact patient to organise MRI scan before first appointment which will reduce the need for a follow up or potentially a first appointment.
• Revise the Haematuria pathway and develop another flow chart which will reduce the need for some referrals.
• Treatment plan for GPs to follow up Prostate Cancers where there cancer removed has a negative margin.
• Referrals for Kidney Cysts – Radiologist to be more informative about Ultrasound – e.g. No evidence of malignancy.

Musculoskeletal (MSK) – led by Hannah Wood, with Dr Mike Saad (CP&R CCG) and Dr Brian Houston (S CCG) (QIPP Value: £32k)

• Ensures that all MSK referrals regardless of provider are sent via e-referral to the CATS team. Once referrals have been triaged, patient choice will be offered. The implementation of phase two builds upon the work of initial pilot and ensures that CATS is a sustainable service. There has been a full review of the prescribing pain management pathway which will be finalised and implemented in October 2016. The community carpal tunnel service has been re-procured and new contracts are being issued to the successful providers. The expected outcomes are to reduce clinical variation, improve access to services, reduce outpatient attendances, improve clinical outcomes and patient experience.

Cardiology – led by Lynne Smith, with Dr Biju Kuriakose (CP&R CCG) and Dr Brian Houston (S CCG)

• The project will scope two main areas: Moving the provision of IV diuretics from an acute inpatient setting to either an intermediate/ambulatory facility or provided within the community. Increasing the inclusion criteria of the community heart failure team to include all HF patients (currently just includes those with LVF <45%). The Project will all focus on the reduction in outpatient activity through the requirement of pre-referral tests and the use of the ‘Advice & Guidance’ function on the E-referral Service (ERS). Implementation date: April 2017
Sustainable Acute Care

Dermatology – led by Lauren Edgeley, clinical lead to be confirmed (QIPP Value: £155k)

• To re-design of existing community pathways to improve access to diagnosis, treatment and care within the community for a range of intermediate and chronic skin conditions, and reduce inappropriate referrals into secondary care as well as follow up rates. This project was approved to be developed by the CCG’s Transformation and Sustainability Committee in October 2016, with an objective to procure and implement a community service in 2017/18.

Diagnostics – led by Vicki Maloney, clinical lead to be confirmed

• The aim of this programme is to look at a range of diagnostic tests with a view to reducing secondary care referrals. The project will review existing services to ensure maximum utilisation and identify further diagnostic services for potential direct access, including Brain MRI and CT Respiratory (for specific areas). Additional scoping to be undertaken for potential delivery of 24hr ECG and 24hr Blood pressure monitoring by locality hubs. Pathology services have recently changed at the Trust and the service now works on a bookable appointment system, urgent appointments can be booked on the same day. The aim of the service re-design was to reduce the long waits in the department as it was working on a first come first serve basis. The Trust has confirmed that queues have reduced considerably.

General Surgery – led by Lynne Smith, with Dr Taz Syed (SCCG)

• This project will focus on schemes to reduce outpatient activity (e.g. pre-referral diagnostics; alternative ways for post operative follow-up).  Implementation date: January 2017
Sustainable Acute Care

UROLOGY – led by Vicki Maloney, with Dr Sunil Gupta (CP&R CCG)
• This project will focus on schemes to reduce outpatient activity. This will include review of current pathways including 2ww wait Prostate Cancer and Haematuria pathway and the implementation of the use of the ‘Advice & Guidance’ function on the E-referral Service (ERS). Implementation date: January 2017

RHEUMATOLOGY – led by Hannah Wood, with Dr Mike Saad (CP&R CCG) and Dr Brian Houston (S CCG)
• This project will focus on schemes to reduce outpatient activity. This will include a scheme to change current yearly follow-up practice and the implementation of the use of the ‘Advice & Guidance’ function on the E-referral Service (ERS). Implementation date: February 2017

Diabetes - Led by Emily Hughes/Jayne Mason, with Dr Sami Ozturk (CP&R CCG) and Dr Jose Garcia (Southend CCG) (QIPP Value: £60k)
• The aim of this transformation programme is to deliver a seamless, integrated care pathway providing high quality, responsive diabetes services spanning primary, community and acute care. The new integrated service for diabetes (adults) will formally launch in January 2017. The service will incorporate insulin pump provision, dietetics, podiatry, consultant led outpatient services, specialist nursing, educational programmes for patients, and support and education for primary care and other health professionals. The service will be delivered initially from Valkyrie surgery (Westcliff), Raphael Centre (Rochford) and Tyrells Centre (Benfleet). Over the coming months an additional location in the Shoeburyness area will be introduced.

Ophthalmology - Led by Emily Hughes/Jayne Mason, with Dr Sunil Gupta (CP&R CCG)
• The project focuses on continual transformation of service delivery across South Essex, enabling much greater integration across primary, community and acute ophthalmic care, using emerging technologies and developing new pathways to mobilise alternative services in the community setting. The Clinical Network continues to review and develop integrated care pathways, with the Shared Care Glaucoma service implemented in spring 2016 and paediatric pathways a focus of current review. Increased capacity across the system and thus easier access to high quality services will improve the patient experience and reduce the pressure of demand on local hospital services, whilst creating sustainable and efficient patient pathways for the future.

• In addition the transformation programme has now extended to all Essex CCGs and Hospital Eye Services and an Essex Plan for ophthalmology has been developed that will support the continued shift of activity from hospital settings. The intention is to work together as a health system to use the resources available to us to ensure continued sustainability of quality services.
Continuing HealthCare

Continuing Health Care – Led by Matt Gillam (QIPP Value: £500k)

According to HSCIC data, CP&R CCG has sustained a position of being in the top 20 CCG’s, Nationally, with the highest number of people, per 50,000 population, eligible for CHC.

2013/14 – 73.3 (ave Q1-4)
2014/15 – 86.3 (ave Q1-4)
2015/16 – 93.5 (ave Q1-4)
2016/17 – 128.6 (Q1)

Since being brought in-house in April 2016, the team are currently engaged with transactional work;

• Data cleansing the inherited CHC electronic management system,
• Establishing closer working relationships with Essex County Council to undertake joint assessments with Social Care colleagues.
• Comprehensive Community-based CHC assessments to seek assurance that where NHS funded care is being delivered:
  – The person is eligible for CHC
  – The Care commissioned is cost efficient and appropriate to meet the identified needs
• Review of inherited systems and processes
• Developing team and individual targets, in line with transactional QIPP
• Exploring opportunities to work differently; ‘NHS Funded Discharge to assess’ for DST and Fast Track processes to streamline the delivery to ensure patients remain at the centre of decision making and care delivery

The Team has individual targets in place and report on a weekly basis against their trajectory. The team are working to ensure they work in the most cost effective way and ensure allocation of resources are equitable and reflect the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012 (Revised). They will review the CCG processes to ensure the patient and family receive timely assessments and placements, if eligible. The team will support the Trusts to ensure a reduction is noted in delayed transfers of care relating to CHC eligible patients. As part of this work the CCG will work with providers to support Discharge to Assess and reablement services.

Much of the initial transactional work should complete in April 2017. Current QIPP (£1M) current trajectory delivery 85% FYE.

Further work is currently in progress:

• Collaborative work with ECC to deliver a formal Without Prejudice agreement; to minimise protracted CHC spend where eligibility is no longer indicated.
• Progressing internal systems to minimise delays with decision-making or communication with families or Social Care Colleagues
• Collaboration with other South Essex CCG’s to consider and procure a replacement data management system.
• Identification of personalised staff development, to support them deliver more robust systems and processes.
Medicines Management

There are a number of challenges raised when considering medicines management:

- An average increase in spend each year of 5%. Budget of over £27 million for 2017/18
- Increase in prescription demand as we treat more patients closer to home
- Managing the introduction of new, more expensive medicines across the health economy
- Inefficient processes that have been identified in care homes, GP practices, Southend Hospital and community pharmacies leading to waste
- Ensuring processes are in place so that complex care involving medicines can be safely transferred into primary care
- To address these challenges we need all prescribing to be undertaken in a safe, evidence based and cost-effective manner.

To achieve this we will:

- Use the Right Care reports to identify areas where prescribing is highlighted as differing to our peers with follow up reviews of Mental Health and Dementia, Musculoskeletal, Cardiovascular Disease and Respiratory medicines during Quarter 1.
- Support the locality models by recruiting and identifying current staff members to work within the multidisciplinary locality teams, focussing on reducing polypharmacy and waste.
- By December 2017, develop a strategy that will improve the repeat prescribing process by providing training to practice staff, utilising Electronic Prescribing Systems, improving relationships between pharmacists and GPs and reducing waste.
- Deliver a Prescribing QIPP plan of £1 million across all major therapeutic areas.
- Support practices to recruit clinical pharmacists to work in GP practices in line with the vision put forward by NHS England, Royal College of General Practitioners and Royal Pharmaceutical Society. Once appointed these pharmacists will be supported by the CCG Medicines Management Team. Three locality based pharmacists by 1 April 2017.
- Use our dedicated care home pharmacist and technician to support new providers working with care homes to ensure medication reviews are undertaken and appropriate actions followed up.
- Through strong clinical leadership and using local data, work with 5 GP practices who have high spends and poor outcomes relating to diabetes. Supportive education and training will be rolled out to improve prescribing and outcomes.
- Further reduce antibacterial prescribing (month on month) through use of comparative data, training and education of our clinicians and public campaigns. Focussed on Quarter 3.
- Ensure that shared care arrangements with our local providers (primarily Basildon Hospital and Southend Hospital) are clear, results can be accessed electronically and a safer system is established by Quarter 1.
- Establish an email link for medicines related issues upon discharge with Southend Hospital by Quarter 1.
- Increase communications with GPs via monthly newsletter and data sharing along with face to face visits so that important medicines related issues are shared in a timely way.
- Reducing waste through public campaigns including promoting self-care messages leading to reduced prescribing of over the counter medicines.

QIPP Value: £940k
Medicines Management

Pharmacy Efficiencies

- Local talks regarding the Success Regime are well underway. As a result discussions regarding the pharmacy services provided by the 3 Trusts (Southend, Basildon & Mid Essex hospitals), and how these services should be delivered in the future, have already commenced. Much of what these discussions relate to is infrastructure services and these have been highlighted as a key area of concern by the Carter Report. The pharmacy management team across the 3 sites has been restructured and a joint Chief Pharmacist for the three sites has been appointed, who will supported by a local heads of department. The restructure will enable the departments to work more closely together sharing non clinical functions wherever possible to maximise clinical time in line with Carter recommendations and the proposed Hospital Pharmacy Transformation Plan (HPTP). A single Chief Pharmacist will bring about continuity to the service and enables economies of scale in areas such as homecare, procurement, Advisory services (Medicines Information) Aseptic compounding services for starters, whilst still ensuring that each department is compliant with all necessary medicines legislation.

Service integration will align with the Success Regime/STP strategy. The three departments will draw up a single overarching strategy (with specific local delivery plans) which will be developed in collaboration with the various stakeholders.

Carter Report

- The CCG are working closely with SUHFT and receiving quarterly reports in relation to the Carter Report and hospital pharmacy efficiencies.

Medicines Optimisation

- The CCG expect to deliver £940k of QIPP through medicines optimisation.
- Plans are being developed (ready for March 2017) that will clearly set out work plans for:
  - Practice based work
  - Scriptswitch
  - Care home review
  - New procurement of stoma and appliance products
  - Reducing waste
  - Improving efficiency of repeat prescribing
<table>
<thead>
<tr>
<th>Summary of QIPP Schemes</th>
<th>Implementation RAG</th>
<th>Budget Area</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Reduction and stop</td>
<td>In-Progress</td>
<td>Acute</td>
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</tr>
<tr>
<td>MSK - Pain Management</td>
<td>Implemented</td>
<td>Acute</td>
<td>32,900</td>
</tr>
<tr>
<td>ESD - Integrated Stroke Service</td>
<td>Implemented</td>
<td>Acute</td>
<td>68,924</td>
</tr>
<tr>
<td>Ophthalmology schemes Phase 3 Enhanced community Ophthalmology Scheme</td>
<td>In-Scoping</td>
<td>Acute</td>
<td>49,478</td>
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<tr>
<td>Diabetes</td>
<td>Implemented</td>
<td>Acute</td>
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<tr>
<td>Dermatology</td>
<td>In-Scoping</td>
<td>Acute</td>
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<td>Service Restriction Policy</td>
<td>In-Progress</td>
<td>Acute</td>
<td>192,931</td>
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<tr>
<td>Urgent Care Pathway</td>
<td>In-Progress</td>
<td>Acute</td>
<td>163,394</td>
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<tr>
<td>Care Co-ordination including community geriatrician</td>
<td>Implemented</td>
<td>Acute</td>
<td>825,000</td>
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<tr>
<td>End of Life</td>
<td>In-Progress</td>
<td>Acute</td>
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<tr>
<td>Primary Care Support for Care Homes</td>
<td>In-Progress</td>
<td>Acute</td>
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<tr>
<td>Mental Health Rebasing</td>
<td>Implemented</td>
<td>Mental Health</td>
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</tr>
<tr>
<td>Mental Health - avoided A&amp;E crisis</td>
<td>Not Started</td>
<td>Acute</td>
<td>100,000</td>
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<tr>
<td>Prescribing Programme</td>
<td>In-Scoping</td>
<td>Prescribing</td>
<td>940,000</td>
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<tr>
<td>Continuing Healthcare Programme</td>
<td>In-Scoping</td>
<td>Continuing Healthcare</td>
<td>500,000</td>
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<tr>
<td>Ambulance Rebasin</td>
<td>Implemented</td>
<td>Ambulance</td>
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<tr>
<td>GP Referral Variation - Planned Care</td>
<td>Not Started</td>
<td>Acute</td>
<td>621,000</td>
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<tr>
<td>Mayfield Ward Closure</td>
<td>In-Progress</td>
<td>Mental Health</td>
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<tr>
<td>Other</td>
<td>Not Started</td>
<td>Other Programme</td>
<td>145,476</td>
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<tr>
<td>Investments Already included in Budgets</td>
<td>Implemented</td>
<td>Other Programme</td>
<td>750,833</td>
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<tr>
<td>Management Cost</td>
<td>Not Started</td>
<td>Other Programme</td>
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<tr>
<td><strong>Total QIPP Target</strong></td>
<td></td>
<td></td>
<td><strong>9,133,000</strong></td>
</tr>
<tr>
<td><strong>QIPP Target</strong></td>
<td></td>
<td></td>
<td><strong>10,153,000</strong></td>
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<tr>
<td><strong>Unidentified QIPP Target</strong></td>
<td></td>
<td></td>
<td><strong>1,020,000</strong></td>
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Introduction and Vision
The CCG, as part of the Mid and South Essex Success Regime, are working closely with our partners to develop transformational models of primary care for our local populations within our four localities, in line with our Primary Care Strategy and GP Forward View (GPFV). See also our dedicated plan that encompasses specific areas outlined in GPFV.

Core Elements for our Vision for Primary across our Localities are set out below

Investment Opportunities
The CCG aims to use the investment outlined in the GPFV to transform ‘out of hospital’ care across our four localities through focus on the four key areas detailed in the GPFV. We see investment coming from a range of sources. These include:
- (Central) Package of Investment in Primary Care
- Local Investment
- Sustainability and Transformation Package
- Fairer Distribution of Funding (Carr-Hill Weighting and GMS)
- Tackling Indemnity Costs (central initiative)
- Local Transformation Plans

Local Schemes
The CCG has a number of local schemes either in progress or in scoping and planning stages, these have been plotted against the 4 x GPFV key areas and funding streams that will be made available over the course of the next two years to support delivery and are summarised in the table below.

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Workload &amp; Capacity</th>
</tr>
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<tbody>
<tr>
<td>GP Development Programme – Time to Care – Funding agreed practices identified (03/17)</td>
<td>Time to Care – Action Plan for 10 High Impact Areas</td>
</tr>
<tr>
<td>GP Recruitment - linked with EU scheme to recruit 20 across Essex</td>
<td>Primary Care Support to Care Homes – Mobilised Sept 16</td>
</tr>
<tr>
<td>Clinical Pharmacists – One per locality (03/17)</td>
<td>Care Co-ordination Service</td>
</tr>
<tr>
<td>Training Care Navigators and Medical Assistants (03/17)</td>
<td>Self Care and Long Term Conditions</td>
</tr>
<tr>
<td>Training Reception and Clerical Staff (04/17)</td>
<td>Social Prescribing - mobilised</td>
</tr>
<tr>
<td>Enhancing Workforce – Role redesign</td>
<td>Piloting Local QOF</td>
</tr>
<tr>
<td>Emergency Care Practitioner Role</td>
<td></td>
</tr>
<tr>
<td>Advanced Nurse Practitioner Roles</td>
<td></td>
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<tr>
<td>Mental Health roles inc local IAPT</td>
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</tbody>
</table>

Infrastructure

<table>
<thead>
<tr>
<th>Infrastructure</th>
<th>Care Redesign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Digital Roadmap</td>
<td>Primary Care Overflow Hubs</td>
</tr>
<tr>
<td>Online Consultation</td>
<td>Extending Access to Primary Care – Weekend Hubs</td>
</tr>
<tr>
<td>Wireless &amp; Mobile Working</td>
<td>Neighbourhood Design – Integrated Teams</td>
</tr>
<tr>
<td>Practice WiFi</td>
<td>Contractual Redesign (MCP)</td>
</tr>
<tr>
<td>Text Appointment Reminders</td>
<td>Local Challenge Fund</td>
</tr>
<tr>
<td>Canvey Primary Care Centre – re-provision (ETTF)</td>
<td></td>
</tr>
<tr>
<td>Improvements Benfleet New Build (ETTF)</td>
<td></td>
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</tbody>
</table>

Estates
An audit of primary care estate has highlighted a varied infrastructure which consists of both large and small buildings providing health care services. The buildings are often unused for large parts of the evening, early morning and at the weekends. It is a real opportunity to change the way services are provided by utilising premises to their maximum potential and focus on specific logistic opportunities within local communities. The vision of the CCG is to utilise these premises to support its theme of Hub and Spoke service delivery model. Two ETTF key schemes are underway.
- 1. The CCG will focus on improving the ground floor of the Canvey Primary Care Centre. Plans include transferring diagnostic services, into the community and creating an appropriate working space for the co-location of the Canvey Locality integrated team.
- 2. We will also work closely with our partners to develop an outline business case for the development of a hub site in Benfleet.
Aim: To redesign services to enable Strong Resilience Urgent and Emergency Care

Integrated Urgent Care (IUC)
- The joint acute team across the two CCGs is leading a collaborative project to redesign and procurement of an Integrated Urgent Care service. The IUC service will provide a single entry point for patients with an urgent care need (with the exception of in hours primary care) – through NHS 111 – with secondary assessment, advice, signposting and referral via a clinical hub 24/7, and delivery of urgent primary care during out of hours periods. The Service will be a key component of urgent and emergency care provision across the CCG localities, spanning the STP footprint. The Service will be able to access a system of integrated care services where organisations collaborate to deliver seamless, patient focused care.

Urgent Care Pathway (QIPP Value: £160k)
- 2017/18 will see the continued implementation and embedding of the new Urgent Care Pathway implemented in September 2016 with Southend hospital. The service focusses on redirecting patients that are clinically assessed as not requiring emergency department services into primary, community and self care.

Stroke – led by Emily Hughes/Hannah Wood, with Dr Biju Kuriakose (CPR CCG) and Dr Brian Houston (S CCG) (QIPP Value: £69k)
- The Early Supported Discharge (ESD) service has been commissioned in line with national standard and is being provided jointly by the acute and community providers. The commissioning of this service will ensure that patients are receiving rehabilitation in the most appropriate setting which will improve patient outcomes and experience. The Stroke Clinical Network continues to be focussed on reviewing the whole patient pathway with a key focus initially on prevention and end of life care. There will be a stroke workshop across the success regime footprint to map out what stroke services will look like in the future.

Neuro Rehab – led by Carol Hogg
- Patients with complex neuro rehab needs are currently waiting for prolonged periods in beds at SUHFT for specialist neuro rehab availability at the Homerton hospital and other providers. This is an Essex wide project which will procure local neuro rehab beds and employ a neuro navigator to ensure that the system flows.
Must do 4: Urgent and Emergency Care

Emergency Surgical Ambulatory Care (ESCA) – led by Emily Hughes/Carol Hogg with Dr Roger Gardiner (CPR CCG) and Dr Sharon Hadley (S CCG)

- The aim of this joint project with SUHFT is to redirect the volume of emergency department patients being admitted into the hospital by changing practices for senior specialists to rapidly assess patients before being admitted. Emergency surgical ambulatory care (ESAC) is a way of managing a significant proportion of emergency patients on the same day without admission to a hospital bed at all, or through admission for only a few hours. This service was implemented in May 2016.

Respiratory

- Together with Southend CCG through the System Resilience Group we have brought together several previously disparate strands through a task and finish group to take forward key areas
- Adult respiratory beds to meet demand – review current bed utilisation and acuity thresholds with external reviewer as part of wider bed review programme. Improve communications between ward staff and Community respiratory nursing teams.
- Sufficient paediatric beds to meet demand (7 closed due to lack of nurses) - Nurses have been recently recruited from abroad and beds re-opened together with review of acuity thresholds and development of paediatric admission prevention model such as linking a registrar more closely to the A&E team.
- Delivery of Respiratory CQUINS – Following CQC action plan have worked with Trust to deliver super CQUIN with respiratory in reach to Accident & Emergency.
- GPs referring appropriately to Community Matron and other community services - Dedicated Primary Care communications plan/activity signposting appropriate community pathways and rapid response services. Additional newsletter has gone to all CP&R & Southend practices, practice nurses and managers.
- Improving Inhaler technique - Use of Care Co-ordination pharmacists to strengthen knowledge of inhaler devices in care home settings, together with practice pharmacists in educating clinic staff re techniques. Use of school nurses in supporting school staff education.
- Flu Vaccination – in approach to winter 2017 implementation of flu vaccination programme.
- The outpatient backlog is continually under review by the Clinical Network. There will be a review of patients that have been on the backlog for 18 months or less to see if they are currently being managed in the community by the integrated team and patients will be discharged back to the care of their GP. Patients that still require secondary care input will remain on the follow up list. Patients that have been on the outpatient list for more than 18 months will be discharged back to the care of their GP.
- Encourage pre-referral tests (e.g. Spirometry and the use of the ‘Advice & Guidance function on the E-referral Service.)
Must Do 5: Referral to Treatment Times and Elective Care

Seven Day Secondary Care Services

- CPR CCG is working in partnership with Southend CCG in the South East Essex system and our providers to increase the 7 day service offer where appropriate across acute, community and primary care services. Southend University Hospital Foundation Trust is a national pilot site for seven day services and has programme of work in place in order to deliver seven days services in an acute setting:
  - Improve continuity of care by having the same level of nursing and medical cover over the weekends
  - Earlier treatment for patients will result in enhanced recovery for patients
  - Review of shift handover
  - Review of diagnostics
  - Transfer to community and primary care

- Delivering 7 day primary care services
  - We have a wide range of community services that are already accessible 7 days a week, including recently commissioned Care Co-ordination service which provides access to a fully integrated health and social care system in the community. We have also:
    - Commissioned two weekend primary care hubs open at weekend and bank holidays (operational July 2015) providing a responsive, timely and accessible service that has increased primary care capacity and provided more options for accessing GP every day of the week.
    - We will continue to evaluate activity through these weekend services to assess and inform potential to extend to 4 x hubs in the future
    - Our future design solution for integrated care focuses on model that operates across four distinct primary care localities, aligned to the principles of seven day services, risk stratification, care coordination, active case management, person-centred care and support to self-manage.

Standard: 7 day services in hospital for 100% of the population.
Must do 6: Cancer

- **Overall 2020 Goals**
  - Deliver recommendations of the Independent Cancer Taskforce, including:
    - Significantly improving one-year survival to achieve 75% by 2020 of all cancers combined (up from 69% currently); and
    - Patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP.

- The CCG will continue working with local authority colleagues who have this year rolled out an integrated Lifestyle Service that not only has specialist in smoking cessation to support smokers but will help them make other life enhancing changes when needed. This service will follow people up beyond the traditional 4 week quit to help sustain healthy lifestyle changes.

- In addition the ‘make ever contact count’, detailed previously, will encourage more people to make healthy changes, including stopping smoking, which will decrease their cancer risk.

- Working hand in glove with NHS England we will take all reasonable actions to promote screening programmes among the population and facilitate high quality engagement and involvement of local NHS clinicians.

- Local Actions include: Appointment of Macmillan GP working directly with practices to provide and educate on initiatives that focus on early detection; Supporting national cancer awareness campaigns; introduce two week wait electronic referral using site-specific templates in line with NICE Guidance.

- **Cancer Alliance Formation in the East of England**: CPR CCG will engage directly with newly formed Cancer Alliance. The CCG will work with and support the Alliance to deliver on its core ambitions, including:
  - Deliver the Cancer Strategy
  - Lead on engagement with the wider system
- Lead on regional cancer intelligence
  - Lead on Research and Innovation

- **Diagnosing Cancer Earlier**: CPR CCG will work to see increasing numbers of patients presenting to healthcare professionals at an earlier stage in their disease, by using our Macmillan GP lead to provide support primary care in improving their awareness and ability to diagnose suspected cancer earlier through a range of mechanisms including participation in national awareness campaigns, supporting cancer awareness champions, rolling out electronic decision aids, tailored education based on GP practice profiles, and improving access to diagnostics. Other core measures the CCG will deliver include:

  - The CCG will ensure that our GPs have direct access to key investigative tests for suspected cancer – blood tests, chest x-ray, ultrasound, MRI, CT and endoscopy
  - The CCG will support Southend Hospital aspiration to establish ACE programme, multi-disciplinary diagnostic centre for vague or unclear symptoms. This should have the capability to carry out several tests on the same day.
Must do 6: Cancer

• **Preventing Emergency Admissions**: As above, working with primary care and public to reduce emergency admissions (initially focus on lung cancer) across Essex.

• **Research and Clinical Trials**: We will work with our Alliance to ensure equitable access for patients into clinical trials across the region and the embedding of cancer research in service delivery.

• **Addressing Commissioning and Compliance Issues**: To ensure that Essex cancer patients are following safe, best practice pathways of care. This includes: supporting the designation of single Essex surgical centre for urology, single Haematology diagnostic service for blood cancers, and – single Essex MDT specialist surgical pathway for anal cancer.

• **Cancer Waiting Times**: CPR CCG will work with acute providers to ensure delivery of the NHS Constitution standards for Cancer Waiting Times including the increasingly challenging ‘62 day from Urgent referral to treatment’. This includes delivery of local action plans and addressing challenging site-specific pathway challenging specialties such as urology and lung.

• **Survivorship**: CPR CCG will work with local providers, network site specific groups and local GPs to reduce the number of patients receiving hospital-based follow up care to just those with complex needs, with the remainder being supported with their follow up care out in the community.

• **Recovery Package**: The CCG will work with providers through contracts to ensure patients able to access the RP interventions, including: all patients have a holistic needs assessment and care plan at the point of diagnosis and at the end of treatment; a treatment summary is sent to the patient’s GP at the end of treatment; a cancer care review is completed by the GP within six months of a cancer diagnosis, and; patients have access to information and support that helps them to self-manage and seek help, locally this is support by local Macmillan Information Centre.

• **Transforming Care in the Community**: To prevent unnecessary readmissions to hospital CPR CCG will work with providers to ensure we have community CNSs in place, working alongside community matrons/care co-ordinators as part of an integrated pathway of care between all teams and services, and acting as community-based key workers for patients once they have finished their acute cancer treatment.

• **Psychological Services**: To ensure equitable, timely access to evidence based psychological therapies and ensure more people are able to access them. CPR CCG will make the links between locally commissioned IAPT services and cancer care.

• **End of Life Care**: To give nursing staff in care and nursing homes the skills and confidence to care for patients in their last months, weeks and days of life. To increase the numbers of patients dying at home (their normal place of residence). This will form part of a range of initiatives led by CPR CCG, throughout facilitation and leadership of the South East Essex (End of Life) Locality Group, aimed at increasing the number of patients supported to die in their Preferred Place of Care.
Must do 7: Mental Health

Mental Health (MH) – Access Standards, Parity of Esteem and Personalisation

The Five Year Forward View for Mental Health forms a key element of the plans for 2017/18. 2017/18 sees a number of areas of work being driven on an Essex wide footprint. The Castle Point and Rochford CCG Operational Plan for 2017/18 focuses on five core priorities for MH. These include:

Delivering access standards;
• Working within Essex towards the delivery of a 24/7 crisis care system in 2021
• Embedding Parity of Esteem initiatives
• Embedding the South East Essex Recovery College within the treatment system and ensuring its strong alignment within primary care transformation
• Transforming the mental health system at an Essex wide level including the delivery of the Essex Wide mental health strategy
• Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against the 2017/18 baseline

Access Standards

The 15% access target for IAPT and the 67% dementia diagnosis target have proved a significant challenge for CPR CCG in 2016/17. 2017/18 sees the access target increase to 16.8%. For IAPT, we are now looking at redesign of the IAPT model and pathway, which can deliver the increased rate. The new model must reduce and maintain low waits for second and subsequent treatment and deliver a recovery rate target in excess of 50%. It has been hard to maintain the significant progress achieved in 2015/16 where we finished the year just over 60%. Action plans have been refreshed and are in place to achieve and maintain a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia for CPR.

Advance planning is in place to ensure we achieve and maintain the two new mental health access standards. This includes:

Early Intervention Psychosis – ensuring that more than 50% of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral. Targets are currently met. Joint commissioner and provider work is underway to agree and plan for changes to resource, skill mix and interventions required to meet expected additional demand and interventions as a result of extended eligibility criteria.
Improving Access to Psychological Therapies

75% of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95% treated within 18 weeks. Recovery plans are included in Appendix 3.

The past few years have seen a change at local and national levels in relation to the attention given to Mental Health and the understanding that a society with robust health and wellbeing must have robust mental wellbeing as well as strong physical health underpinning it. This aspect of considering the importance of mental health alongside physical health is captured through the national Parity of Esteem (POE) agenda.

Various workstreams are underway to further POE including:

- Crisis Care - Improved responses to those that present with a mental health crisis (Work to be completed by 1st April 2017)
- RAID – Sustainability of model in South east Essex (In place)
- Access Targets - Introduction of waiting time standards for Early intervention in Psychosis (EIP) and Increasing Access to Psychological Therapies (IAPT) Investment agreed on both and in place by 1st April 2017;
- Access to Childrens MH, including Autism Spectrum Disorder assessments. Commission unique service by 1st April 2017
- All people with low-level mental health need (clusters 1-3) to be principally cared for by their GP as their Named Accountable Professional. Longer term transformational piece – by 1st April 2018
- Community mental health teams to form part of primary care multi-disciplinary teams 1st April 2018
- IAPT services to be integrated into primary care based health teams, increasing the focus and support to people with long-term conditions. 1st April 2018
- Psycho- geriatricians and older people community mental health teams to be integrated into the new care of the elderly community teams. 1st Feb 2017
- Introduce specified pathway of health prevention work with individuals who suffer from a mental health problem (e.g. obesity / alcohol). 1st April 2018

South East Essex Recovery College

This year has seen the implementation of the South East Essex Recovery College. It is anticipated that the Recovery College will delivery strong transformational impact in South East Essex as stakeholder from the 3rd sector, secondary care mental health and those with lived experience work together in the new co-produced venture. The Recovery College is seen as a key tool in helping to achieve the ambition of reducing the secondary care caseload by 40% as stated in the Mental Health Strategic review. In place.
Reduction in Suicide Rates

**Standard:** Reduce suicide rates by 10% against 2016/17 baseline.

The Suicide rates for our local population have increased over the last 3 years and are currently above the England average.

**Actions being taken by the CCG to support suicide prevention:**

Working with public Health colleagues at Essex County Council Public Health who are co-ordinating a prevention strategy for Greater Essex. We will:

- Support the Trust who has identified within the Sign Up to Safety Campaign, 7 key areas with one area being identified as reduction of suicide. Monitored through the quarterly quality report.
- Review of Serious Incidents from the Trust all new themes and trends identified and lessons learned.
- 24/7 crisis care review for Greater Essex underway. The review of all crisis services should ensure that those in need of crisis care should be able to identify support in either the community or secondary care setting to reduce risk of harm.
- Working with the Police to support the Street Triage car to identify those at risk of S136 detentions and potential admissions due to suicidal risk or need for treatment options to diminish risk.
- Commissioning of IAPT services and RAID provision in line with best practice to give early support to those in need of mental health services.

### Suicide: age-standardised rate per 100,000 population (3 year average) (Persons)

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<th>Period</th>
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<tr>
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Source: ONS special request
Mental Health Taskforce

The CCG is now in receipt of the Five Year Forward View for Mental Health for the NHS in England. This national strategy, which covers care and support for all ages, was published in February 2016 and signifies a strategic approach to improving mental health outcomes across the health and care system, in partnership with the health arm’s length bodies.

The CCG is committed to adopting the core recommendations within local delivery plans. This includes:

Delivering ‘Future in Mind’ and key recommendations to improving children’s mental health

• Delivering on current and new access targets and care pathways for mental health
• Improving Perinatal mental Health Care
• Improving Access to IAPT for patients with Long Term Conditions
• Working in partnership with Essex to deliver high quality employment support
• Delivering the access targets and NICE standards for Early Intervention Psychosis
• Improving Crisis Care including working towards 24/7
• Access to acute liaison services – RAID
• Secure Care Pathway (in partnership with specialist commissioning)
• Using and Sharing Data in mental Health
• Learning from Mental Health Vanguards
• Physical Health Outcomes for patients with mental Health
• Delivering Specialist services for older mental health
• Focus on co-production and Recovery College development
• Focus on Mental Health Prevention
• Learning from suicides and reducing numbers - The commitment is ‘Zero Suicide’ guided by a suicide prevention strategy from 2017

A&E Mental Health Task and Finish Group and developing a 24/7 Crisis Care response

A sub-group has been formed by the System Resilience Group. The A&E Mental Health Task and Finish Group the group has made further progress following it inception in 2015/16. It has seen the continuation of the Mental Health Suite and the RAID service. It has also focused its attention on key operational issues that require strong partnership approaches and solutions. Examples have included the review of AMHP provision across Essex and the embedding of a mini-RCA system for reviewing incidents, where systems issues have adversely affected the care a patient with presenting with a mental health crisis has received. This year has also seen more coordination between the task group and the work that is taking place at an Essex wide level.

Standard: 50% of people experiencing first episode of psychosis to access treatment within 2 weeks and 75% of people with relevant conditions to access talking therapies in 6 weeks; 95% in 18 weeks.
Essex Mental Health Strategy

2016/17 has seen a greater focus on commissioning and transformation at an Essex Wide level. The Five Year Forward View for Mental Health and the Essex Wide review have both indicated clear areas where joint efforts can deliver greater impact at scale.

Essex commissioners commit to the following principles for future delivery:

• to develop a joint working arrangement across health and social care to reduce fragmentation of commissioning and improve working with providers (April 2017)

• to define what we mean by integrated services in each locality and provide clarity to providers on how we see our mental health services being commissioned in the future (April 2018)

• to develop an Essex wide strategy for mental health which defines clear patient outcomes; and to implement this strategy through the commissioning of outcome based services (April 2018)

• Services will be evidence based, and the local need for services will be clearly quantified based on available data.

• The recommended actions will be delivered over a 5 year time scale which will include the procurement of new services to ensure services deliver the outcomes required.

• The draft commissioning path in the Essex Mental Health Review has set a clear direction of travel that up to 40% patients currently treated in secondary care services would in 3-5 years’ time have their needs met in primary care mental health services. This will extend beyond people with low-moderate levels of anxiety and depression to include people with psychosis whose needs are low, and people with dementia. (by 2019 – 2022)

Adult Mental Health – Inpatient Services and Out of Area Placements

Locally we have a very low level of adult acute mental health out of area placements. We do however, have a small number of instances where patients have needed out of area placements to psychiatric intensive care units (PICU). We are developing plans to address this within Essex in line with our new mental health strategy. This will include using RightCare methodologies to assess variability in patterns of admission and lengths of stay within SEPT and between SEPT and the specialist mental health Trusts in our RightCare comparator CCGs.

Moving away from pure Block Contracts - A key piece of work that commenced in 2015/16 and related to introduction of new contracting currency that moves away from block to cost per case. Is continuing to evolve. Through the work that has been done there is now a much more developed understanding of what the care cluster data means and how it might influence outcome contracting in 2017/18.
The recent JSNA on Dementia found that Essex is currently not meeting all of the Prime Minister’s Challenge key aspirations, which now form part of the priorities for action for Essex and will assist in setting targets.

- Essex diagnosis rate for registered population with Dementia is below the national average (59.17%). CPR CCG has improved diagnosis rate dramatically over last 12 months and currently is just below 60% falling short of the 67% target.

Dementia – Our Approach

- Through our established Care Coordination model we have developed an integrated approach and team for risk stratification, and planning and case managing dementia. Over 2017/18 we will work with key stakeholders to continue to ensure that we have a higher level of local service to support people with dementia in their own homes and avoid the need for residential care.

In 2017/18 we will:

- Work with South Essex Partnership Trust to ensure sufficient access and capacity in our specialist memory assessment service clinics (1/4/16);
- Ensure sufficient capacity and access to Dementia Community services and Dementia Intensive Support Team (1/4/17);
- Ensure the provision of dedicated CHC Nursing Homes beds for the management of dementia patients with challenging behaviour (11/1/17);
- Continue to support individual GP practices where diagnosis rates are falling below target (ongoing).

The Prime Minister’s challenge on dementia 2020, sets out a number of key aspirations that the government would like to see implemented by 2020. These aspirations are included for the CCG and include:

- Appointing a lead GP for dementia (Dr Sunil Gupta) to oversee local deliver plans for dementia. In place
- Supporting Essex public health programme to improve public awareness and understanding of the factors which increase the risk of developing dementia and how people can reduce their risk by living more healthily. Underway
- Working with lead provider deliver 6 week standard for an initial assessment following a referral from a GP. in place.
- Using our established Care Coordination service ensure GPs are playing a leading role in ensuring co-ordination and continuity of care for people with dementia. in place.
- Ensuring that every person diagnosed with dementia has meaningful care following their diagnosis which supports them and those around them in accordance with National Institute for Health and Care Excellence (NICE) quality standards (in contract).
- Ensuring all NHS staff have received training on dementia appropriate to their role (embedded in contract requirements).
- All hospitals and care homes meeting agreed criteria to becoming a dementia friendly health and care setting (embedding in contract requirements)
- Ensuring our CCG contributes to the Alzheimer’s Society target to deliver an additional 3 million Dementia Friends in England, and encouraging our lead providers to do the same.
- Going forward with our plans for transforming primary care and the development of neighbourhood ‘hubs’ provides an opportunity to consider optimum dementia models for CPR CCG. We will do this by considering the models advocated by NHS England for dementia assessment and diagnosis. 1st April 2016.
Learning Disability (LD) – Transforming Care

The national programme defines the areas of transformation as above and has set and is assuring performance against the targets for the numbers of in-patients. *Building the Right Support* in October 2015, re-iterated that the approach should be to implement the national service model which provides the blueprint for a transformed service that will meet the short-comings in the current system. In short, the scope of the Transforming Care Partnership is the implementation of the national service model and to deliver the outcomes specified in Building the Right Support.

The overarching purpose of the Transforming Care Partnership Board is to implement an Essex wide programme of work. The purpose of the project is to re-design the pathways and commission / define the necessary services to transform outcomes for adult with learning disabilities. There are a range of changes that the project expects to deliver, including pathway re-design for adult service users where they have a range of interfaces between different service areas, re-procurement of specialist Learning Disability health resources and definition of areas for further improvements – notably the interfaces with mental health and children’s services, including Autism and alignment with local need.

The national programme has defined expectations that all Transforming Care Partnership Boards are required to review the framework and model for Childrens Learning Disability services. This work is in the early stages across Essex, but further work is expected in year as the wider stakeholder network is engaged in delivering the outlined priorities for Children and Young People with a Learning disability.
Inpatient bed numbers trajectories

• The Partnership signed up to a bed closure trajectory that would meet the mandated targets over the three years.

• This is a Partnership target with no calculation or expectation that these targets are translated down to CCG level.

• Therefore the performance of each CCG contributes to how the Partnership is measured overall.

• The original trajectories submitted have been slightly amended in discussions with NHS England – which has been a national process. The trajectories now provide a little more leeway in 2016/17 – mainly because the TCP has 3 new patients identified in Specialist Commissioning beds since April.
IMPROVING ACCESS TO HEALTHCARE FOR LEARNING DISABILITY PATIENTS

• During 20-16/17 the CCG have been working with our G.P.s to encourage the facilitation of Health Checks and Health Action Plans.

• Following an AQP procurement an additional process was implemented in 2016/17 by the GP Federation to enhance the availability of Health Checks to our Learning Disability population by direct delivery of the Annual Health Checks and formulation of Annual Health Action Plans.

Plans to deliver 75% of Annual Health Checks by 2020 include:
• A real time evaluation of the AQP contract that is currently in operation and is commissioned until December 2018 will be undertaken by the CCG. This will inform further commissioning of appropriate services.
• Consideration of a financial penalty within the co-commissioning arrangements for the non-delivery of the required service to support equal access for patients with a Learning Disability on each GP Learning Disability Register where there has been no evidenced on active endeavours to engage the patient and the family in completing an annual health check.
Reduce premature mortality by improving health services, education and training staff, and by making necessary reasonable adjustments for people with LD and/or autism

• Within commissioning intentions for acute, mental health and community contracts a recommendation to include reasonable adjustments and training for staff is included.
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<td>3) Integrated Commissioning, increased personalisation and PbP / PbPs</td>
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<td>Personal Budgets and Personal Health Budgets</td>
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<td>4) Market Management, workforce development</td>
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<td>6) Data Capture, demand modelling and measurement of success</td>
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<td>7) Governance</td>
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<td>8) Key Meetings: Board/Regional/Regional and Events</td>
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Create the Safest, Highest Quality Health and Care Services

Care Quality Commission (CQC) Visit – Southend University Hospital NHS Foundation Trust

Southend University Hospital NHS Foundation Trust underwent a CQC inspection in January 2016, the report was published in August and rates the Trust as “requiring improvement”.

Area of outstanding and good practice were noted.

Key findings showed:

• Issues relating to staffing; both ratios and morale, although staff went the extra mile for patients and demonstrated caring and compassionate attitudes. Action plan takes a risk-based approach to increasing staffing through an accelerated recruitment plan, in line with the safer staffing model and working towards the reduction of agency staff, improved rostering systems and increased clinical productivity. There will also be a dependency assessment of patients to staffing ratios and a plan to recover the trust position on non-elective and elective care. The Trust awaits the rating from the CQC. The CCG and system partners will progress the agreed plan until the report is received.

• High numbers of elective surgery cancellations creating alert status, capacity and congestion within the hospital.

• Good patient outcomes were evidenced; in particular the stroke service.


• Cleaning undertaken by nurses and technicians for November and December 2015 of high risk equipment was 95% and 97% compliance rates. There were no MRSA cases reported and lower than the England average rates of C.Diff.

• Mortality and morbidity meetings took place but lacked structure, learning and lacked timescales.

• We saw several areas of outstanding practice including:
  – The emergency department
  – Stroke service
  – Early Rehabilitation and Nursing team
  – Calls for Concern service,
  – The learning tool in place within Radiology
  – Mystery Shopper scheme
CQC Visit – South Essex Partnership University NHS Foundation Trust
During the last CQC visit in 2015, the CQC rated South Essex Partnership University NHS Foundation Trust as ‘good’ overall. Full details can be found in last year’s operational plan.

- The Trust has action plans in place to address the areas raised of concern by the CQC and the CCG continues to monitor performance against these through formal contract meetings.
- Reducing deaths related to health care. Part of the learning culture in Castle Point and Rochford is sharing of learning from serious incidents at the quarterly “no harms event”. Providers report monthly on avoidable/unexpected deaths and are monitored through Clinical Quality Review Group and the Serious Incident reporting process.
- Mortality rates whether pertaining to specialist areas, avoidable deaths or the Summary Hospital-level Mortality Indicator (SHMI) are reviewed and analysed within the committee.
- Serious incidents that relate to avoidable deaths are also reviewed for provider services.

Patient Experience
Experience of care, clinical effectiveness and patient safety together make the three key components of quality in the NHS. Good care is linked to positive outcomes for the patient and is also associated with high levels of staff satisfaction. The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. The CCG is actively working with all provider organisations including General Practice to ensure that feedback is monitored, measured and acted upon by providers.

An integral component of our infrastructure for quality is the Quality and Governance Committee, a formal sub-committee of our Governing Body. This Committee has the role of assuring the Governing Body of the quality and safety of all health interventions that we commission. The Committee is the formal mechanism by which the CCG discharges its responsibilities for clinical quality and sets the strategic direction for clinical governance.

The remit of the committee is to:

- Provide oversight and give assurance to the Governing Body that the patient and patient feedback is kept at the centre of all decision making
- Assure the quality and safety of the services commissioned
- To promote continuous improvement, learning and innovation with respect to, clinical effectiveness, safety of services and patient experience
- The CCG is currently underway to explore opportunities to increase the uptake of CHC PHBs.
- The CCG monitors providers to provide assurance that the service are having discussions with patients to identify and support their preferred place to die.

Standard: Increase the number of people recommending services in the FFT.
Reduction in Avoidable Deaths

• The NHS is expected to treat patients in a safe environment and protect them from avoidable harm. Patient safety issues are the avoidable errors in healthcare that can cause harm to patients. Harm in this context means injury, suffering, disability or death.

• Recognising the potential for clinical situations that indicate a patient is seriously unwell and requires intervention moreover providing preventative measures for those residents of Castle Point and Rochford who are at high risk; such as those with learning disabilities, is a key priority. The CCG will ensure services work to reduce premature mortality by improving access to health services, education and training of staff and by making necessary adjustments for people with a learning disability and/or autism. This will be undertaken via contracting, monitored via CQRG and other indicators such as complaints, family feedback and patient experience.

• The CCG actively assures itself through contract monitoring, quality visits and patient feedback that the areas below are being effectively monitored by its in-house Quality Team led by the Chief Nurse.

• Achieve a significant reduction in avoidable deaths, with all trusts to have seen measurable reduction from their baseline on the basis of annual measurements.

• Achieve increase in recognition and response of deteriorating patient to put appropriate measures in place to support the patient.

• Support NHS Improvement to significantly increase the number of trusts rated outstanding or good, including significantly reducing the length of time trusts remain in special measures.

• Support the NHS to be the world’s largest learning organisation with a new culture of learning from clinical mistakes, including improving the number of staff who feel their organisation acts on concerns raised by clinical staff or patients.

• Internal and external measures of quality: two areas of focus are Sepsis and Acute Kidney Injury,

• There are no NHS Trusts in special measures following CQC Inspections. One Trust has the rating of good.

• The Quality team maintain support to the Trusts and via quality assurance visits review the areas highlighted from inspections but also review other areas are maintaining standards. This will continue to be undertaken by reviewing performance and quality indicators and triangulating these against announced and unannounced quality assurance visits and feedback from patients, carers and relatives.
Diabetes

• Through the established Diabetes Network for South East Essex, the CCG have been working with partners to develop and implement an Action Plan for Diabetes Prevention. The prevalence of Type 2 diabetes is rapidly increasing both, nationally and locally. Nationally, over 60% of the adult population is overweight and local figures in Castle Point and Rochford show that 27% and 28.1% respectively of the adult population are considered to be obese. Childhood obesity is also impacting on these national figures and this increase is noted in local childhood figures too.

• The CCG is already working with local Public Health partners to support individuals who wish to improve their health through making healthy dietary choices and to take more exercise, in a bid to reduce their individual risk of developing in diabetes.

• Brief interventions are provided in General Practice environments to those actively requesting support but the CCG acknowledges the need to transform this support into more community delivered initiatives utilising centres of delivery such as Community Centres and children’s centres.

• In line with national NHSE commitment, the South East Essex Diabetes Network have developed a plan for local roll-out of the diabetes prevention programme.

• NHS CP&R CCG launched an integrated diabetes pathway in September 2016 but for this pathway to adequately meet the needs of the diagnosed cohort of patients, a preventative model needs to be developed locally with Public Health Colleagues to reduce the numbers of those developing Type 2 diabetes in the first instance.

Enrolling people at Risk in the Diabetes Prevention Programme

• The CCG and its partners in the Essex project have been awarded funding to roll out the Diabetes Prevention Programme over the next two years.

• The NHS Diabetes Prevention Programme set out the ambition to implement at scale a national evidence-based diabetes prevention programme modelled on proven UK and international models, and linked where appropriate to the NHS Health Check.

Its aims are:

• to reduce the incidence of type 2 diabetes;

• to reduce the incidence of complications associated with diabetes - heart, stroke, kidney, eye and foot problems related to diabetes; and

• over the longer term, to reduce health inequalities associated with incidence of diabetes.

• The service went live in Essex in October 2016. We plan, through case finding, to have referred more than 400 patients per year to the programme by 2018.
Diabetes Integrated Community Service

Tier 4
Hospital
Inpatient
& specialist Care
for diabetic patients

Tier 3 – Integrated Service
MDT format - Consultant, Dietitian, Podiatrist and Diabetes Specialist Nurse led care and education provided in a community setting for diabetic patients with more complex needs. Primary Care education and engagement

Tier 2 – Integrated Service
Clinical Triage by Diabetes Nurse Specialists
Enhanced Diabetes care delivered by Diabetes Nurse Specialists & Allied Health Professionals
Insulin conversion and Insulin Pump Management

Exclusions which require Tier 4 Referral:
diabetes in pregnancy (including pregnancy planning advice & post-partum care)
diabetic foot disease requiring multi-disciplinary care
* diabetes in renal disease (stage 4/5 CKD and diabetic nephropathy)
* paediatric & adolescent care and complex (e.g. brittle) diabetes – transition joint clinics

Tier 1 – Primary Care
Diabetes prevention/targeted screening: Essential care (based on QoF and contractual requirements) and basic diabetic care for type 1 non-complex and type 2 patients delivered by general practice in primary care
Domestic Violence and Abuse

- Domestic abuse impacts on quality of life and can ultimately destroy people’s lives. Despite being a significant contributor to crime statistics it is also a pattern of behaviour that often happens behind closed doors and is grossly under-reported. It is an issue that cuts across all social, geographical and cultural groups. Domestic abuse causes harm to both adults and children, both directly and indirectly, and is of high financial cost to public agencies, the economy, the individuals concerned and wider society. Furthermore it produces pattern of behaviour that are often replicated from generation to generation and these inter-generational cycles must be broken. In the past year in Essex, there were over 35,000 victims of domestic abuse living with more than 16,000 children.

- The health service is in a unique position to help people who suffer domestic abuse get the support they need. Virtually every victim uses the healthcare system at some point. Identification of victims by health partners, with subsequent management and support, will have a system wide impact. The quality of life and the health and well-being for our families will be transformed.

- In 2015 the Greater Essex Joint Commissioning Strategy for Domestic Abuse (DA) was approved by the Essex Domestic Abuse Strategic Board on behalf of partner agencies operating across Essex, Thurrock and Southend.

- The vision for Essex - Everyone in Essex lives a life free from Domestic Abuse. The Strategy aims to assist partnerships and agencies across Essex in delivering appropriate joined up responses to those affected by domestic abuse; underpinned by a recognition and an understanding that no single agency can address this complex issue in isolation. The strategy will ensure that by working together partners can make the best use of existing collective resources, and draw upon additional resources, to address the issue of domestic abuse.

Prevent Agenda

The Prevent strategy, published by the Government in 2011, is part of the overall counter-terrorism strategy, CONTEST. The aim of the Prevent strategy is to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism, Prevent will be a focus of key performance indicators within provider contracts for 2017/18 and 2018/19 and the CCG will support and develop GP practices with their training programme.
Safeguarding

The following measures remain in place to ensure that safeguarding and promoting the welfare of children and adults is given priority and is discharged effectively across the whole local health community:

• Our Accountable Officer and Chief Nurse hold the Governing Body responsibility for ensuring that we have safe systems in place for discharging its safeguarding responsibilities.
• Our Quality and Governance committee receives a six monthly report including and annual report on safeguarding issues for children and any exceptional issues are escalated to the Governing Body.
• Executive level CCG membership of Essex Safeguarding Children Board Health Executive Forum ensures that safeguarding is at the forefront of service planning.
• Our Accountable Officer is a member of the Health and Wellbeing Board.
• We work in close collaboration with Essex County Council to assess and ensure the provision of coordinated integrated services to meet the needs of the local population, including specialist services for vulnerable groups and looked after children.
• We ensure that providers’ safeguarding children strategies and associated policies are in place.
• We ensure that providers of services are held to account through regular review of safeguarding arrangements through quality scrutiny processes.
• Designated nurses and doctors offer professional expertise and advice regarding safeguarding matters.
• As part of our primary care development offer, we commission safeguarding training for our GP member practices.

Embedding Safeguarding within Primary Care

• In 2016 the CCG secured a Named GP to support the safeguarding children and LAC agenda in Primary Care alongside the Designate and Associate Designate Nurse. The plan for 2017/18 will be supporting primary care to ensure that robust safeguarding arrangements remain in place, neglect and abuse is recognised and responded to and that information is shared with other agencies to safeguarding children.

• The CCG will develop face to face safeguarding adult training in line with current safeguarding children levels which includes Prevent, domestic abuse, modern day slavery and female genital mutilation. It will also to align closely to safeguarding children.
Safeguarding Children

• The Children Act (2004) makes the safeguarding of children a statutory responsibility for all NHS organisations. We have a duty to ensure that we make arrangements to safeguard and promote the welfare of children and young people that reflect the needs of the children in Castle Point & Rochford.

• To comply with national safeguarding requirements, we ensure that safeguarding is reflected within all partnership agreements. NHS Standard Contracts require providers to comply with the local Commissioner’s Safeguarding Policies.

Safeguarding Clinical Network

• The Designate, Associate and Named Safeguarding and Looked after Children (LAC) professionals, and Chief Nurse work in collaboration with the seven Essex CCGs in the Safeguarding Clinical Network on areas of mutual interest. This to promote the safeguarding children and LAC agenda across health services in Essex and avoid duplication of work.

Essex Safeguarding Children Board (ESCB)

• The CCG is an active participant in the work of ESCB and from 2016 CP&R CCG Accountable Officer and Chief Nurse took over the lead responsibility to represent 5 CCGs located within the Essex Local Authority area for health executives and chair the Health Executive Forum. Membership of ESCB sub group is shared responsibility with the other CCGs.

• The Designate, Associate and Named Safeguarding and Looked after Children (LAC) professionals support the LSCB key priorities in protecting children and young people from neglect and abuse which includes:
  – the impact of adult mental ill health on children
  – Child Sexual Exploitation
  – Female Genital Mutilation
  – Forced marriage and other forms of so called honour based abuse
  – the impact of domestic abuse on children
  – Modern Slavery and trafficking
Maternity Services

• The outcome of the National Maternity Review has been published and will inform the actions required to deliver safe and sustainable maternity services locally. The Mid and South Essex STP footprint has submitted Expression of Interest to become ‘early adopter’ to fast track key recommendations.

• Women’s experiences of maternity services based on the 2015 CQC National Maternity Services Survey will contribute to the CCG’s plan to develop our local Maternity Dashboard which will result in the collection of data including access to care, choice within the maternity pathways and postnatal care to demonstrate positive outcomes for women and babies.

• Collaboration with our Local Maternity Liaison Committee, membership of which includes parents, GPs, Hospital professionals, Community Midwives, specialist midwives e.g. peri-natal mental health professionals, commissioners and Health Visitors, will capture parent views and feedback in the planning and implementation of service redesign in the context of the Maternity Review.

Overall Goal: Reduce the rate of stillbirths, neonatal and maternal deaths and brain injuries caused during or soon after birth by 50% by 2030 with a measurable reduction by 2020.
Children’s Services

Autism Spectrum Disorder

• The CCG is committed to developing and substantive Autism Spectrum Disorder service that is tailored to our local need, recognising the challenges and existing pathways which will need to be considered.

• A decision to invest in Autism Spectrum Disorder (ASD) services through parity of esteem monies has been agreed, with an aim to implement an assessment service for 2016/17. However, procurement was unsuccessful. Interim arrangements in place and business case to be consider in November to secure sustainable long term service provision.

0-19 Pathway – Essex-wide procurement

• The CCG supports the development of transformation to Community Paediatric Services for our population of children, young people and families. The vision is to transform our existing (often described ‘fragmented’) children’s services into a whole system integrated approach to deliver a joined-up children’s community service model.

• This would mean a single children’s community service provider in CP&R locality across health and social care. It is recognised that the benefit for integrating specialist health services with Essex County Council, Public Health pre-birth 19yrs services works across the whole system to drive delivery and achieve holistic outcomes for children, young people and families.

The final evaluation of bids for the Universal Pre-Birth – 19 service commences the week of 17 October 2016 and concludes on 1 November 2016. Contract award notices will be issued at the beginning of December 2016. After which the CCG will plan to present findings and recommendations to support the case for integration.

Childhood obesity

• Working in an integrated approach with partners the CCG will continue its efforts to stem and reverse the increase of children who are overweight and obese. This involves a multifaceted approach, any individual aspect of which will be inadequate but collectively they amount to systematic, co-orientated action. The CCG will work with partners to support a physical environment that supports an active lifestyle, reduces access to unhealthy foods near to schools. Working with partners we will promote healthy eating and activity and the provision of specific support for those children identified as obese.
Children’s Mental Health

- CCG recognise key requirement commission high quality mental health services for CYP so that at “at least 32% of children with a diagnosable condition are able to access evidence based services by April 2019, including all areas being part of CYP IAPT by 2018” (In place)
- CPR CCG have been directly involved in the transfer of Children’s Emotional Health and Well Being (EMHWB) Services to new provider (North East London Foundation Trust) for Essex. The new provider has been operational since November 2015 hosted by West Essex CCG. We are working in partnership with West Essex, through Essex delivery board, to oversee and deliver the Essex transformation plans for children and young people mental health. This includes actions to improve prevention and early intervention activity and deliver the national commitment roll out children and young people’s IAPT programme by 2018.
- We will work with partners to build effective, evidence-based outcome-focused EMHWB services, working in collaboration with children, young people and families. Delivering the national ambition requires local, system wide leadership and ownership, as well as the participation of children, young people and their families. We believe the operational infrastructure is in place to deliver this.
- NHS England is developing a major service transformation programme to significantly re-shape the way services for children and young people with mental health needs across Essex are commissioned and delivered across all agencies over the next five years in line with proposals put forward in ‘Future in Mind’.

The CCG will work with partners through the board to support this programme, this includes:
- To maintain improvements made over the last few years in supporting children, young people and those who care for them to be more fully involved in their care and in the development and feedback to services.
- To develop integrated services with clear care pathways from early intervention to crisis and inpatient care.
- To develop the infrastructure to deliver services that can demonstrate outputs and outcomes, including waiting and access times.
- Work with Health Education England to support workforce planning.
- Work with other partners across the system to implement the agreed outcomes from the Mental Health Taskforce and Future in Mind.
- Working in partnership with children and young people and families will remains an essential element of our work within the CCG.
- Commission community eating disorder teams so that 95% of CYP receive treatment within 4 weeks of referral for routine cases and 1 week for urgent cases.
Care Homes

The CCG has progressed on two significant work streams that link to Care Homes: 1. Provision of Care Homes Beds 2. Primary Care Support and Quality in Care Homes

1. Bed Provision Work stream
Like many areas there is a shortage of residential and nursing home beds available to NHS patients locally.

The key issues are:

- The shortage of residential care beds in the community has increased recently.
- Competition within the low income market has driven a staffing shortage locally within care homes and domiciliary providers.
- Geographical spread of the locality reduces the appetite of care agencies to provide staff to homes on the outskirts of the locality.

The CCG are progressing plans in place to:

- Working directly with providers to develop a bedded community intermediate care/Reablement facility. This includes review of NHS void estate for potential care facilities and existing facilities.
- Domiciliary Discharge to Assess pilot commenced in May 2016 and funded through Continuing Health Care funds.
- Implementation of the new Reablement contract: The contract increases the range and capacity of the Reablement service picking up more people with a greater level of complexity, to increase the number of people sustained in their own homes.

2. Primary Care Support and Quality Focus

Proactive Primary Care Solution to Care Homes
Commissioned in 2016, the enhanced service aims to support practices to provide proactive care to their registered elderly patients living in residential or nursing homes with the intention of reducing avoidable emergency admissions and A&E attendances, improving medicines management ensuring advanced care planning is in place and reducing demand on general practice.

The service is delivered by a multi-disciplinary team and provides a range of services over and above GMS core services.

We have currently secured over 50% coverage with the third and final phase in both Canvey and Rochford Localities being implemented by the end of the financial year.

Other Initiatives

- Dedicated Nurse working with CCG Quality team to work directly with practices on delivering high quality care and innovation
- Improving EOL care through provision of Gold Standards Framework training to targeted care homes
- Piloting teleconferencing facilities linked care home to aligned practice
- Introducing CCG newsletter to our Care Homes
Engaging Communities – Reference Groups

• We are fortunate to have a very effective Commissioning Reference Group (CRG), with dedicated GP leadership. This enables a cross-section of local residents who represent different groups to contribute their distinctive perspective. The CCG’s Commissioning Reference Group has been used as a case study as part of a review by the DH, Public Health and NHS England into the voluntary sector. They have assisted us in making sure we reach local residents with protected characteristics or those that experience health inequalities in the most appropriate and efficient way.

• The group meets regularly with each meeting being themed to the CCG’s corporate objectives accordingly to pre-agreed workplan. Members are also invited to suggest any topics that they would like to see on future agendas. Speakers are invited to give presentations each week which enables providers to give their unique perspective on service provision and the opportunities and challenges the local system faces. Members have also contributed to a number of successful projects including the development of two children’s books which formed part of a system resilience campaign to encourage parents and children to act responsibly. They will be supporting the CCG with its aim to reduce waste and encourage residents to use services responsibly in a future communications project.

• Since last year we have significantly enhanced our ability to engage with the broader community through delivering a number of tactics to establish locality patient reference ‘groups’ linked to our ‘out of hospital’ transformation strategy.
Engaging Communities – Innovation

Having delivered the first phase of our ‘Simpler, Better, Together’ engagement programme we have worked alongside colleagues in Essex County Council to:

• Engage with local residents in order to create a mutual understanding of the need for change
• Outline the vision for development of new integrated models of care
• Gather new, and build on existing, insight from patients, stakeholders and the public about their use of health and care services and how they feel we could improve
• Compile of a register of “interested parties” wishing to be involved at a more regular/detailed level – with has been broken down into respective locality groups
• To help gather the views and ideas of local residents, the CCG organised a ‘Simpler, Better, Together’ roadshow which toured Canvey, Rayleigh, Rochford and Benfleet. We have consequently engaged with all ‘interested parties’ via a series of events both specific to the CCG and as part of the Success Regime conversation.
• During the last six months of 2016, we hosted engagement discussions concerning potential changes to local health and care services. Two focus groups and two public workshops have taken place alongside several working groups within the local NHS and other public services to look at new ways to provide health and care services in the future.
• Engagement and appropriate consultation regarding the overall direction for the next five years for health and care in mid and south Essex in a Sustainability and Transformation Plan (STP) will follow.
• In addition to our core engagement model, we have embarked on innovative and thoughtful engagement harnessing technology to communicate and engage with our local community and wider stakeholders.

Examples of this include:

• As exclusive partnership with a local community Facebook forum called ‘8 out of 10 mums’ to host a GP led event for local mums around using A & E and other local services effectively
• Quality Awards event to recognise excellent practice in member practices in the locality. It allowed CCG staff, member practice staff, partner agencies and members of the public to recognise care in practices. We developed a video featuring staff from our 25 GP practices to help showcase their excellent work.
• Development of AGM video which has already attracted over 300 views – compared to the average NHS AGM audience of 20 members of public in a community hall.
• Bespoke engagement solutions are also developed for our commissioners to gain insights at different stages of the commissioning process.
Health and Social Care Integration

- During 2015/16 the CCG, in partnership with Essex County Council, identified its strategic direction for adults as being the creation of integrated care models, creating a healthier and more sustainable future for the population served, through the commissioning of high quality care in the most appropriate place and the optimal time.

In March 2016 the CCG Governing Body agreed a business case that outlined how the system would better integrate both health and social care commissioning and provision.

The detail behind this plan can be found at http://castlepointandrochfordccg.nhs.uk/about-us/our-governing-body/governing-body-meetings/2016/31-march-2016

Developments made during 2016/17 include:

- Joined up commissioning – development of a Strategic Commissioning Partnership Board across CCG and Local Authority to start aligning commissioning decisions and strategies and remove the conflicting priorities that can arise from two commissioners covering the same patient/client group.
- Commissioning joined up care – working with ECC and incumbent providers we have started to work through options for realigning incentives and redeveloping patient pathways across the system. This will lead to the development of alliance type principles being in place for 2017/18, and a move towards new contracting forms and a new model of care.
- Providing joined up care – As set out in the Mid and South Essex Sustainability and Transformation Plan highlighted below, the CCG is moving towards closer integration with social care.

The BCF plan will focus on 4 key areas:

- **Maintenance, provision and transformation of community services**: Through the BCF we aim to continue providing community services whilst developing a transformation plan aligned to the Essex Success Regime and focused on Localities. The Locality model will deliver integrated health and social care interventions – this represents a shift away from hospital to the community. Through a long term plan of transformation each locality will utilise existing (or new) NHS / ECC estate to provide a fit for purpose care service for patients and their carers. The locality (aligned to the redesign of social care) will also provide primary care services working in a Multi-Disciplinary Team environment.
- **Reablement**: continue to provide reablement services to residents of CPR which will support our low DToC rates and also ensure we continue to minimize those still at home 91 days after discharge from hospital. A newly commissioned reablement service, commissioned in partnership between the CCG and Local Authority, will enhance capacity available for the system, and increase the number of residents able to access reablement.
- **Disabled Facilities Grant (DFG)**: ensure the outcomes derived from the capital spend associated with the DFG are aligned and in support of those outcomes we derive from our integrated care commissioning activity.
- **Protecting Social Services**: In accordance with the national requirements the BCF apportions funding to support and protect social services. Whilst this fund will be used to maintain existing integrated health and social care services Adult Social Care are currently reviewing how services are delivered and alignment to the locality model.
Health and Social Care Integration

Context

Our model of health and care cannot succeed without closer integration with social care

Despite the complex landscape in Mid and South Essex – three upper tier local authorities – there is a consensus focussing on three key areas:

Prevention: Supporting our communities
- Support individuals and promote resilient communities which help people to maintain their health and independence e.g., education on healthy lifestyle/obesity in schools co-ordinated with primary care

Delivery: seamless services in localities
- Re-designed, integrated pathways for people who are Frail, End of Life e.g., social workers as an integral part of MDT
- Personalised services wrapped around service users which meet their whole needs and build on their strengths

Enablers: working more efficiently together
- Multi-skilled workforce e.g., up-skilling frontline staff to cross-cover health and care roles
- Leveraging technology and better use of estates e.g., sharing IT platforms and estates

Our approach

Prevention
- Social prescribing
- Integrated messaging
- Self-care and resilient communities

Delivery
- Integrated locality teams – MDTs, joint care planning
- Redesigned Frailty and EOL pathways
- Multi-agency approach to urgent and emergency care

Enablers
- Technology (e.g. shared care records; health and care apps)
- Shared, multi-skilled workforce
- Shared approach to estates (e.g. multi-service hubs)

Whole population
Service users
Our workforce / organisations
Enablers: IT and Estates

Our aim is to have a digitally connected health and social care system that provides safe and informed care to the population of Castle Point and Rochford and contribute to delivering Paper Free at the Point of Care as articulated in the Five Year Forward View.

At the heart of this is the shared care record, recognising the GP record as the core and having interoperability with each of the neighbouring electronic systems that interface with a patient’s journey throughout Health and Social Care.

CPR CCG led the development of the Local Digital Roadmap (LDR) on behalf of the Mid and South Essex STP footprint. Our vision is that we need to get to a position of:-

• The digital citizen - intelligent through technology in prevention and management of their health and care
• All data is coded at the point of care, as a part of the ‘normal note taking’
• All relevant patient data can be accessed across all care settings
• Irrespective of the clinical application, data is shared and interpreted accurately by the receiving system
• Clinical pathways are clear and proactive
• All data is contemporaneous without any need for duplication
• Transcribing information between systems should become redundant
• High risk and vulnerable patients are identified and cared for.

Further to the LDR, we have our own local CCG IT strategy which sets out seven strategic imperatives:-

1. Leading and Driving through Commissioning
2. Interworking with Social Care Providers
3. Interworking with Acute Providers
4. Interworking with other Health Providers
5. Enablement of Community Hub working
6. Driving and Supporting Innovation
7. Improve Efficiency for GP practices / CCG

As part of our CCG IM&T Strategy we ensure that all IM&T innovation fits with the following core principles:-

• IM&T will be driven by business or clinical need.
• New technologies may stimulate business or clinical change but will not drive it.
• Systems installed will be exploited to provide maximum benefits.
• Where possible, the CCG will be the Data Controller.
• Choice of systems will include requirements for interoperability.
• Choice of providers will include understanding their own development plans to ensure they are innovative, pro-active and in-keeping with the direction of Castle Point and Rochford CCG.
• Providers will conform to Information Governance requirements and patient consent at all times.
• Working with our member GP practices we will:
• Ensure that all GP practices (and future primary care providers) are using a GP Systems of Choice (GPSoC) compliant system as defined by the by NHS Digital.
• Continue to deliver against the universal capabilities and local capabilities outlined within our Local Digital Roadmap. For example:
  – Ensure practices are able to offer patient access to detailed coded records
  – Ensure practices are able to offer facilities for patients to book appointments and order repeat prescriptions online.
  – Work with healthcare organisations to reduce the use of fax by promoting the use of electronic referrals.
  – Assist practices if they wish to merge with neighbouring practices.
Enablers: IT and Estates

- In-line with national guidance CPR CCG will provide a core IM&T infrastructure including, but not limited to:
  - PCs and Monitors
  - Black and White printers / multi-functional copiers
  - N3 / Internet Services
  - Core software – Microsoft Office, Windows operating system etc.
  - SMS messaging to patients

- In the financial year 2016/17 we secured Estates and Technology Transformation Funding (ETTF) which we have prioritised to deliver:
  - Mobile working to GPs
  - WiFi to GP surgeries
  - E-Consultations

E-referrals
- Continue working with main provider and primary care to achieve 60% use of e-referrals in March 2017 and increase thereafter to meet 100% e-referrals by April 2018. Primary care will be provided with training and support to make e-referrals and the hospital will as part of their CQUIN work with each specialty to become e-referral access only and thereby ensuring slots are available to book e-referrals.

Estates
- We also secured ETTF funding to develop Canvey Primary Care Centre in-keeping with our Estates Strategy which identifies Canvey as being a integrated neighbourhood. This funding will be used to develop the premises into a multi-purpose healthcare site delivering a more effective healthcare offering to Canvey residents. The centre will offer GP services, voluntary and third sector services, community services as well as phlebotomy and diagnostic facilities all on-premise all of which will prevent the patient from having to travel to hospital.

- Linking with our IT colleagues, we are looking to implement shared IT access which will enable social care and other NHS workers to come into our buildings and seamlessly connect their devices to our network or wireless in order to access their own systems.

- Working with a partner organisation, we are carrying out condition surveys of our primary care estate.

- Castle Point and Rochford are an active member of the Castle Point Regeneration Partnership.
Enablers: Workforce

- Nearly 7 million people of working age in the UK are disabled or have a health condition. Historically there has been a significant gap between the proportion of disabled people employed compared with non-disabled people, (Employing disabled people and people with health conditions HM Gov 2015).

The CCG will work towards supporting and retaining those with a disability in employment. As a commissioning organisation there is the potential to influence how we employ staff, plans are in place to actively support a member of the Learning Disability community to engage in employed activities in the organisation. We believe as a CCG the importance of recognising the skills of those with long-term conditions and our staff have formed an informal network to provide information and support for those employed with long-term conditions in the workforce. This buddy system is intended to enhance understanding in those not affected, promote flexible working if required and dispel myths around the ability of those with long term conditions to be actively and productively employed.

- NHS employees are part of one of the world’s largest workforces and the health and well-being of this significant proportion of the UK working population is crucial to the delivery of continued improvement to patient care. The CCG will work with health organisations to develop an approach to support the health and well-being of their staff, creating healthier workplaces and supporting the Fit for Work initiative employers and employees can benefit from free work related health advice through a telephone advice service and website. Fit for Work provides advice to help support employees when a health condition is affecting their job.

- As the CCG moves towards more integration, there is the opportunity to work more closely with Local Authority partners. Indeed meetings are arranged with local District Council members to promote opportunities to local residents surrounding employment in the health and social care spheres. As apprenticeship programmes are developed collaboratively there is a real opportunity to support individuals who have long-term health problems or disabilities to return to employment. Community Safety Partnership is a forum where such discussions are already taking place.

- The CCG has a well-established Staff involvement Group Chaired by the Chief Nurse. All directorates are represented at this forum and it gives the opportunity to all staff to feedback on issues that maybe affecting the health and well-being of staff. Indeed the SIG has promoted the development of IAPT services in-house and has positively endorsed the relocation of the CCG offices for individual health. Staff are currently looking at re-establishing a lunchtime walking club and promoting healthy eating within the organisation.

- The Mid and South Essex STP recognises the need to move to innovative models of working to deliver quality care:
  - Newly formed LWABs will provide governance and drive workstreams.
  - Essex Workforce Strategy developed to support transition to future workforce e.g. ANPs leading LTC management with support of specialist therapists such as podiatrists.
Workforce: Education and Training

- CP&R CCG will use the National Quality Board’s (NQB) resources and measure quality to ensure safe, sustainable and productive services. Our Workforce Strategy evidences our commitment to ensure that the right staff with the right skills are available at the right time. The Workforce implementation plan will continue to be implemented during 2017/18 and there will be on-going monitoring using the National Quality Board’s measures of quality. We recognise that there is a pressing need to improve the quality and provide best value in delivering care.

- CP&R CCG has developed strong partnership working with GPs, Essex County Council, HEE and other stakeholders. The first stage of assessing the development of an integrated health and social care has been undertaken. Detailed analysis and research has been completed with a forward looking focus on creating and developing new roles to deliver services across historic boundaries. This has been articulated to the Governing Body and local residents through our workforce strategy which outlines the need for enhanced recruitment and retention within the CCG, member practices and to support future visions of new care delivery.

- The strategy seeks to continue our workforce transformation journey in considering the current key workforce issues. It is important to consider how these may need to be addressed, highlight the developments achieved to date, and identify what potential new roles may be needed as part of integration aligned with the Neighbourhood Team Service model in development. Discussions have taken place with HEE to secure funding to implement schemes to enhance skill development. The CCG is an active partner in the EPIC steering group and Essex wide development groups.

- The CCG will continue with the Time for Care programme which commence in Dec 2016, and are looking to develop future GP leaders.

- The development and approval of the Workforce strategy clearly articulates the vision and the direction of travel for the CCG, the integration agenda and the needs of member practices. Close working with the LETB, HEE and the local partnership groups will ensure that the implementation of the strategy is possible and financially resourced to drive success. Success will be measured by the NQB quality measures.

- Equally important is the role of this work in relation to the ‘programme to sustain services and improve care’ of the Mid and South Essex Success Regime of which CP&R CCG is a member organisation. The Success Regime has identified workforce and talent gaps as a key challenge and this strategy is part of the work that CP&R CCG will use to address that challenge. We will monitor and evaluate the activities of our new Essex workforce development centre to ensure that our population achieves maximum benefit from this initiative.

- Drawing on the resources of the National Quality Board, Southend University Hospital NHS Foundation Trust has adopted the safe, sustainable and productive staffing model https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf. South Essex Partnership Trust are also looking at adapting the staffing level guidance as this is not directed at mental health and use part of the National Quality Board guidance where relevant. The CCG currently review at our Clinical Quality Review Group and this is undertaken in line with the guidance and resources published by the National Quality Board.
Risks to Delivery

The risks have been rated Red, Amber, Green in accordance with our risk rating system being and the top five risks are noted below:

Top Five Risks

• Failure to meet 2017/2018 constitutional standards.
• Delivery of 2017/18 financial Plan at the level required to hit financial balance.
• Achieving pace within a year for required reductions in emergency admissions.
• The potential scale and pace of the Capability and capacity with the workforce is insufficient to deliver the correct level of outputs to meet the QIPP challenge, particularly with the impact of Success Regime and transformation agendas e.g. change required in relation to the Success Regime and transformation agendas could cause a reaction from political groups or the public, who may want to prevent change from occurring.
• SUHFT bed capacity/shortages.
Appendices

- Appendix 1 – Operational Delivery Plan
- Appendix 2 – GP Five Year Forward Plan
- Appendix 3 – Performance Recovery Plans

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