

# Operational Plan

## 2014-16

**Important Note:**

This document is draft and subject to final development, review and consideration.

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## How this plan has been developed

This plan has been completed by Southend Clinical Commissioning Group in conjunction with member practices and a number of partner organisations (relative to specific sections). Notably this includes joint working with Southend-on-Sea Borough Council in respect of proposals for implementation of the Better Care Fund and joint commissioning of services; and Castlepoint and Rochford Clinical Commissioning Group in respect of joint commissioning.

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## Document approval

Southend Health and Wellbeing Board	March 2014
Southend CCG Governing Body	March 2014

**PENDING**



# **EXECUTIVE SUMMARY**

## Foreword


NHS Southend Clinical Commissioning Group's (Southend CCG) Operational Plan for 2014-16 outlines the direction of travel for commissioning across Southend, describing our Vision and how we are working across the health system to improve quality and drive efficiency. The Operational Plan demonstrates how commitments made to implement the Vision are being translated into programmes of work.

The Operational Plan describes our major work streams, highlighting what we are doing and how we plan to do it amidst a national context of profound financial challenge. Being clear about our financial position, our underlying activity assumptions and risks allows us to demonstrate the level of ambition we are aspiring to when planning service change, redesign and increased efficiency savings for the Southend healthcare system.


The Southend CCG Team has held individual discussions with both Southend University Hospital NHS Foundation Trust (SUHFT) and South Essex Partnership NHS Foundation Trust, our main providers, and commissioning partners Southend-on-Sea Borough Council and Castle Point and Rochford CCG, outlining the main elements of this operational plan and ensuring we are strategically aligned.

We have also met individually with our partners from across the Southend Health system to discuss and align commissioning intentions.

We are working together as a health and social care economy to be clear about how the system will achieve sustainable service and financial performance whilst delivering quality and productivity improvements.



**Dr Paul Husselbee**  
Clinical Chief Officer  
Southend CCG



**Dr Bilquis Agha**  
Chair  
Southend CCG



# **SOUTHEND CCG AND THE WIDER HEALTH SYSTEM**

## OUR VISION

Our vision is that Southend will be the healthiest town in England by 2020.

We will achieve our vision by creating a sustainable health and social care system which delivers quality care in the most appropriate setting, improving the health and wellbeing of the population and achieving value for money

This strategy has been agreed by the major stakeholders across the Southend health system.

## OUR VALUES

Our values, which have been shaped by our staff and stakeholders, fully align with the principles laid out in the NHS Constitution

**Clinically Led** Clinicians will play a central role in leading our organisation

**Centred on Patients, Families and Carers** We will place patients, families and carers at the centre of everything we do

**Equalities** We will be relentless in our efforts to reduce inequalities in our population

**Safety** All providers we commission must demonstrate delivering a safe service is their top priority. Safeguarding training for all staff groups.

**Quality** We will strive to maximise quality by promoting optimal use of evidence based guidelines

**Best Use of Public Money** We will demonstrate strong population involvement, governance and accountability to assure we are achieving best value for money

**Excellence and Professionalism** We will create a professional environment that motivates its people to perform and excel

**Working Across Organisations in Partnership** We will be proactive in seeking opportunities to advance our cause through joint collaboration with neighbouring commissioners, commissioning support unit, acute, community and mental health trusts, local council, and other key stakeholders

## About Southend CCG – story to date

NHS Southend Clinical Commissioning Group was formally established in April 2013.

In our first year, we embarked on a programme of organisational development to ensure that we would be properly set up, with the right skills to execute our responsibilities as the primary commissioners of health services in Southend.

We have been working with a team of organisational development experts to design and implement a bespoke organisational development programme.

Implementation began in October 2013, with initial activities focussing on our governing body and clinical executive. We have also held a joint leadership development day with Castlepoint and Rochford CCG and there is an on going leadership development programme in place.

In 13/14 we did not deliver against the statutory requirements for clinical commissioning groups. This included achieving financial balance and delivering the NHS constitutional measures.

To ensure that we deliver our statutory obligations in 2014 and beyond, we have identified four areas for development. We have already taken actions in these areas, and have planned actions for immediate and longer-term implementation as follows:

### **Development area 1: Changes to our organisational makeup**

We conducted a review of our own organisation and the services bought in from Central Eastern Commissioning Support Unit (CECSU).

The governing body has approved recommendations to: change our specification with CECSU; build capacity within our organisation by increasing the number of directly delivered functions; and explore opportunities for joint commissioning with Southend-on-Sea Borough Council in learning disabilities and children's services.

Our plans for 2014-15 include:

- Recruiting to new internal structures
- Negotiating with CECSU including development of business cases for BDU; refining service specs with CECSU
- Ongoing programme with staff/leadership experts
- Allocating a team to oversee our plans to improve staff engagement and organisational readiness and resilience

### **Development area 2: Changes to our governance and decision making processes, where we have cross-boundary decisions to make with CPR**

We have established joint clinical executive with Castlepoint and Rochford CCG. From April 2014, this will ensure decisions regarding shared providers are considered and made together.

### **Development area 3: Greater discipline around QIPP and financial planning**

We are in the process of establishing a financially-focussed programme management office to ensure robust planning and delivery.

### **Development area 4: Redefining the clinical leadership role**

We have redefined the clinical leadership roles and are in the process of appointing a smaller number of clinical leads to start from 1 May 2014.

## Governance and risk management

### Governance

Southend CCG has robust structures and procedures in place for governance and risk management.

These are set out in our constitution, standing financial instructions and scheme of delegation [INSERT HYPERLINK].

Leadership roles and executive portfolios are clearly defined and it is clear where accountability sits for each of our major areas of work.

Our committees provide scrutiny and assurance for their areas of responsibility, which are as follows:

Audit & Risk Committee – scrutiny of all corporate, clinical and financial governance and discharge of CCG’s statutory duties; review of internal control

Quality, Finance & Performance Committee – high level scrutiny of the CCG’s financial and quality performance as well as procurement decisions

Clinical Executive Committee – engine room of clinical innovation and clinical leadership

Remuneration Committee (REMCO) – for recommendations on very senior manager and governing body pay/non-NHS pension scheme issues

### Openness and transparency

In line with our constitution, the governing body meets every two months in public.

The minutes of the committees are shared with the governing body at these meetings, with the exception of the Remuneration Committee.

In the conduct of all our business activities, we ensure adherence to the Nolan Principles of public life.

### Risk management

Our risk management strategy includes risk prevention, internal control and understanding of risk appetite.

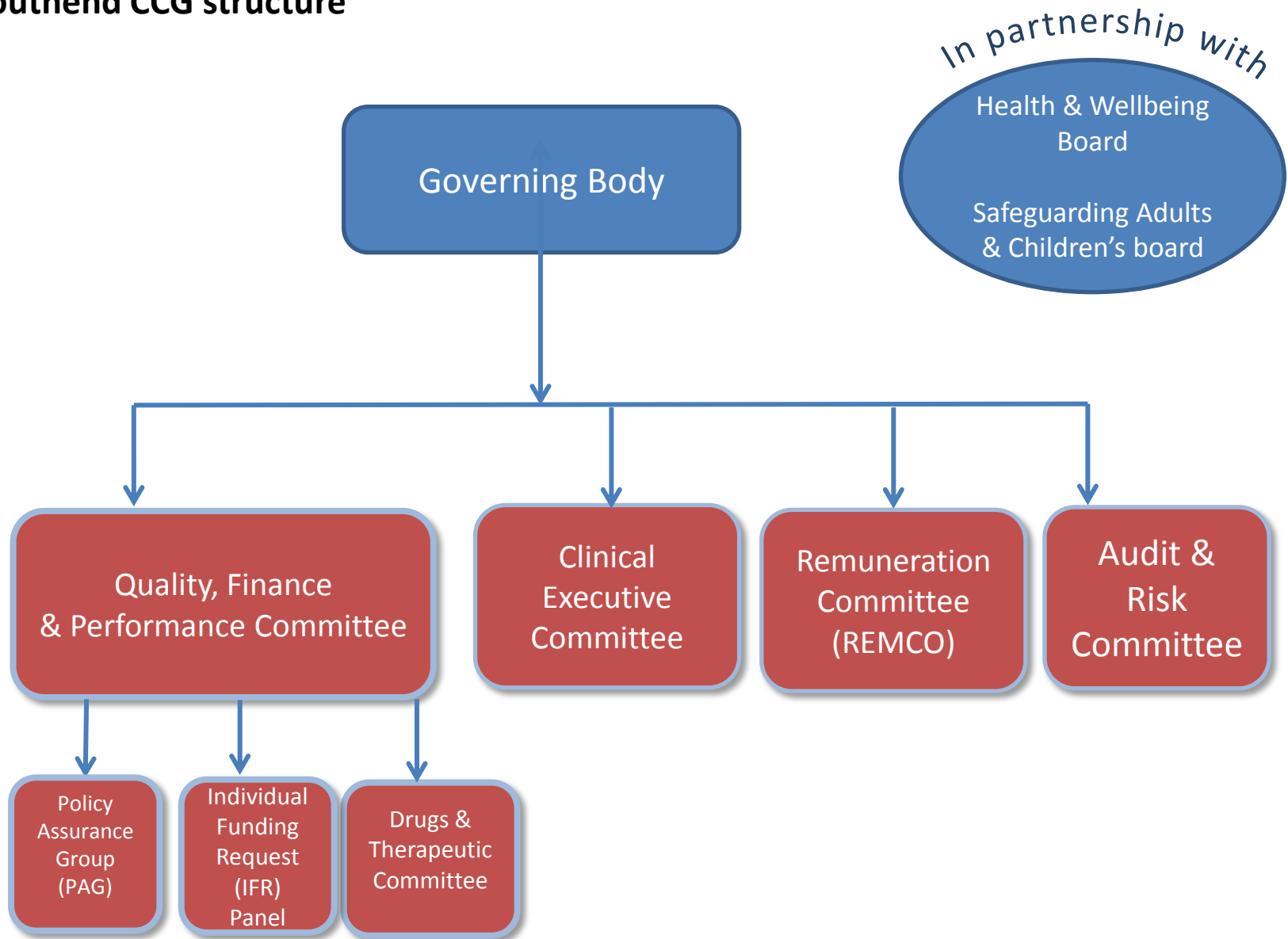
The Governing Body Assurance Framework (GBAF) shows strategic risks and is presented every time the governing body meets in public.

The Corporate Risk Register is for operational risks and is presented to the Quality, Finance & Performance Committee at each of its meetings.

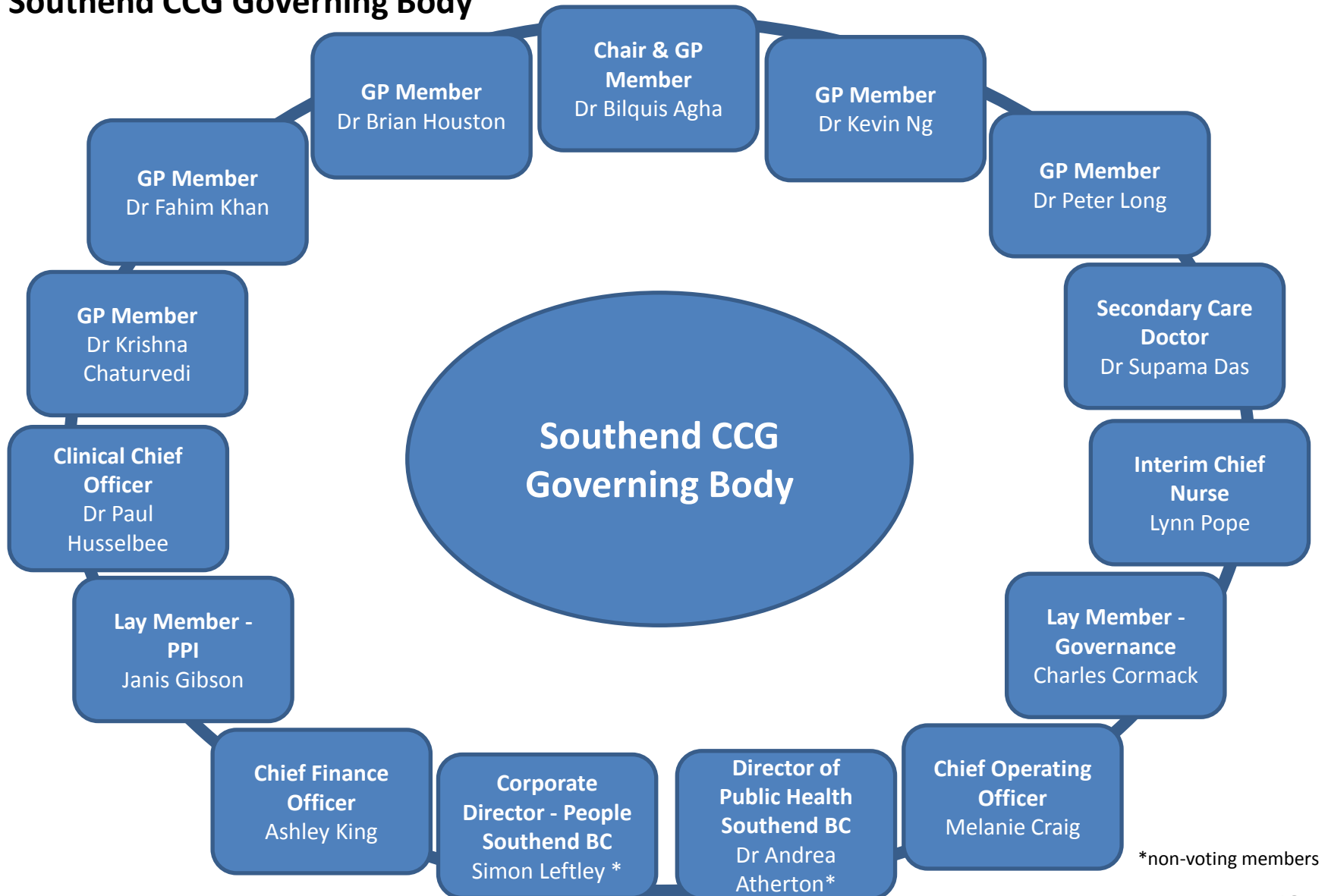
Service level agreements are in place with the local counter-fraud service, internal and external auditors and local security management services.



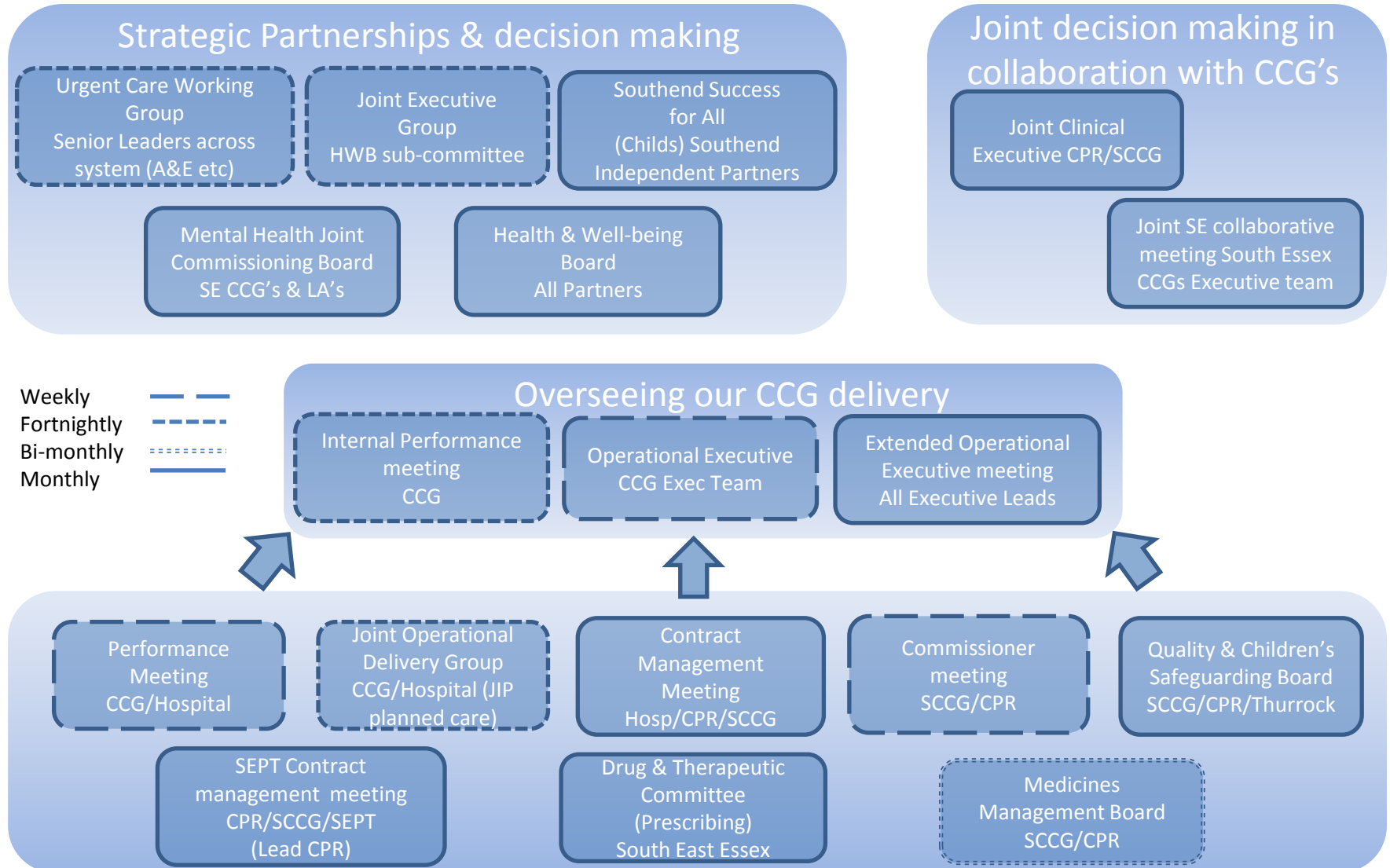
## Southend CCG structure



## Southend CCG Governing Body



# Southend health system – Southend CCG, its partners and providers



## Southend Health and Wellbeing Board and the Joint Executive Group

Southend-on-Sea's Health and Wellbeing Board is made up of local statutory organisations and health related partners who are working in partnership to improve health and wellbeing for Southend's residents.

Its ambition is that everyone living in Southend-on-Sea has the best possible opportunity to live long, fulfilling, healthy lives.

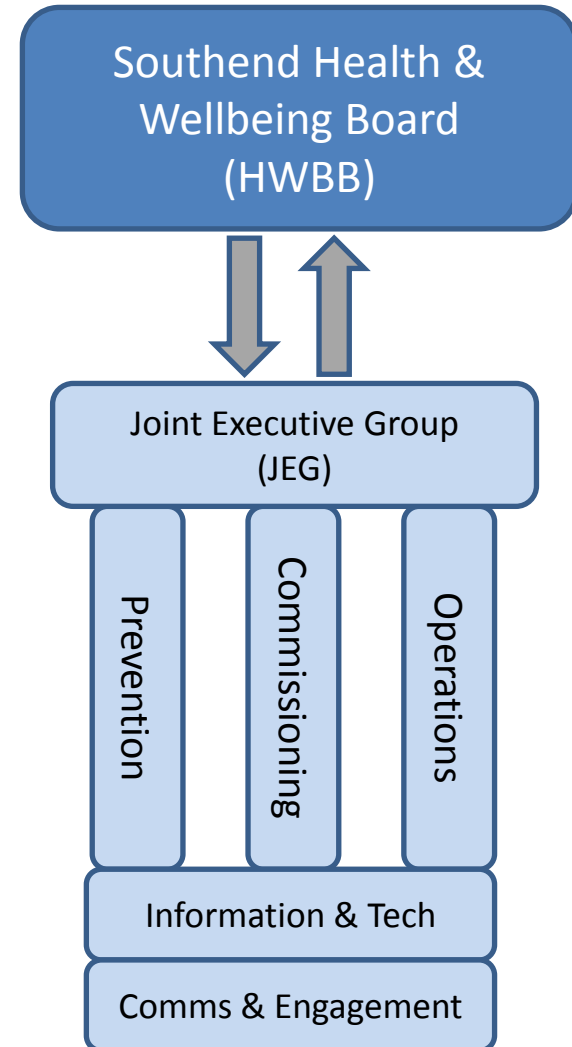
The Joint Executive Group comprises representatives from:

- Southend CCG
- Southend-on-Sea Borough Council
- Southend University Hospital NHS Foundation Trust
- South Essex Partnership NHS Foundation Trust
- Castlepoint and Rochford CCG
- Southend Association of Voluntary Services

The JEG's primary areas of focus will be:

- Better Care Fund
- Integrated Pioneer Status
- Access to 7-day services

It will also deal with ad-hoc requirements delegated from the Health and Wellbeing Board.



## Specific local challenges

The Southend health system serves a population of over 180,000 people.

29 per cent of the population is under 25 years old, while 18.3 per cent are aged over 65. The proportion of the population aged 85 or older is 2.9 per cent [SOURCE].

Our population is ageing faster than populations in many other areas [SOURCE]. By 2020, the total population is expected to grow by over 6000, which will drive a modest increase in demand for health services. However, a major increase of almost 12,000 in the population aged over 55 will drive a much greater increase in demand.

The health of Southend's population is generally on par with the rest of the country, however there are a number of areas where we have a higher disease prevalence than the England average. These include cardiovascular disease, heart failure, hypothyroidism and mental health [CCG Outcomes Tool].

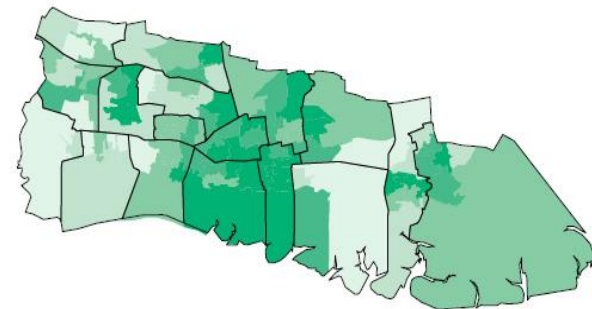
Southend is expected to face significant increases in the prevalence of several chronic diseases including COPD (projected 11% increase by 2015), diabetes (projected 12.5% increase by 2015), stroke (projected 9.5% increase by 2015) and hypertension (projected 4.5% increase by 2015).

There are significant inequalities for the population of Southend with regards to deprivation and life expectancy.

Figure A shows the differences in deprivation levels across the Borough [Index of Multiple Deprivation 2010]. The darkest coloured areas are the most deprived.

There is significant disparity between the life expectancy at birth for those living in the least deprived areas of Southend and those living in the most deprived areas. Based on death rates for 2006-2010, life expectancy for males living in the least deprived areas is 9.1 years longer than those living in the most deprived areas. For females, the range of difference is 8.8 years.

Fig. A – Southend mapped by level of deprivation





# **FRAMEWORKS, MEASURES AND DELIVERY**

## Our frameworks and measures

We are committed to improving the health and wellbeing of our local communities and ensuring that the population of Southend has appropriate access to high-quality, safe care.

We will measure the impact of our work using a series of frameworks and measures.

We have developed a series of aspirational trajectories for our performance over the next five years using the NHS Outcomes Framework.

These measures in turn also align to the Better Care Fund (delivered in partnership with SBC), quality premium, NHS Constitution Measures and additional local measures where relevant.

The NHS Outcomes Framework sets out 5 domains for improvement. These are:

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

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

To develop our targets against each of the 7 outcome measures we have examined our historical and current performance and the performance of comparator peer CCGs (using Commissioning for Value comparator group).

In many cases we set our target on the basis of improving performance to achieve the next CCG quartile across the target period.

Where there is a national target, we will aim to reach that target.

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

‘Percentage of patients with long-term conditions who feel supported to manage their condition’.

We will be working with our partners from across the Southend health system to design the solutions that will enable us to deliver the ambitions we have set. A workshop is due to take place in early May 2014 to explore the challenges with our partners. The system-wide solutions will form part of our five-year strategy and will feature in our Strategic Plan.

## Our frameworks and measures at a glance

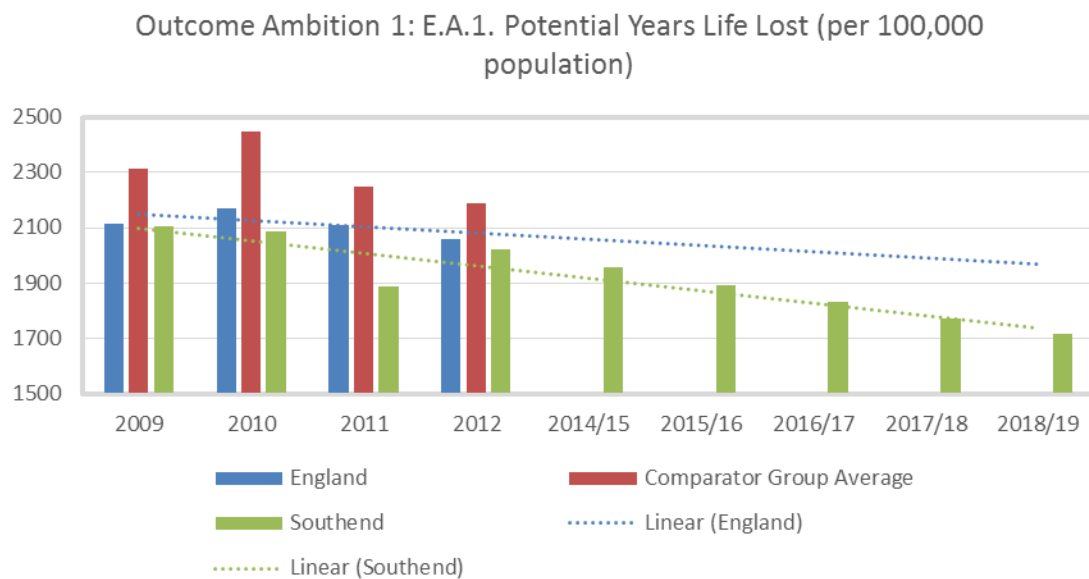
Measure	Outcome Ambition	Quality Premium	Better Care Fund	Other	Target Level
EA1: Potential years of life lost from causes amenable to healthcare (adults, children and young people)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			3.2% YOY Improvement 15% Quality Premium
EA2: Health related quality of life for people with one or more long-term conditions	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			0.7% YOY Improvement
EA3: IAPT Rollout		<input checked="" type="checkbox"/>			15% Quality Premium
EA4: Reducing the amount of time people spend avoidably through hospital through better and more integrated care in the community	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		1.3% YOY Improvement 25% Quality Premium
Increasing the proportion of older people living independently at home following discharge from hospital	<input checked="" type="checkbox"/>				No target set / baseline not available
EA5: Increase the proportion of people having a positive experience of hospital care	<input checked="" type="checkbox"/>				1.3% YOY Improvement
EA6: Friends and Family Test national target for 2014/15 and 2015/16		<input checked="" type="checkbox"/>			Target to be set with HWB 15% Quality Premium
EA7: Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community	<input checked="" type="checkbox"/>				2.3% YOY Improvement
EA8: Make significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	<input checked="" type="checkbox"/>				No target set / baseline not available
EA9: Increase of medication related safety incidents		<input checked="" type="checkbox"/>			Target to be set with HWB 15% Quality Premium



## Our frameworks and measures at a glance (cont.)

Measure	Outcome Ambition	Quality Premium	Better Care Fund	Other	Target Level
Local Measure: C2.2 % of patients with long-term conditions who feel supported to manage their condition		<input checked="" type="checkbox"/>			Attain 71.5% in 2014/15 15% Quality Premium
Permanent admissions of older people (aged 65+) to residential and nursing care homes per 100,000 population			<input checked="" type="checkbox"/>		Bring admissions down from 220 in 2013/14 to 200 in 2014/15
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services			<input checked="" type="checkbox"/>		Attain 86% target
Delayed transfers of care from hospital per 100,000 population			<input checked="" type="checkbox"/>		?
Patient/service user experience			<input checked="" type="checkbox"/>		?
Local Measure: % of patients with long-term conditions who feel supported to manage their condition			<input checked="" type="checkbox"/>		Attain 71.5% in 2014/15
Number of C.Difficile Infections (2014/15)				<input checked="" type="checkbox"/>	Target of 24 Incidents
Dementia diagnosis rate (2014/15 and 2015/16)				<input checked="" type="checkbox"/>	Attain 67% in 2014/15 and 2015/16
IAPT Recovery Rate (2014/15 and 2015/16)				<input checked="" type="checkbox"/>	Attain 50% Target
Activity trajectories A&E attendances				<input checked="" type="checkbox"/>	Attain 2% Reduction

## Outcome Ambition 1: E.A.1: Potential years of life lost from causes amenable to healthcare (per 100,000 population)



Date	Southend Result / Target	% Change
2009	2,103.7	
2010	2,086.8	-0.78%
2011	1,886.7	-9.59%
2012 (Baseline)	2,021.0	7.12%
2014/15 (2014 CY) (QP Target)*	1,956.3	-3.2%
2015/16 (2015 CY)	1,893.7	-3.2%
2016/17 (2016 CY)	1,833.1	-3.2%
2017/18 (2017 CY)	1,774.5	-3.2%
2018/19 (2018 CY)	1,717.7	-3.2%

**Definition:** This indicator measures the number of premature deaths occurring. Premature deaths are based on identified categories where it is believed that death could be avoided due to high quality healthcare being delivered. This is greatly impacted by health behaviours throughout life (e.g. smoking).

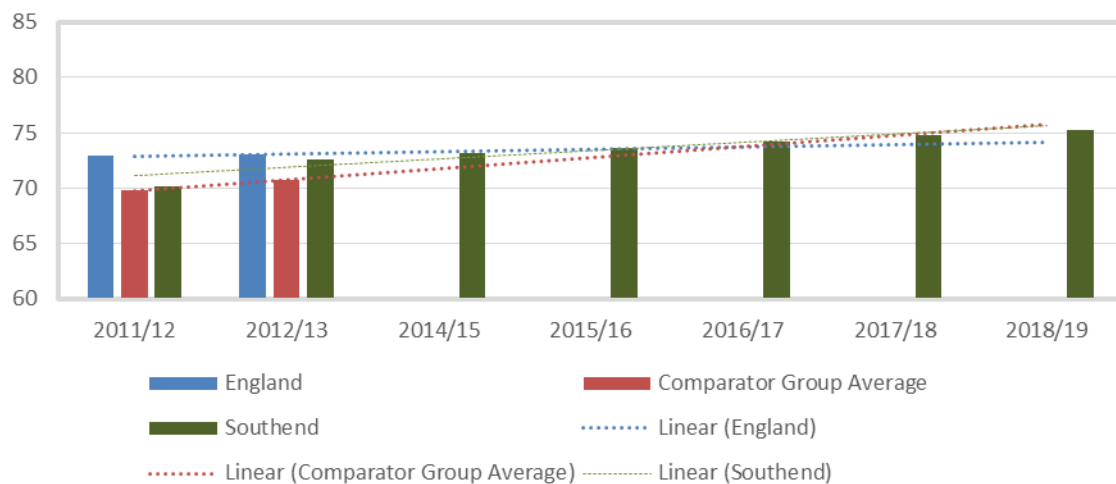
**Good performance is a low value.**

**Frameworks:** Outcome Ambition Measure and Quality Premium Measure (15% of Quality Premium). Please note: Quality Premium is based on the 2014/15 target.

**Target:** The national (Quality Premium) target is set at a 3.2% decrease from 2013 to 2014. This decrease has therefore been applied year on year to this measure. We have assumed that this 3.2% decrease will be applied year-on-year.

## Outcome Ambition 2: E.A.2: Health related quality of life for people with one or more long-term conditions

Outcome Ambition 2: E.A.2. Health related quality of life for people with one or more long-term conditions



Date	Southern Result / Target	% Change
2011/12	70.2	
2012/13 (Baseline)	72.6	3.4%
2014/15	73.14	0.7%
2015/16	73.68	0.7%
2016/17	74.21	0.7%
2017/18	74.75	0.7%
2018/19	75.29	0.7%

**Definition:** This indicator measures the average health status score of individuals who identify themselves as having a long-term condition (crude rate).

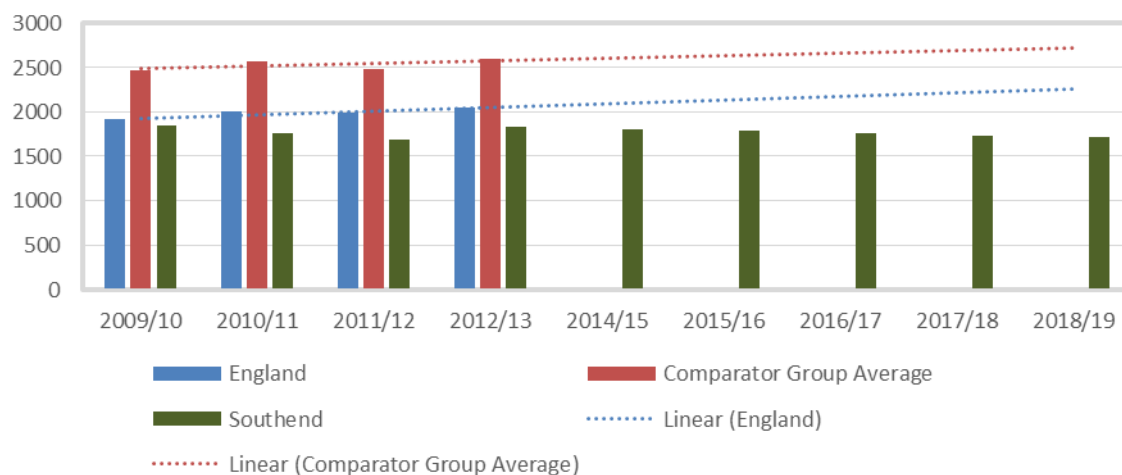
**Good performance is a high value.**

**Frameworks:** Outcome Ambition Measure.

**Target:** Given current performance, setting the 2018/19 target at 75.29 would bring the CCG into the existing best quartile (top 25%).

## Outcome Ambition 3: E.A.4: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community

Outcome Ambition 3: E.A.4. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community



Date	Southend Result / Target	% change
2009/10	1848.7	
2010/11	1761.8	-5%
2011/12	1679.9	-5%
2012/13 (Baseline)	1830.6	9%
Q1: 2014/15	435.1	-3.9%
Q2: 2014/15	401.3	-3.7%
Q3: 2014/15	456.6	-7.7%
Q4: 2014/15	514.0	-7.6%
2014/15	1807.0	-1.3%
2015/16	1783.3	-1.3%
2016/17	1759.7	-1.3%
2017/18	1736.1	-1.3%
2018/19	1712.5	-1.4%

**Definition:** This is a composite measure of: Unplanned hospitalisation for chronic ambulatory sensitive care conditions; unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s; emergency admissions for acute conditions that should not usually require hospital admission; emergency admissions for children with lower respiratory tract infections;

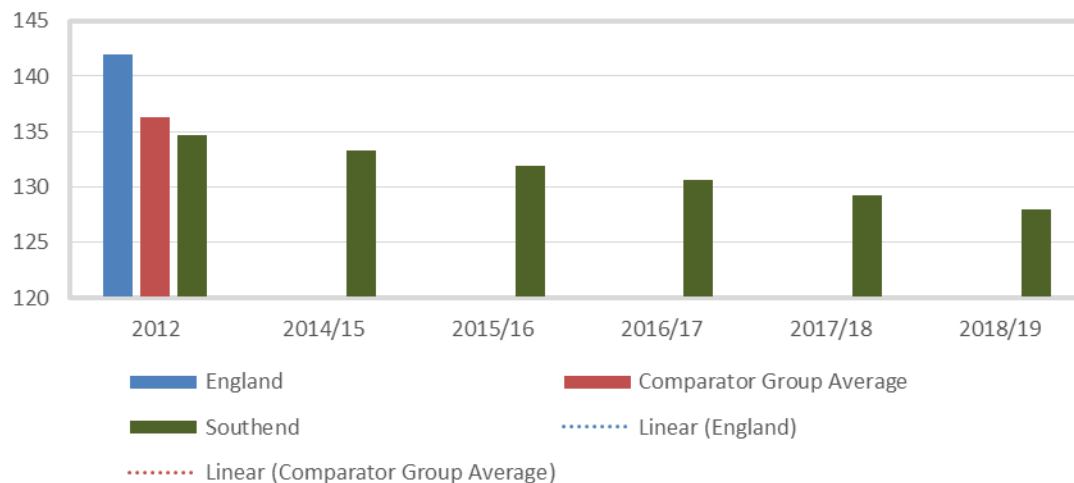
**Frameworks:** Outcome Ambition Measure and Quality Premium Measure (accounts for 25% of Quality Premium) and Better Care Fund measure (although this works on a different geography). Please note Quality Premium is quarterly 2014/15 targets.

**Good performance is a low value.**

**Target:** The target has been established as bringing the CCG to the next quartile (1712.5) by 2018/19. The Quality Premium target is a part of the overall 2014 target.

## Outcome Ambition 5: E.A.5: Increase the proportion of people having a positive experience of hospital care

Outcome Ambition 5: E.A.5. Proportion of people receiving a 'poor' experience of inpatient care per 100 patients



Date	Southend Result / Target	% change
2012 (Baseline)	134.63	
2014/15	133.29	-1%
2015/16	131.95	-1%
2016/17	130.60	-1%
2017/18	129.26	-1%
2018/19	127.91	-1%

**Definition:** This indicator measures the rate of responses of a 'poor' experience of inpatient care ('all care') per 100 patients. It is based on 15 questions relating to care. The target should therefore be to reduce the level of 'poor' responses (crude rate: applied to the CCG population).

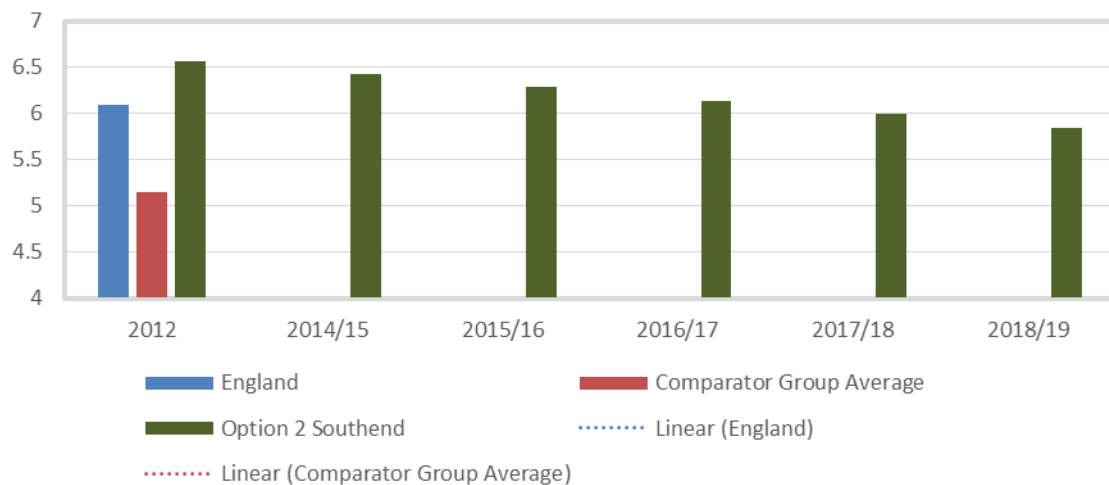
**Good performance is a low value.**

**Frameworks:** Outcome Ambition Measure.

**Target:** The minimum CCG score from 2012 was 108.6 and maximum 208.8 per 100 patients. The target was established as a 5% reduction on the baseline.

## Outcome Ambition 6: E.A.7: Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community

Outcome Ambition 6: E.A.7. Proportion of people receiving a 'poor' experience of GPs and Out of Hours per 100 patients



Date	Southend Result / Target	% Change
2012 (Baseline)	6.57	
2014/15	6.43	-2.2%
2015/16	6.28	-2.2%
2016/17	6.14	-2.3%
2017/18	5.99	-2.3%
2018/19	5.85	-2.4%

**Definition:** This composite indicator measures the number of people saying that they receive a fairly poor or very poor experience across 2 questions: GP surgery and Out of Hours service per 100 patients (crude rate: applied to the population)

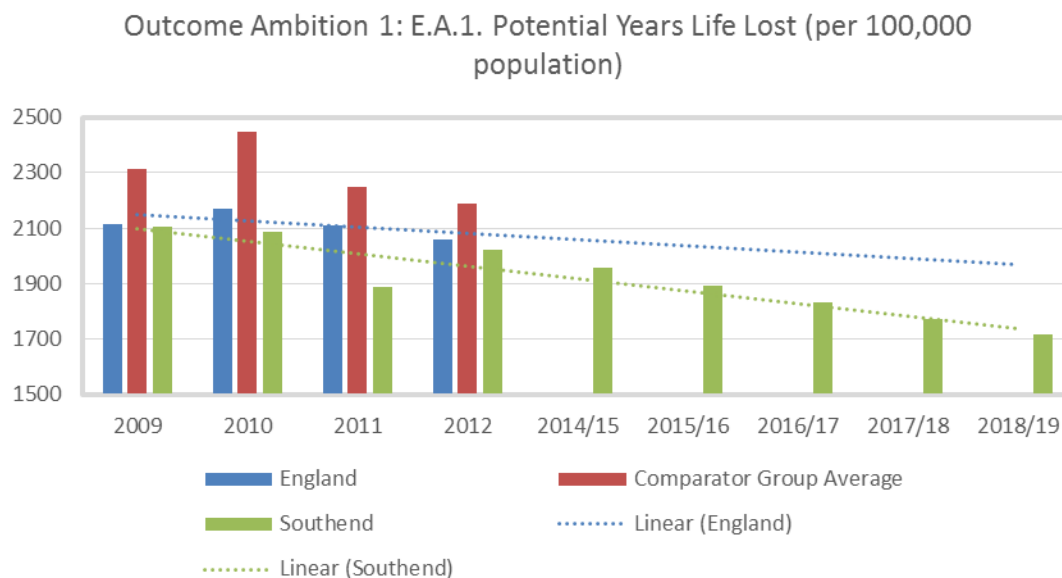
**Good performance is a low value.**

**Frameworks:** Outcome Ambition Measure

**Target:** The England average is 6.1 per 100 patients and comparator group average is 5.2 per 100 patient. The stretch improvement based on moving the CCG to the next quartile by 2018/19.

## Quality Premium: E.A.1: Potential years of life lost from causes amenable to healthcare (per 100,000 population)

Value of KPI for Quality Premium: £132,270 (15%)



Date	Southend Result / Target	% Change
2009	2,103.7	
2010	2,086.8	-0.78%
2011	1,886.7	-9.59%
2012 (Baseline)	2,021.0	7.12%
2014/15 (2014 CY) (QP Target)*	1,956.3	-3.2%
2015/16 (2015 CY)	1,893.7	-3.2%
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2017/18 (2017 CY)	1,774.5	-3.2%
2018/19 (2018 CY)	1,717.7	-3.2%

**Definition:** This indicator measures the number of premature deaths occurring. Premature deaths are based on identified categories where it is believed that death could be avoided due to high quality healthcare being delivered. This is greatly impacted by health behaviours throughout life (e.g. smoking).

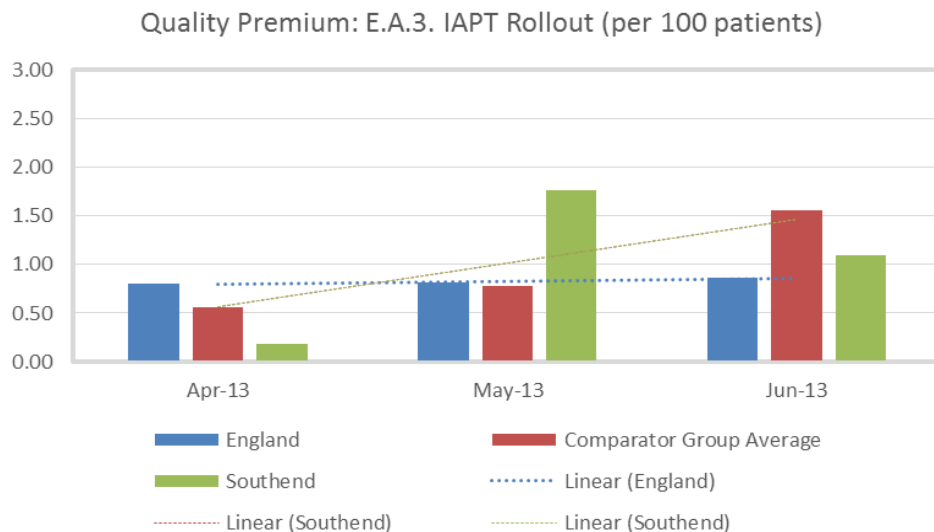
**Good performance is a low value.**

**Frameworks:** Outcome Ambition Measure and Quality Premium Measure (15% of Quality Premium). Please note: Quality Premium is based on the 2014/15 target.

**Target:** The national Quality Premium target is set at a 3.2% decrease from 2013 to 2014. This decrease has therefore been applied year on year to this measure. Based on option 2 the target would be lower quartile (next band down). If accepting option 2 a discussion may need to take place with the Area Team in respect of the 3.2% year target applied.

## Quality Premium: E.A.3: IAPT Rollout

Value of KPI for Quality Premium: £132,270 (15%)



Date	No. people who receive psychological therapies	Number of people who have depression and/or anxiety disorders	Proportion
Q1 2013/14	671	22,104	3.0%
Q1 2014/15	845	22,546	3.7%
Q2 2014/15	1,690	22,546	7.5%
Q3 2014/15	2,536	22,546	11.2%
Q4 2014/15	3,382	22,546	15.0%
2015/16	3,450	22,997	15.0%

**Definition:** This indicator measures the improved access to psychological services for people with depression and/or anxiety disorders. This measure assesses the number of people who enter treatment against the level of need in the general population (based on the National Adult Psychiatric Morbidity Survey). Please note that the comparable data is per 100 people (return requires raw data) and is only available since April 2013 for CCGs.

**Good performance is a high value.**

**Frameworks:** Quality Premium measure for 2014/15. This equates for 15% of Quality Premium.

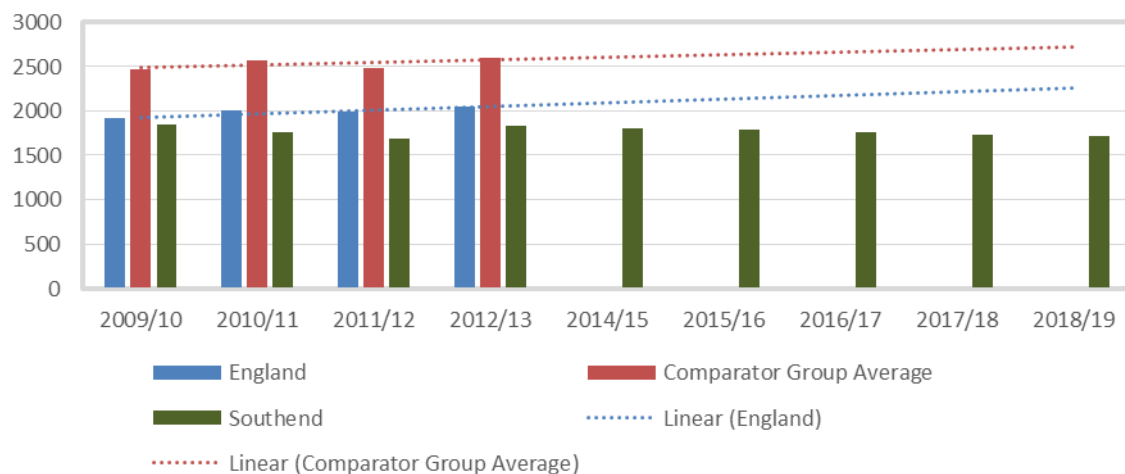
**Target:** Ongoing improvement is anticipated. The target is at least 15% of adults with relevant disorders having timely access to services (3.75% per quarter). The target is based on reaching 15% by the end of 2014/15 and an annual target for 2015/16. If the CCG's IAPT access was 13% of more by 31 March 2014 then the March 2015 target should be no less than an additional 3.2% increase (population increase) applied to number of people who have depression and / or anxiety disorders.



## Quality Premium: E.A.4: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community

Value of KPI for Quality Premium: £220,450 (25%)

Outcome Ambition 3: E.A.4. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community



Date	Southern Result / Target	% change
2009/10	1848.7	
2010/11	1761.8	-5%
2011/12	1679.9	-5%
2012/13 (Baseline)	1830.6	9%
Q1: 2014/15	435.1	-3.9%
Q2: 2014/15	401.3	-3.7%
Q3: 2014/15	456.6	-7.7%
Q4: 2014/15	514.0	-7.6%
2014/15	1807.0	-1.3%
2015/16	1783.3	-1.3%
2016/17	1759.7	-1.3%
2017/18	1736.1	-1.3%
2018/19	1712.5	-1.4%

**Definition:** This is a composite measure of: Unplanned hospitalisation for chronic ambulatory sensitive care conditions; unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s; emergency admissions for acute conditions that should not usually require hospital admission; emergency admissions for children with lower respiratory tract infections;

**Frameworks:** Outcome Ambition Measure and Quality Premium Measure (accounts for 25% of Quality Premium) and Better Care Fund measure (although this works on a different geography). Please note Quality Premium is quarterly 2014/15 targets.

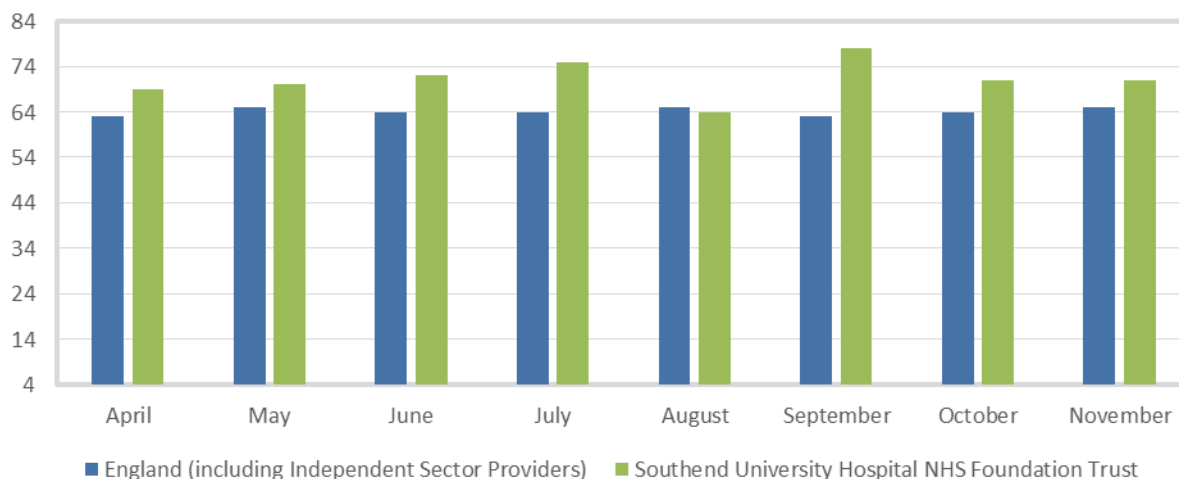
**Good performance is a low value.**

**Target:** The target has been established as bringing the CCG to the next quartile (1712.5) by 2018/19. The Quality Premium target is a part of the overall 2014 target.

## Quality Premium: E.A.6: Friends and Family Test

Value of KPI for Quality Premium: £132,270 (15%)

Combined Friends and Family Score - Southend University Hospital NHS Foundation Trust



Date	Southend University Hospital Score (high is good)
April	69
May	70
June	72
July	75
August	64
September	78
October	71
November	71

### Definition: CCG's will need to:

- Agree a plan with local providers with specified actions and milestones for actions arising from 2013/14 FFT results, particularly issues relating to poor care, and for i). actions to be achieved in line with milestones; ii). The number of negative responses received via FFT from patients reduces between Q1 and Q4 of 2014/15;
- Obtain appropriate assurance and evidence that providers have taken action in response to FFT feedback;
- Support local providers to coordinate the rollout of FFT by the end of 2014/15 and address rollout issues. Appropriate evidence should be recorded by the CCG.
- There is an improved average score between 2013/14 and 2014/15 for one of the patient improvement indicators set out in the CCG Outcomes Indicator Set with the specific measure agreed by the Health and Wellbeing Board, NHS England area team and local providers.

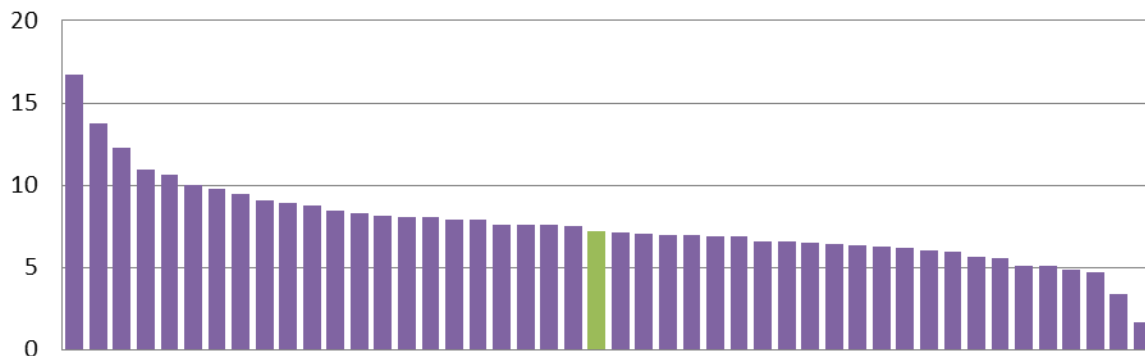
**Target:** The template asks whether there is an agreement to the above. **Good performance is a high value.**

**Frameworks:** Quality Premium measure for 2014/15. This equates for 15% of Quality Premium.

## Quality Premium: E.A.9: Improved reporting of medication related safety incidents

Value of KPI for Quality Premium: £132,270 (15%)

Rate of incidents recorded per 100 admissions – medium acute trusts  
(1<sup>st</sup> October 2012 – 31<sup>st</sup> March 2013)



	Southend University Hospital Score	%
Total incidents reported	3,228 based on 5 months (7.2 per 100 admissions)	
Of which no harm	2,679	83.0 %
Of which low harm	445	13.8 %
Of which moderate harm	81	2.5 %
Of which severe harm	21	0.6 %
Of which death	2	0.06 %

**Definition:** A CCG will earn this proportion of the quality premium if :

- It achieves a specified increased level of reporting of medication errors from specified local providers between Q4 2013/14 and Q4 2014/15 and
- These providers achieve the specified increase;

A local provider, except for where the local improvement measure is in terms of improved reporting of medication-related safety incidents from primary care, is a provider that represented 10% or more of the CCG's total activity for Q1 and Q2 of 2013/14.

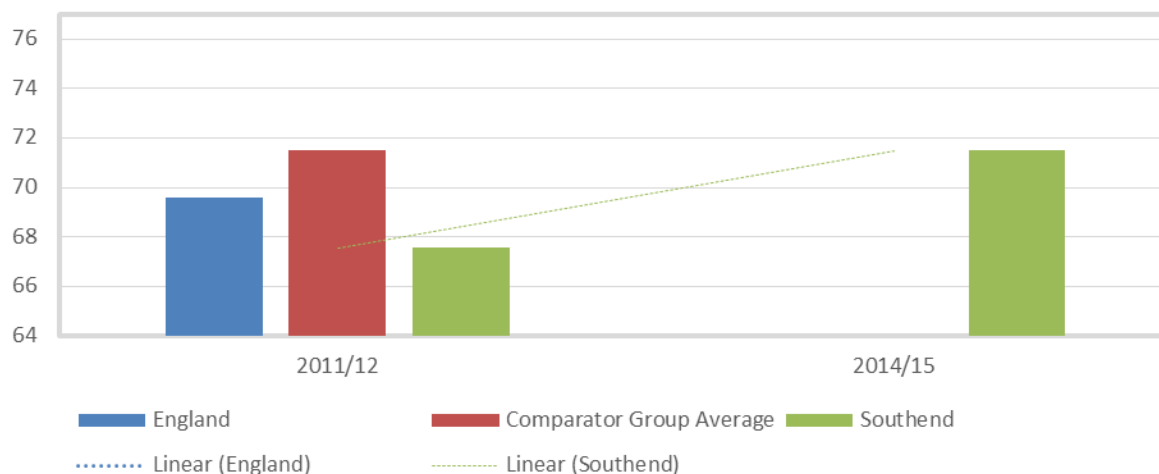
**Target:** The template asks for whether a specified increase in reporting of medication errors has been agreed with the Health and Wellbeing Board. At the initial submission this was in development, to be agreed.

**Frameworks:** Quality Premium Measure for 2014/15. This equates to 15% of the Quality Premium.

## Quality Premium: Local Measure Option: % of patients with long-term conditions who feel supported to manage their condition

Value of KPI for Quality Premium (if chosen): £132,270 (15%)

Local Measure: % of people who feel supported to manage their long-term condition



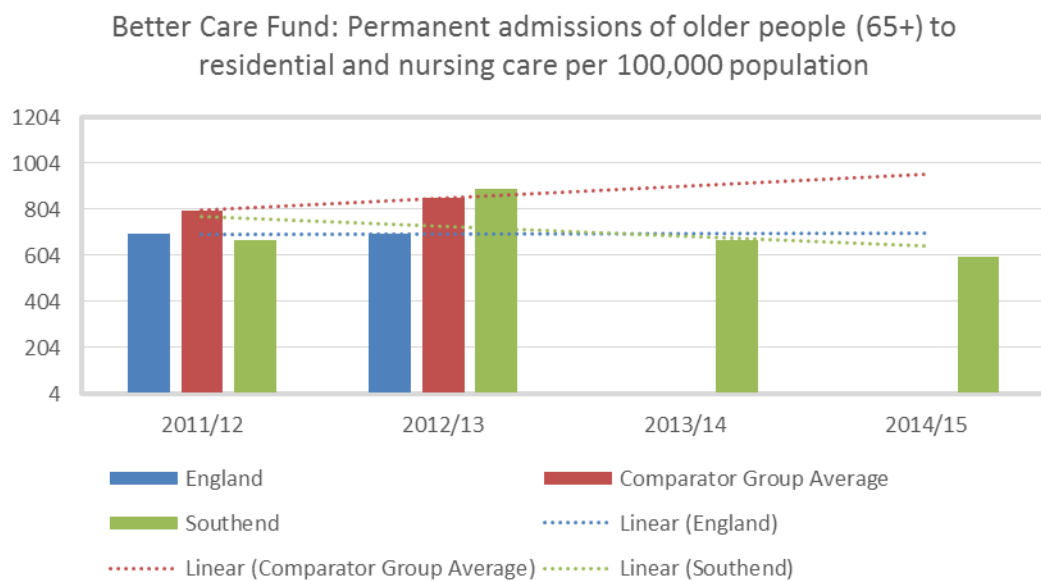
Date	% of people who feel supported
2011/12 (July 2011 to March 2012)	67.56% (25 <sup>th</sup> percentile)
2014/15 (July 2014 to March 2015)	71.50% (60 <sup>th</sup> percentile)

**Definition:** This measure focuses on the percentage of patients with long-term conditions who feel supported to manage their condition. It is measured from the GP Patient Survey and the data is collected in two waves (July to September and January to March). Data was released in September 2013 for the period July 2011 to March 2012.

**Framework:** This is a proposed local measure for Quality Premium and Better Care Fund.

**Target:** Current performance is lower than the England and comparator group average (25<sup>th</sup> percentile). The national average is currently 69.57% and comparator group (using Commissioning for Value comparative group) is 71.5%. The proposal is therefore to bring Southend in line with its comparator group (71.5%) for the period July 2014 to March 2015.

## Better Care Fund: Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population



Date	Southend value	% Change	Numerator	Denominator
2010-11	633.3			
2011-12	671.1		210	30,990
2012-13 (Baseline)	888.8	32.4%	285	31,995
2013-14	671.9	-24.4%	220	32,744 (Southend Council)
2014-15*	599.6	-10.8%	200	33,357

**Definition:** This indicator measures the rate of Council supported permanent admissions of older people to residential and nursing care relative to the size of the over-65 population. Please note that numerator and denominator is rounded to the nearest 5.

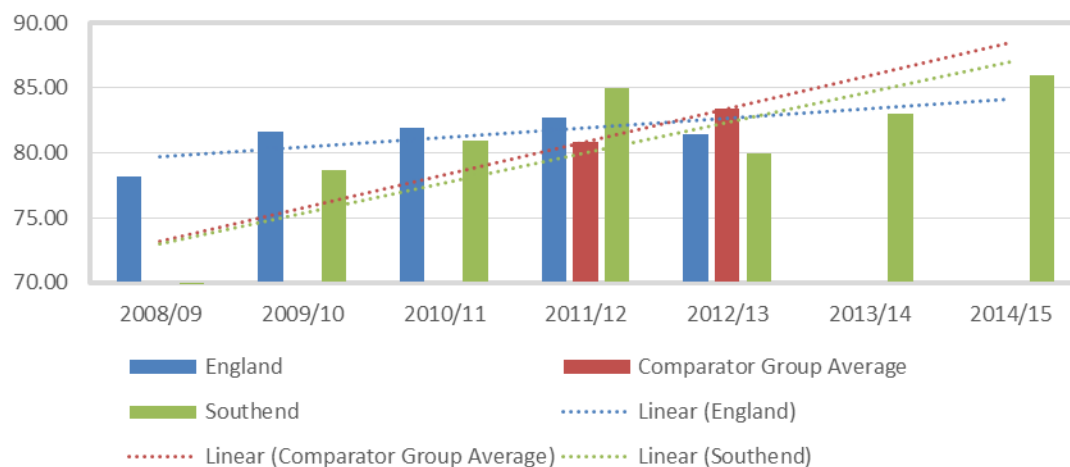
**Good performance is a low value.**

**Frameworks:** Better Care Fund measure. Please note: Target has been based on a reduction from the projected 2013-14 figure.

**\*Target:** For this measure, payment will be made in October 2015 and this will be based on 2014-15 data. There was an increase in number of permanent admissions to residential and nursing care between 2011/12 and 2012/13 such that the LA rank with the rest of the country increased from 68<sup>th</sup> to 132. The target is to bring the number of admissions down from 220 in 2013-14 (projected) to 200 in 2014-15.

## Better Care Fund: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Better Care Fund: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement or rehabilitation



Date	Southend Result / Target	% Change	Numerator	Denominator
2008/09	66.67%		50	75
2009/10	78.65%	18.0%	350	445
2010/11	80.95%	2.9%	170	210
2011/12	84.30%	5.0%	255	300
2012/13 (Baseline)	79.90%	-6.0%	185	230
2013/14	83.0% (Apr - Sept)	3.9%	Southend to confirm	Southend to confirm
2014/15	86.0%	3.6%	860	1,000

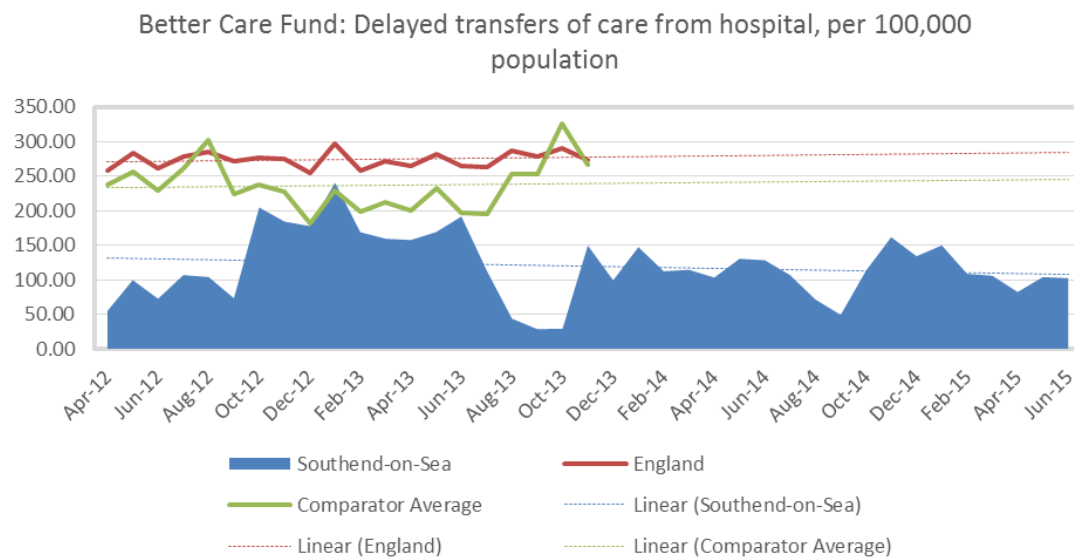
**Definition:** This indicator measures the proportion of older people who were still at home 91 days after discharge from hospital into reablement / rehabilitation. This measure works to delay dependency and reduce avoidable admissions.

**Good performance is a high value.**

**Frameworks:** Better Care Fund.

**Target:** For this measure, payment will be made in October 2015 and this will be based on 2014-15 data. Please note that data from 2010/11 previous should be treated with caution. Numerator and denominator rounded to the nearest 5. Using the BCF statistical calculator a statistically significant change would be an increase to 86.0% (a 7% increase on the baseline). **The target is also consistent with the locally agreed Southend Council target.**

## Better Care Fund: Delayed transfers of care from hospital per 100,000 population



Date	Southend value	Numerator	Denominator
April 2012	55.39	76	137,200
May 2012	99.85	137	137,200
June 2012	72.89	100	137,200
July 2012	107.14	147	137,200
Aug 2012	104.23	143	137,200
Sept 2012	73.62	101	137,200
Oct 2012	204.81	281	137,200
Nov 2012	184.40	253	137,200
Dec 2012	177.84	244	137,200
Jan 2013	240.52	330	137,200
Feb 2013	169.10	232	137,200
March 2013	159.62	219	137,200
April 2013	157.68	218	138,253
May 2013	169.25	234	138,253
June 2013	191.68	265	138,253
July 2013	113.56	157	138,253
Aug 2013	44.12	61	138,253
Sep 2013	28.93	40	138,253
Oct 2013	29.66	41	138,253
Nov 2013	149.73	207	138,253
Baseline			
Apr – Dec 2014	1,001	1,391.6	139,081
January to June 2015	6,54.5	916	139,949

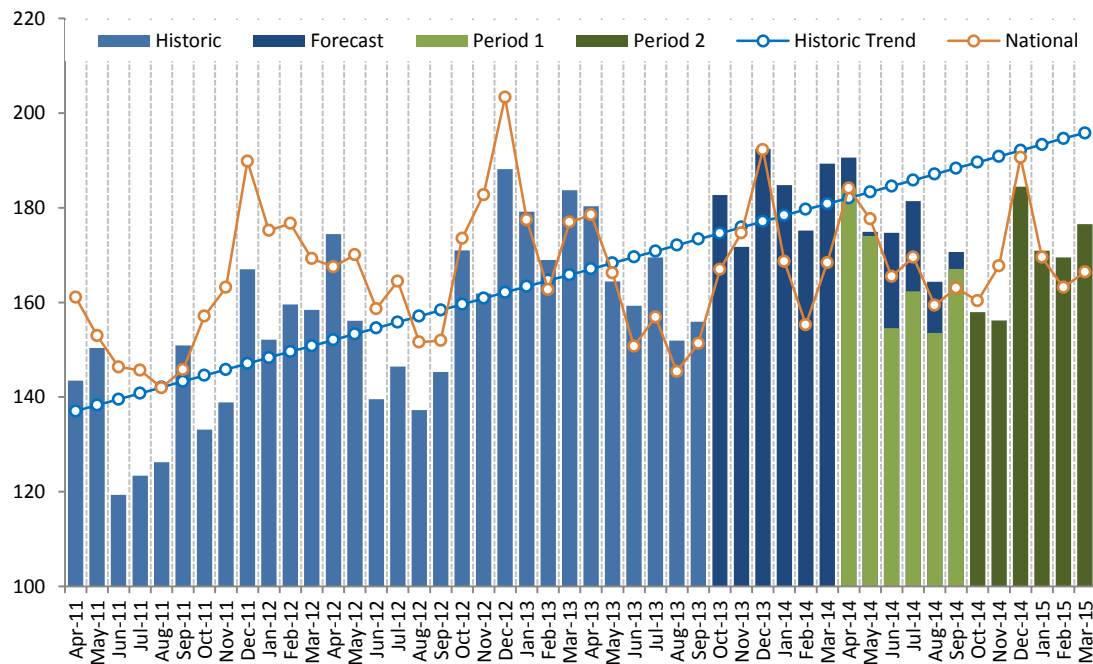
**Definition:** This indicator measures the number of delayed discharges of care per 100,000 population (attributable either to health, social care or both). A delayed transfer occurs when a patient is ready for a transfer from a hospital bed but is still occupying that bed.

**Good performance is a low value.**

**Frameworks:** Better Care Fund. Please note that the rate is divided by the total number of months included in the numerator to give average monthly delayed discharges.

**Target:** April 2015 payment will be made on the period April to December 2014 (performance for April to December 2013 was 120 per 100,000). October 2015 payment will be based on the period January to June 2015 (performance for January to June 2013 was 181 per 100,000). 2012/13 baseline is 137.45 per 100,000.

## Better Care Fund: E.A.4: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community



Date	Southend Result / Target	Numerator	Denominator
Baseline FY 12/13	1939.58	3421	176379
Forecast FY 13/14	2067.58	3671	177533
Performance underpinning April 15 payment (Apr – Sep 14)	995.77	1768	177533
Performance underpinning Oct 15 payment (Oct – March 15)	1012.26	1809	178710

**Definition:** This is a composite measure of: unplanned hospitalisation for chronic ambulatory sensitive care conditions; unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s; emergency admissions for acute conditions that should not usually require hospital admission; emergency admissions for children with lower respiratory tract infections;

**Frameworks:** Outcome Ambition Measure and Quality Premium Measure (accounts for 25% of Quality Premium) and Better Care Fund measure. Please note that this measure is for the Better Care Fund.

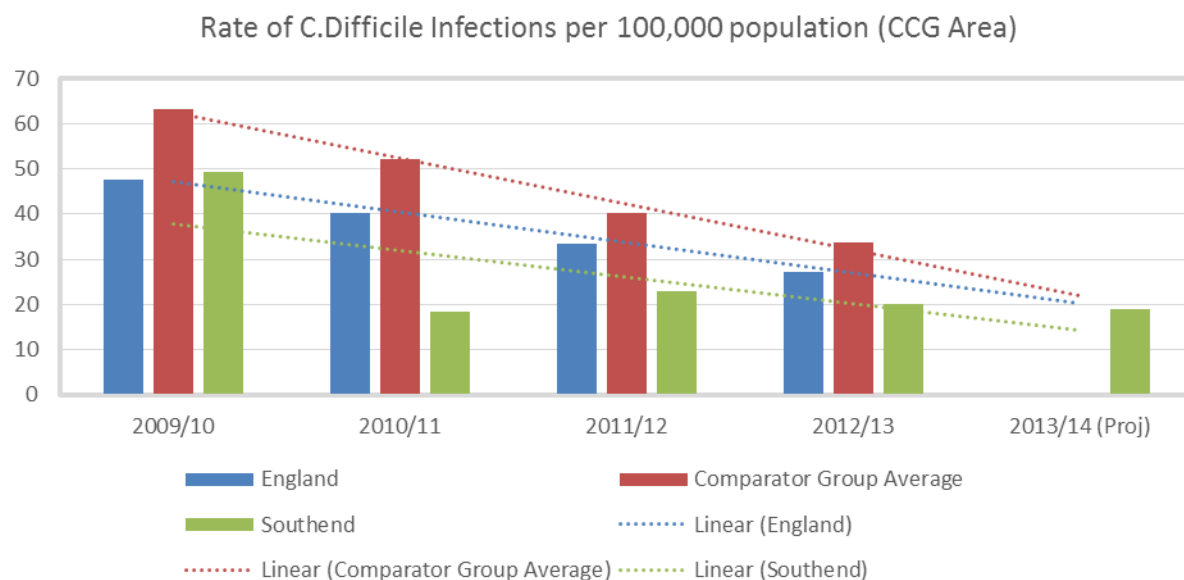
**Good performance is a low value.**

**Target:** BCF payment will be based on performance from April 2014 to September 2014 (995.77) and October 2014 to March 2015 (1012.26).

This has taken historical and baseline data, applied a statistically significant reduction using the NHSE ready reckoner tool. The resultant targets show a steady reduction towards this result.



## Other Measure: E.A.S.5: Number of C.Difficile Infections (and Quality Premium Local Measure Option)



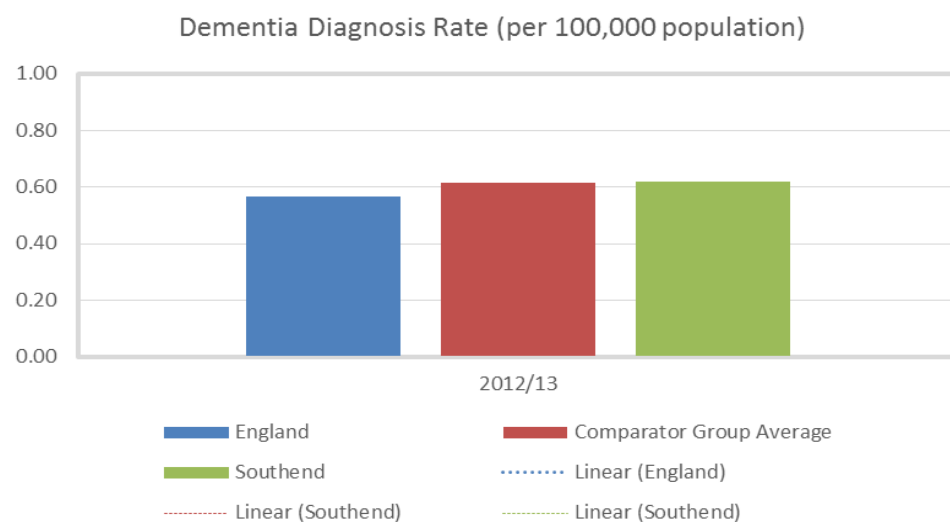
**Definition:** This measure considers the number of C.Difficile infections reported in over 2 year olds. National data is available from April 2013 to September 2014 for incidents.

**Target:** C.Diff target is taken from 2013/14 26 per year national target . The national target for 14/15 has been set at 36 cases.

The current trajectory is above the target. The number of actual incidents reduced from 41 to 36 between 2011/12 and 2012/13 and is projected to reduce to 34 in 2013/14.

Date	Southend Result / Target
April 2013	5
May 2013	2
June 2013	3
July 2013	2
August 2013	2
September 2013	3
April 2014	2
May 2014	2
June 2014	2
July 2014	2
August 2014	2
September 2014	2
October 2014	2
November 2014	2
December 2014	2
January 2015	2
February 2015	2
March 2015	2

## Other Measure: E.A.S.1: Dementia Diagnosis Rate



	No. people diagnosed	Prevalence of dementia	% diagnosis rate
2012/13	1486	2999	49.60%
2014/15	2049	3059	67.0%
2015/16	2049	3059	67.0%

**Definition:** This measure assesses the diagnosis rate for dementia as a % of overall prevalence. This relates to QOF DEM1. Data is available annually. The planning guidance states that the increase to the national dementia target rate of 67% should be achieved by March 2015. Option 2 therefore takes this into account.

Please note that comparative data is taken as per CCG population rather than per overall prevalence of dementia. However, current performance is currently above that of England.

**Framework:** Other Measures requested in the Planning Framework.

## Other Measure: E.A.S.2: IAPT Recovery Rate

Date	No. people who have completed treatment having 2+ treatment contacts moving to recovery	No. people completing treatment attending 2+ treatment contacts minus no. people completing treatment not at clinical caseness at initial assessment	% recovery rate
2013/14	1056	1956	53.9%
2014/15	998	1995	50.0%
2015/16	1018	2035	50.0%

**Definition:** The primary purpose of this indicator is to measure improved access to psychological services (IAPT) for people with depression and/or anxiety disorders.

**Please note:** To establish the baseline 2013/14 baseline taken as first 3 quarters (1,467) giving quarterly average (489) and therefore yearly total (1956) and the same applied for the numerator first 3 quarters (792) giving quarterly average (264) and therefore yearly total (1056). No comparative data is yet available for this measure at CCG level.

**Target set as 50.0% national target.**

## Other Measure: E.C.7-8: Activity Trajectories A&E Attendances

	A&E Attendances – All Types	% Reduction	Ambition
2014/15 Total	54,515	0.5%	The trend over 13/14 is a decrease in all type A&E attends by 3.88%. Due to this a 2% decrease on activity has been applied.
2013/14 Forecast	54,789		
Forecast Growth 2014/15	-0.5%		
2015/16 Total	54,242	2.0%	
2015/16 Forecast Growth	0.5%		
2016/17 Total	53,971	2.0%	
2016/17 Forecast Growth	0.5%		
2017/18 Total	53,701	2.0%	
2017/18 Forecast Growth	0.5%		
2018/19 Total	53,433	2.0%	
2018/19 Forecast Growth	0.5%		



# **IMPROVING THE HEALTH AND WELLBEING OF OUR COMMUNITIES**



## Improving the health and wellbeing of our communities

We have devised a services of work streams to help us improve the health and wellbeing of people in Southend by the way that we commission services.

Each of these work streams will help us achieve our ambitions as outlined in the 'Frameworks, measures and delivery' section of this plan.

All of these improvement work streams have been devised by taking a system-wide view of the health needs of the Southend population.

Where possible and appropriate, we are commissioning services jointly with our partners

We have robust monitoring and governance processes in place to ensure the effective delivery of our improvement work streams.

Detailed implementation plans for each of these work streams, including milestones and key performance indicators, can be found at appendix X.

LEADS: M. DOOLEY, DR B . HOUSTON, DR A. IRLAM, DR K. CHATURVEDI

## IMPROVEMENT WORK STREAM ONE: PLANNED CARE

### **Aim: Implementing pathway improvements to deliver sustainability**

It is jointly recognised across the Southend healthcare system that in order to achieve affordability of the services we offer to our patients without compromising on clinical quality or patient outcomes we need to operate collectively and in a different way.

#### **Joint Improvement Planning Framework**

Working collaboratively with key partners, we have instigated the development of a Joint Improvement Planning Framework (JIPF).

The framework is predicated on the principles of openness, transparency and collaboration and takes QIPP delivery from commissioner-led demand management to system-wide joint improvement planning as a recognition of both the in-year affordability challenge and the requirement to develop and implement sustainable service delivery in partnership.

This new approach represents a strategic change of direction for Southend and affords significant opportunity to transition the way we deliver our services across a range of schemes to embed future sustainability.

It is recognised that there are a range of opportunities to drive improvement in service areas where activity at a speciality level is evidently inconsistent with national and local averages.

Comparative PbR benchmarking data and SUHFT peer group benchmarking analysis has been used to drive reporting to highlight opportunities for improvement.

Analysis has been conducted using the Capita PbR Audit Commissioning Volume Analysis Benchmarking Tool. This tool enables the comparison on observed levels of activity and cost against expected levels based on national averages and weighted for population variations.

The analysis used has been at Provider level for all clinical commissioning groups, rather than at CCG specific level. This has enabled discussion to span both SCCG and neighbouring CP&R CCG, and opportunities are therefore respective of both organisations combined.

Further opportunity will be defined and explored through the sustainability review across Southend and the wider strategic SE Essex Acute Services Review as to the viability of future service delivery and opportunity for strategic reconfiguration.

## IMPROVEMENT WORK STREAM ONE: PLANNED CARE (cont.)

### **Aim: Implementing pathway improvements to deliver sustainability**

We will be focussing on the following approaches to drive improvement and sustainability across planned care:

- Service Restriction Policy – joint ownership and clarity to ensure principles of SRP are embedded into local clinical practice, managed through the emergent SCCG referral management process
- New to follow-up ratios – delivering improvement across a range of specialties to facilitate performance to national upper quartile
- Productivity and efficiency measures – to improve and align service delivery against agreed benchmarked levels

We have used comparative data to benchmark performance opportunities and target areas of immediate impact, as well as those with most financial significance.

We have agreed that the Joint Improvement Plan will focus specifically on the following areas in 2014-15:

- Elective admissions (including daycase)
- Outpatient activity in the areas of but not limited to:
  - Trauma and Orthopaedics (priority focus)
  - Urology
  - Cardiology
  - Paediatrics
  - General Medicine
  - Respiratory Medicine
  - Obstetrics

- Stroke
- Ophthalmology

Further granular analysis will be undertaken by the commissioning organisations and SUHFT to expand on areas of opportunity at HRG and procedural level in order to target on-going opportunity.

#### **Governance**

Informed business intelligence will support and guide the levels of focus for individual health economy-wide programmes of work under the framework of the JIPF to the in-year priorities and transitional arrangements through to point of delivery. These priorities will be managed through an overarching monthly delivery group led by the Chief Operating Officers from SCCG and SUHFT.

This group will feed into existing formal contractual mechanisms.

This group will set the agenda for each work stream and hold to account individual work streams for the delivery of specialty led focus schemes spanning commissioner and provider domains.

These groups will include clinical and managerial representation with dedicated responsible scheme owners.



# IMPROVEMENT WORK STREAM ONE: PLANNED CARE – OPHTHALMOLOGY PROJECTS

## **Aim: Implementing pathway improvements to deliver sustainability**

### **Objectives**

- Establish sustainable, quality ophthalmology services
- Develop high quality alternative service provision in the community
- Ease demand and capacity pressures faced by SUHFT
- Standardise referral practices and reduce variation in Primary Care
- Maximise patient choice from the most appropriate services available
- Improved clinical outcomes and reduction in waiting times
- Excellent patient/family/carer experience
- Collate intelligent data to inform future commissioning decisions

### **Activities**

- South Essex Ophthalmology Network established, members from all 4 CCGs, SUHFT consultants and managers, LOC representatives, local opticians and GPwSI.
- Commission a short term specialist triage to understand demand, conditions referred, source of referral
- Monitor and analyse data from specialist triage to inform decisions on commissioning of community services.
- Develop a Shared Care Glaucoma service specification to manage long term follow ups
- Continued commissioning of Glaucoma triage service from local opticians

### **Governance**

- Clinical leadership via Planned Care Lead
- Bi-monthly monitoring by South Essex Network
- Monthly monitoring of KPI data via CCG Performance meeting
- Monthly reporting to Executive level via Quality, Finance & Performance meeting
- Escalation clauses written into contract in the event of poor performance or breach of contract
- Clinical Executive or Governing Body recommendation and/or decision in the event grave concerns about performance

### **Measurement**

- Contractual KPIs relating to quality and outcomes
- Reduction of GP referrals from baseline levels at CCG and practice levels
- Reduction in cost of referrals from baseline levels
- New to follow up ratio
- Trend relating to rejected referrals or referrals returned for additional information
- % referrals directed to alternative specialties or services

(continues overleaf)

## IMPROVEMENT WORK STREAM ONE: PLANNED CARE – OPHTHALMOLOGY PROJECTS (cont.)

<b>Planned care – ophthalmology projects risk matrix</b>	
<b>Risk</b>	<b>Mitigation</b>
Failure to achieve system wide consensus on the way forward	Network role to facilitate discussion and recommend next steps
Failure to attract appropriate providers	Market research undertaken, wide scope of potential providers
Provider non-compliance with protocols, thresholds, pathways etc. resulting in increased volumes	Strict monitoring through KPIs, escalation route to be agreed through contract
Member practices failing to use electronic triage system	Practice level data reviewed monthly, any change in practice to be discussed clinician to clinician (clinical champion)
High cost provision of triage negating any savings made	short term service provision to gather intelligence to inform commissioning decisions to address demand and capacity issues, overall aim is not to make financial savings
Disengagement of member practices	Information pack to be developed explaining benefits of integration, pathways, positive changes etc.

This work stream contributes to the achievement of the following targets, standards and ambitions: Outcome Ambition 6: E.A.7: Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community

# IMPROVEMENT WORK STREAM ONE: PLANNED CARE – CLINICAL ASSESSMENT AND BOOKING

## **Aim: Implementing pathway improvements to deliver sustainability**

### **Objectives**

- Improve the quality and consistency of referrals via the use of shared clinical knowledge and expertise
- Ensure patients receive the right care in the right setting, first time
- One single point of access/referral
- Ensure all referrals made through choose and book/e-referral
- To standardise referral practices and reduce variation in Primary Care
- Maximise patient choice from the most appropriate services available
- Positive patient/family/carer experience via timely and efficient patient booking service
- Collate intelligent data to inform future commissioning decisions
- To enhance GP and AHP knowledge through structured education
- To reduce demand on secondary care services
- Effective use of resources, via a sustainable service providing good value for money

### **Activities**

- Procure an electronic clinical assessment and patient booking service for all 36 member practices

- Concentrated engagement with member practices up to and beyond implementation
- Phased implementation in 3 waves over a 4 month period
- Monitor KPIs to ensure the service is meeting quality requirements
- Minimum of annual audit to provide assurance service is achieving aims and objectives
- Monitor strict adherence to Service Restriction Policy, commissioner specifications, thresholds and referral guidelines
- Provision of timely, accurate and detailed referral data to all member practices.
- Targeted practice visits, clinician to clinician
- Provision of monthly structured education through dedicated time to learn sessions and peer review

### **Governance**

- Clinical Champion to lead project
- Monthly monitoring of KPI data via CCG Performance meeting
- Monthly reporting to Executive level via Quality, Finance & Performance meeting
- Escalation clauses written into contract in the event of poor performance or breach of contract
- Clinical Executive or Governing Body recommendation and/or decision in the event grave concerns about performance

## IMPROVEMENT WORK STREAM ONE: PLANNED CARE – CLINICAL ASSESSMENT AND BOOKING (cont.)

### Measurement

- Contractual KPIs relating to quality and outcomes i.e. assessment and patient booking turnaround times
- Reduction of GP referrals from baseline levels at practice and specialty levels
- Reduction in cost of referrals from baseline levels
- Trend relating to rejected referrals or referrals returned for additional information.
- Trend relating to referrals redirected to alternative specialties or services

### Planned care – clinical assessment and booking risk matrix

Risk	Mitigation
Disengagement of member practices	Clinical champion to be appointed with a focus on disengaged practices. Information pack to be developed explaining process to be followed, timelines, contact details, booking details etc.
Failure to attract appropriate providers	Market research undertaken, wide scope of potential providers, site visits undertaken to review operational set up
Provider non-compliance with protocols, thresholds, pathways etc. resulting in increased volumes	Strict monitoring through KPIs, escalation route to be agreed through contract
Member practices failing to use electronic triage system	Practice level data reviewed monthly, any change in practice to be discussed clinician to clinician (clinical champion)
High cost provision of triage negating any savings made	Short term service provision to gather intelligence to inform commissioning decisions to address demand and capacity issues, overall aim is not to make financial savings

This work stream contributes to the achievement of the following targets, standards and ambitions:

Outcome ambition 6 – increase proportion of people have a positive experience of care outside hospital, in general practice and community.

Quality Premium - % patients with LTCs who feel supported to manage their condition.

Better Care Fund - % patients with LTCs who feel supported to manage their condition.

## IMPROVEMENT WORK STREAM ONE: PLANNED CARE – SERVICE RESTRICTION POLICY

### **Aim: Implementing pathway improvements to deliver sustainability**

#### **Objective**

- Clear, concise clinical thresholds to inform treatment decisions
- Underpinned by documented clinical guidelines and evidence
- System wide acknowledgement and adherence
- Reduced levels of activity in areas of limited clinical effectiveness
- Collaborative perspective with Castle Point & Rochford CCG
- Effective use of resources, providing good value for money

#### **Activities**

- Clinical review of policy against best practice and latest guidance
- Agree areas where Prior Approval or Individual Funding Requests apply
- Concentrated engagement with GP member practices.
- Embed in all provider contracts
- Implement a prior approval process for identified treatments/interventions
- Integrate into Clinical Assessment service provision
- Monitor strict adherence to Service Restriction Policy and agree baselines
- Minimum of annual audit to provide assurance providers are adhering to policy

#### **Governance**

- Clinical Champion to lead project
- Monthly monitoring of KPI data via CCG Performance meeting
- Monthly reporting to Executive level via Quality, Finance & Performance meeting
- Escalation clauses written into contract in the event of poor performance or breach of contract
- Clinical Executive or Governing Body recommendation and/or decision in the event grave concerns about performance

#### **Measurement**

- Reduction of activity from baseline levels at practice and specialty levels
- Reduction in cost of activity from baseline levels

(continues overleaf)

## IMPROVEMENT WORK STREAM ONE: PLANNED CARE – SERVICE RESTRICTION POLICY (cont.)

<b>Service restriction policy risk matrix</b>	
<b>Risk</b>	<b>Mitigation</b>
Failure of GP member practices to adhere to policy	Concentrated engagement with GP member practices
Provider non-compliance with protocols, thresholds, pathways etc. resulting in increased volumes	Strict monitoring through KPIs, escalation route to be agreed through contract
Challenge to accurately monitor activity at procedure level	Procedure codes identified
Challenge to determine levels of non compliance	Audit of outlying areas
Prior approval process unable to cope with demand	Contingency plans to be developed

## IMPROVEMENT WORK STREAM TWO: LONG TERM CONDITIONS MANAGEMENT

Southend on Sea demonstrates a higher prevalence than the England average for a range of long term conditions (LTCs).

The changing demographic of the South East Essex population displays a significant increase in the number of people aged 65 and above, this coupled with improved healthcare and the effect of lifestyles which can adversely impact on our health indicate this figure is set to increase over the next 10 years, particularly those people with 3 or more conditions at once.

Examples of long term conditions include high blood pressure, chronic obstructive pulmonary disease (COPD), diabetes, coronary heart disease, dementia and arthritis.

Having a long term condition can have a significant effect on a person's life; physically, emotionally, psychologically and socially; as well as on the lives of those who care for them. We aim to ensure that as far as possible people with long term conditions are able to maintain or enhance their quality of life through high quality services and supported self- management. People with long term conditions and their carers must be at the heart of how we plan, design and deliver treatment and care to optimise health outcomes.

There is a very high estimated prevalence of COPD in Southend, although premature mortality from the condition is lower than the national average. Whilst the observed levels of COPD are low, the prevalence of smoking would suggest that there are a large number of people with the condition that are as yet undetected. Increased clinical awareness and the implementation of 'community care bundles' for COPD patients will foster and enhance self-management skills through the delivery of structured education and accessible services.

Diabetes is identified as an area of lower spend and poorer outcomes; the indicators for management of the condition are generally significantly worse than the national average. Improved management in primary care underpinned by the planned implementation of a high-quality and responsive, integrated, acute and community service will enhance outcomes and reduce the level of emergency hospital admissions. A clinical education programme will be developed to enhance the skills of primary care clinicians and reduce the variation of care accompanied by increased capacity in patient structured education.

**Aim: Ensure that safe, effective and person-centred services are in place to support people with long term conditions**

# IMPROVEMENT WORK STREAM TWO: LONG TERM CONDITIONS MANAGEMENT - DIABETES

## **Aim: Ensure that safe, effective and person-centred services are in place to support people with long term conditions**

### **Objectives**

- Fully integrated acute and community service underpinned by Primary Care across South East Essex
- High quality, seamless & responsive diabetes service
- Tiered management approach, multi-disciplinary, consultant led
- Reduce the variation of care delivered in primary care through clinical education
- Individualised care planning agreed in partnership with patient, carers & health care professional
- Improved self-management by patients and their family/carers through inclusion of goal setting
- Improved access to structured education delivered by accredited trainers
- Improved clinical outcomes and reduction in emergency admissions
- Reducing the risk of complications due to diabetes
- Excellent patient/family/carer experience

### **Activities**

- Agree single contract with one chain of command and performance management route.
- Implement a defined integrated pathway with onward referral and management protocols embedded into the diabetes pathway.

- Tiered patient management approach:
  1. GP led routine care and fulfilment of QOF
  2. Diabetes Specialist Nurse led clinics for patients with poorly controlled diabetes referred via GP.
  3. MDT approach, Consultant, DNS & Dietician. Complex & challenging patients referred via GP or DNS
  4. Hospital led care i.e. advanced renal disease, acute foot, pregnancy, complex co-morbidities
- Clear referral/acceptance criteria for tiers 2, 3 & 4 and clear discharge protocols (with management plan)
- Provide structured education to primary care clinicians and AHPs
- Additional structured education provision for patient/carers
- Utilise agreed prescribing formulary throughout primary, community and acute care

### **Risks & Mitigation**

- Failure to achieve true integration of acute and community services – Service specification details service requirements and expectations
- Failure to agree financial envelope for entire pathway provision – detailed scoping and analysis
- Failure of member practices to participate in education – structured sessions for both GPs and PNs, clear focus areas and CPD points.

(continues overleaf)



## IMPROVEMENT WORK STREAM TWO: LONG TERM CONDITIONS MANAGEMENT – DIABETES (cont.)

- Disengagement of member practices - Information pack to be developed explaining benefits of integration, pathways, positive changes etc.
- Provider non-compliance with protocols, thresholds, pathways etc. resulting in increased volumes – strict monitoring through KPIs, escalation route to be agreed through contract

### **Governance**

- Clinical leadership via Planned Care Lead
- Monthly monitoring of KPI data via CCG Performance meeting
- Monthly monitoring of prescribing activity via Drugs & Therapeutics Committee.
- Monthly reporting to Executive level via Quality, Finance & Performance meeting

- Monthly monitoring of prescribing activity via Drugs & Therapeutics Committee.
- Monthly reporting to Executive level via Quality, Finance & Performance meeting
- Escalation clauses written into contract in the event of poor performance or breach of contract
- Clinical Executive or Governing Body recommendation and/or decision in the event grave concerns about performance

### **Measurement**

- Contractual KPIs relating to quality and outcomes i.e. patient participation in structured education
- participation in structured education
- Reduction of emergency admissions for diabetes
- Reduction in cost of prescribing from baseline levels
- Improved QOF achievement at practice level

This work stream contributes to the achievement of the following targets, standards and ambitions:

Outcome Ambition 1: E.A.1: Potential years of life lost from causes amenable to healthcare

Outcome Ambition 2: E.A.2: Health related quality of life for people with one or more long-term conditions

Outcome Ambition 3: E.A.4: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community

Outcome Ambition 6: E.A.7: Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community

Quality Premium: E.A.4: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community

Quality Premium: Local Measure Option: % of patients with long-term conditions who feel supported to manage their condition

Better Care Fund: E.A.4: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community

Better Care Fund: Local Measure Option: % of patients with long-term conditions who feel supported to manage their condition

## IMPROVEMENT WORK STREAM TWO: LONG TERM CONDITIONS MANAGEMENT - STROKE

### **Aim: Ensure that safe, effective and person-centred services are in place to support people with long term conditions**

#### **Objectives**

- Support SUHFT to drive forward innovation in stroke care and achieve HASU (Hyper Acute Stroke Unit) status
- Support the move towards centralised specialist stroke centres
- Achieve the level of success demonstrated by London HASUs
- Achieve further reduction in stroke mortality
- Support continued partnership working between acute and community stroke specialist services
- Increase capacity of Stroke Early Supported Discharge Services (ESD)
- Support stroke specialist community services to deliver appropriate levels of therapy
- Improved clinical outcomes and reduced long term dependency
- Increased patient awareness of signs and symptoms i.e. FAST campaign

#### **Activities**

- Established local Stroke Network to continue
- Collaborate with neighbouring CCGs and acute Trusts to centralise specialist stroke services
- Collaborate with SUHFT and Strategic Clinical Network to work towards HASU status

- Work with SUHFT to split the national stroke tariff to accommodate changes to service (this will be a challenge but is a critical success factor)

#### **Governance**

- Strong Clinical leadership through Planned Care Lead and Lead Stroke Consultant
- Monthly monitoring of national SSNAP data via CCG Performance meeting
- Bi-monthly monitoring of national SSNAP data via local Stroke Network
- Monthly reporting to Executive level via Quality, Finance & Performance meeting
- Quality concerns monitored via SUHFT & SEPT CQRG meetings
- Escalation clauses written into contract in the event of poor performance or breach of contract
- Clinical Executive or Governing Body recommendation and/or decision in the event grave concerns about performance

#### **Measurement**

- Contractual KPIs relating to quality and outcomes i.e. % of time spent on the stroke unit.
- Reduced mortality rates

(continues overleaf)

## IMPROVEMENT WORK STREAM TWO: LONG TERM CONDITIONS MANAGEMENT – STROKE (cont.)

### Long-term conditions management – stroke risk matrix

Risk	Mitigation
Failure to achieve HASU status – SUHFT is nationally recognised as a stroke centre of excellence	
Additional investment may be required, specifically for ambulance services and recruitment – Additional activity numbers (from neighbouring areas) will lead to increased income to offset costs	
Failure to recruit stroke specialist staff – HASU status will attract suitable personnel, however there is a limited pool of stroke specialists	
ESD service is joint venture with SUHFT, Community and Social Care, agree will be required from all to increase capacity – long term sustainability of stroke services	
Additional investment will be required for ESD services – outcomes will offset	

This work stream contributes to the achievement of the following targets, standards and ambitions:  
 Outcome Ambition 1: E.A.1: Potential years of life lost from causes amenable to healthcare; Outcome Ambition 2: E.A.2: Health related quality of life for people with one or more long-term conditions; Outcome Ambition 3: E.A.4: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community; Outcome Ambition 6: E.A.7: Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community; Quality Premium: E.A.4: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community; Quality Premium: Local Measure Option: % of patients with long-term conditions who feel supported to manage their condition; Better Care Fund: E.A.4: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community; Better Care Fund: Local Measure Option: % of patients with long-term conditions who feel supported to manage their condition

## IMPROVEMENT WORK STREAM TWO: LONG TERM CONDITIONS MANAGEMENT - COPD

### **Aim: Ensure that safe, effective and person-centred services are in place to support people with long term conditions**

#### **Objectives**

Redesign respiratory (COPD) pathway to ensure:

- 100% of patients to be discharged from a respiratory bed to receive a care bundle
- 50% increasing to 75% of patients discharged from other areas of the hospital with their first exacerbation of COPD to receive a care bundle
- Primary care to be notified of the discharge within 48 hours to ensure follow up at the practice level MDT
- Increase the number of patients being managed in the community by community matrons

#### **Activities**

- Clinical leads to work with the outlying practices to identify respiratory admission and attendances and benchmark against their peers
- Review the capacity of pulmonary rehabilitation to support patients with a community setting
- The hospital to develop a robust implementation and delivery plan

#### **Measurement**

- Number of patients discharged with a care bundle.
- Reduction in the number of respiratory non elective admissions.
- Increase in the number of patients with a COPD discussed at practice level MDT.

- Improved patient outcomes.
- A greater number of patient being able to self-manage their long term condition
- Increase the number of patient with a new diagnosis of COPD being recorded on the QOF register.
- All patients with COPD to be known to the community matrons.

## IMPROVEMENT WORK STREAM THREE: INTEGRATED CARE

Good integrated care sees multiple organisations and professionals working closely together to achieve better outcomes for the patient, such as being able to remain independent in their own homes for longer and managing their conditions in a community setting rather than requiring hospitalisation.

Developing good integrated care in Southend is crucially important as Southend's growing and ageing population will increase the demand on the health and social care economy – growth in funding will not increase at the same rate.

The development of integrated care in Southend is already well underway. For example, partners have established a Single Point of Referral (SPOR) which is helping professionals work better together to prevent avoidable admissions to acute care of older people who require health or social care interventions.

Another integrated care initiative that has been established in Southend is the Community Specialist MDT. This weekly forum meets to discuss and develop care plans for patients who have been deemed at high risk of having an admission to hospital. The Community Specialist MDT is led by a community geriatrician and includes representatives from district nursing, social care, community matrons, community dementia nurses, DAU, end of life, the SPOR and East of England Ambulance Service.

### **Leading the way for health care reform**

Southend has been named as national pioneers in health and social care integration, an accolade which recognises the great progress partners have made in joining up and improving health and social care services.

Over the next two years, the pioneer partnership comprising NHS Southend Clinical Commissioning Group, Southend-on-Sea Borough Council, Southend University Hospital NHS Foundation Trust and South Essex Partnership University NHS Foundation Trust, will improve the way that services are commissioned and contracted to achieve better value for money for local people, with a specific focus on support for the frail elderly and those with long term conditions.

In addition, Southend is a 'Year of Care' pilot site. As one of only 14 pilot sites in England, Southend will receive additional funding, support and guidance to develop integrated care and change the way care for people with long term conditions is funded. As part of the scheme GPs will have more control over the way money is spent to manage the care of their patients with certain specified long-term conditions.

## IMPROVEMENT WORK STREAM THREE: INTEGRATED CARE – ambulatory

**Aim: improving the integration of health and social care services to prevent avoidable admissions to hospital and support people to manage their health conditions in the community**

### Objectives

- Implement a redesigned ambulatory care pathway in SUHFT to reduce the number of patients with a 0-1 lengths of stay

### Activities

- Review the current ambulatory care pathways
- Develop a seamless, integrated patient pathway for ambulatory care

- Provide patient education around alternative health care services
- Improve the quality of ambulatory care

### Measurement

- Reduction in the inappropriate A&E attendances
- Reduction in 0-1 lengths of stay
- Better patient experience

Integrated care – ambulatory risk matrix	
Risk	Mitigation
Pressures on the system continue to rise	Assess the changes already made to ensure that they are fit for purpose and are not increase the pressure on the system, Additional work to be carried out to developed additional reductions to reduce the increase pressure
Lack of clinical engagement at the start of the redesign work will delay the implementation	Full stakeholder engagement is required though out the mapping of the pathway.
Patient education not reaching patients who frequently use emergency services inappropriately	Communication plan to be developed and actioned to ensure the message reaches communities who are high users of emergency services
Patient outcomes do not improve with in ambulatory care.	Evaluation the changes made to identify way the service has not improved.

## IMPROVEMENT WORK STREAM THREE: INTEGRATED CARE –A&E attendances

### **Aim: improving the integration of health and social care services to prevent avoidable admissions to hospital and support people to manage their health conditions in the community**

#### **Objectives**

- Reduce the total number of A&E attendances by reducing inappropriate A&E attendances

#### **Activities**

- Increase access to primary care
- Health education for both patients and health professionals
- Develop alternative health care provision for minor injuries
- Benchmark and peer review of practices with high A&E attendances
- Develop admission avoidance alternative in partnership with the Ambulance service

- Develop the SPOR to include care home referrals
- Increase the awareness of NHS 111 as an alternative to A&E minor's service

#### **Measurement**

- Reduction in inappropriate A&E attendances
- Better patient experience
- Reduction in the number of A&E attendance from care home registered patients
- Increase in the number of referral made to SPOR for registered care home patients
- Increased access to primary care for emergency appointments

<b>Integrated care - A&amp;E attendances risk matrix</b>	
<b>Risk</b>	<b>Mitigation</b>
A&E activity continues to growth over and above the national growth	A recovery plan needs to be developed and agreed by all of the stakeholders and actioned on.
Primary care access does not improve to meet the demand of the population	Ensure that all of the practices within Southend CCG have the correct number of appointment slots for their patients. If this is not achieved practices will be contract managed by NHS England.
Alternative provision does not reduce A&E activity but generates a greater demand	Review the activity flowing through the alternative provision to identify the need is greater than first identified
Patient experience does not improve.	Evaluation the changes made to identify way the service has not improved.
Care home continue to use A&E and the first contact when a suitable clinical alternative is available.	Education for care homes is essential to ensure that they are full aware of the alternative service available.
Ambulance service continues to convey patients to A&E when a suitable clinical alternative is available.	Engagement with the ambulance service at the start of the process to ensure the service is suitable for their needs and is fully utilised.

## IMPROVEMENT WORK STREAM THREE: INTEGRATED CARE – GP coordination of 75+ care

### **Aim: improving the integration of health and social care services to prevent avoidable admissions to hospital and support people to manage their health conditions in the community**

#### **Objectives**

- All patients over the age of 75 to have robust co-ordinated care which is managed by the GP

#### **Activities**

- Supporting practices with the administration and risk stratification of patients to be discussed at the MDT.
- Increase the usage of Caretrak to risk stratify patient to help identify patients at high risk of an acute admission
- Ensure that all GP practices undertake a practice level MDT at least quarterly to better manage high risk older patient within the community
- Increase the usage of SPOR by primary care
- Support the practices with the usage of Caretrak to help identify patients through risk stratification.
- Support the surgeries to ensure that all patients over 75 have a named GP
- Expand the SPOR services to include District Nursing and any other services which are agreed.
- Extend the current operational hours of SPOR and increase the SPOR to 7 day working
- Extend SPOR to except referrals for care homes for admission avoidance

- Develop a clear criterion for care home and suitable referrals

#### **Measurement**

- Decrease in the number of patients being admitted with a 0-1 length of stay
- Reduction in inappropriate A&E attendances for the over 75's
- Increase the number of patients managed within the own homes
- Improved patient outcomes
- Increase in the number of patients being discussed at the practice level MDTs
- Increase the use of Caretrak within the practices
- Increase number of referrals made to the SPOR by both GP and Care homes
- Reduce the number of patients over the age of 65 A&E attendances

(continues overleaf)



## IMPROVEMENT WORK STREAM THREE: INTEGRATED CARE – GP coordination of 75+ care (cont.)

Integrated care - GP coordination of 75+ care risk matrix	
Risk	Mitigation
Practices are unable to identify patients who are suitable for practice level MDT	Use Caretrak to help practices to identify patients who are high risk of an emergency admission
Patients not having a named GP to coordinate their care	Additional support is being offered to GP surgery in facilitating MDT's at practice level.
Not carrying out the MDT on a regular (Monthly) basis will show no impact on the high risk patients, as patients will attend and be admitted to A&E before the MDT has taken place.	National Direct Enhanced Service (DES) for risk stratification of patients available. Additional support is being offered to GP surgery in facilitating MDT's at practice level.
National restrictions in data sharing done not allow us to use Caretrak to access both health and social care records.	Currently working with the Department of Health to develop a solution in the short term.
Unable to agree the services to be available through SPOR	Gain agreement from SBC, CP&R and Essex CC at the scoping document
Unable to secure the additional funding for the extend on hours	Gain agreement from SBC, CP&R and Essex CC at the scoping document Ensure that SPOR has a suitable level of staffing to manage the increase in demand
Care homes referring to SPOR as an alternative to accessing the GP in primary care	Develop a clear criterion for care home and suitable referrals
SPOR unable to manage the additional referrals and as a result GP stop using the service	Ensure that SPOR has a suitable level of staffing to manage the increase in demand.
Risks and mitigations (intermediate care)	
Unable to achieve the required level of provision of intermediate care with in the Southend area.	Partnership working to ensure that the job description is appealing to potential recruits
Unable to secure the nursing home beds to be able to carry out the nursing home pilot.	Engagement with the care home at the start of the process to ensure the service is suitable for their needs and is fully utilised.
Unable to secure the clinical engagement for developing the nursing home model.	Source clinical buy-in at the start of the scoping process to help ensure the correct clinical engagement is met.
Unable to secure the partnership working to support the nursing homes with managing the patients and as a result there are poor patient outcomes	Engagement of the partners at the start of the process

## IMPROVEMENT WORK STREAM THREE: INTEGRATED CARE – care homes

### **Aim: improving the integration of health and social care services to prevent avoidable admissions to hospital and support people to manage their health conditions in the community**

#### **Objectives**

- Commission community geriatric service with a focus on reducing the number of emergency admissions and A&E attendances within care homes.
- Develop a one GP to manage one care home model within Southend to ensure a better working relationship between care homes and primary care.
- Better management of patients in the care home and avoid unnecessary admission to hospital

#### **Activities**

- Employ a community geriatrician, with an increase community facing role.
- Community geriatrician to work closely with care homes that have a high ambulance call out rate.
- Care homes being able to contact the community geriatricians directly to prevent unnecessary NEL activity.
- Develop a communication and education programme for care homes on admission avoidance.
- The designated GP to complete a ward round of the care home once a week.
- All new patients who have been admitted to the care home to be visited by the GP within 72 hours.
- Increase the SPOR remit to include referrals for care homes as an alternative to A&E

- Develop an education programme for care home on community services available
- Provide training and support GPs so that they can provide a high-quality end-of-life service to patients and increase the number of people dying in their usual place of residence

#### **Measurement**

- Reduction in the number of inappropriate care home A&E attendance and 0-1 LOS.
- Reduction in the number of inappropriate ambulance call outs.
- Reduction in the number of inappropriate domiciliary visits requested by the care homes
- Improved patient outcomes

## IMPROVEMENT WORK STREAM THREE: INTEGRATED CARE – care homes (cont.)

<b>Integrated care – care homes risk matrix</b>	
<b>Risks</b>	<b>Mitigation</b>
Unable to recruit to the service.	Partnership working to ensure that the job description is appealing to potential recruits.
Care homes unwilling to engage with the community geriatricians.	Engagement with the care home at the start of the process to ensure the service is suitable for tier needs and is fully utilised.
Care homes engaging but still having a high number of A&E and 0-1 LOS within the acute.	Education for care homes is essential to ensure that they are full aware of the alternative service available.
Care homes not using the additional services provided.	Offer care homes training on admission avoidance.

## IMPROVEMENT WORK STREAM THREE: INTEGRATED CARE – increasing the capacity within the Day Assessment Unit (DAU)

### **Aim: improving the integration of health and social care services to prevent avoidable admissions to hospital and support people to manage their health conditions in the community**

#### **Objectives**

- Increase capacity of the DAU to allow for same-day access.
- Increase the number of referrals that are made to DAU by primary care.
- Increase the number of appropriate complex patients deemed high risk referred to the specialist MDT

#### **Activities**

- Extend the operational hours of the DAU to offer same day access after 3pm.
- Increase the medical cover within DAU.
- Relocate services which are currently housed within DAU which are unrelated to elderly care to other areas of the hospital.
- Develop a communication plan to ensure the primary care is aware of the service and how to refer a patient.
- Increase the number of comprehensive geriatric assessment carried out within DAU.
- Improve reporting arrangements as current arrangements do not allow for proper assessment of DAU operation.
- Help practices identify complex high risk patients via Caretrak and risk stratification for discussion at the specialist MDT

- Develop a strong clear business case to show the benefits of investments.

#### **Measurement**

- Increase number of referrals to DAU for primary care.
- Reduction in the number of admissions to A&E for patients over the age of 65 who could have been seen in DAU.
- No patient delay in the fragility pathway.
- Improved patients outcomes which allow more patients remain independent in their own homes.
- Reduction in the number of health care care home placements.

## IMPROVEMENT WORK STREAM THREE: INTEGRATED CARE – increasing the capacity within the Day Assessment Unit (DAU)

<b>Integrated care- increasing the capacity of DAU risk matrix</b>	
<b>Risks</b>	<b>Mitigations</b>
Lack of clinical engagement from the acute consultants.	Strong engagement with all of the key stakeholders at the start of this project to ensure that it meets the needs of all the services involved.
Lack of investment to implement change.	Develop a strong clear business case to show the benefits of investments
No estates to re-home non-DAU services	Southend hospital to develop a estates plan to ensure it is able to manage the demand of the services on the hospital site
Unable to recruit the additional medical staff to support additional capacity.	Partnership working to ensure that the job description is appealing to potential recruits.

## IMPROVEMENT WORK STREAM THREE: INTEGRATED CARE – intermediate care

### **Aim: improving the integration of health and social care services to prevent avoidable admissions to hospital and support people to manage their health conditions in the community**

#### **Objectives**

- Ensure that intermediate care capacity both bedded and non-bedded is able to manage the growing population demand.

#### **Activities**

- To carry out a comprehensive review of bedded and non-bedded intermediate care needs, both now and over the next 5 year.
- Develop an action plan based on the result of the comprehensive review with all of the key stakeholders.

- Develop a pilot using nursing home beds as an alternative for intermediate care and to increase the capacity within the short term

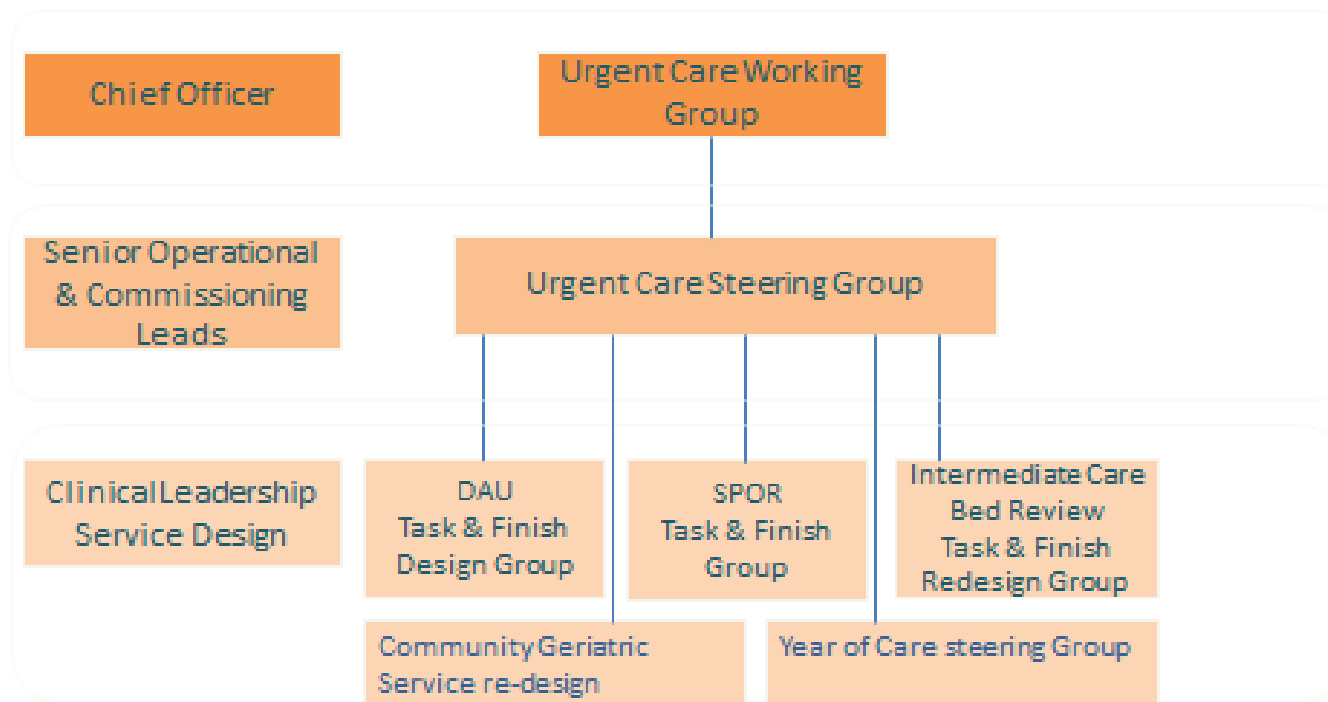
#### **Measurement**

- The number of beds available within the community compared to the number required for our population and the future.
- A reduction in the number of patients who receive an intermediate care intervention who then require long term nursing home care.
- Increase in better patient outcomes

<b>Integrated care – intermediate care risk matrix</b>	
<b>Risks</b>	<b>Mitigations</b>
Unable to achieve the required level of provision of intermediate care with in the Southend area.	Partnership working to ensure that the job description is appealing to potential recruits.
Unable to secure the nursing home beds to be able to carry out the nursing home pilot.	Engagement with the care home at the start of the process to ensure the service is suitable for their needs and is fully utilised.
Unable to secure the clinical engagement for developing the nursing home model.	Source clinical buy-in at the start of the scoping process to help ensure the correct clinical engagement is met.
Unable to secure the partnership working to support the nursing homes with managing the patients and as a result there are poor patient outcomes	Engagement of the partners at the start of the process.

## IMPROVEMENT WORK STREAM THREE: INTEGRATED CARE

# System Reporting Framework



## IMPROVEMENT WORK STREAM FOUR: MENTAL HEALTH

Mental health is one of our key priorities and we are fully committed to delivering parity of esteem.

Relative to other CCGs, we have a slightly lower than average spend on mental disorders, but significantly worse outcomes. Secondary care mental health admissions are significantly higher than the national average.

The CCG compares unfavourably to national levels for care review of patients with dementia, although well for patients on the mental health register.

Dementia is a cause for concern as the increasing age profile of the local population suggests that the level of need in Southend will increase.

Southend has higher than average numbers of people receiving treatment for anxiety and depression, indicating that access to psychological therapies has improved. In common with many similar seaside towns, there is a higher than average rate of suicide.

We have made significant progress in a number of areas in 2013/14 and intend to build on this over the next two years.

The aims of the mental health work stream are set out within the South Essex Joint Commissioning Strategy. These are to improve the health and social care outcomes of the population of south Essex, by ensuring that:

- People will have good mental health
- People with mental health problems will recover
- People with mental health problems will have good physical health and people with physical health problems will have good mental health
- People with mental health problems will achieve the best possible quality of life

Considerable progress has been made in implementation of the strategy but we recognise that we have a long way to go. Some of the key health and social care achievements in mental health in 2013/14 included:

- Retendering the supporting people services within the context of the accommodation strategy
- Developing a GP crisis line
- Developing electronic referrals
- Piloting a recovery college model
- Developing personal health budgets in mental health
- Piloting psychological therapies in COPD/Stroke pathways
- Piloting the community transformation model in Southend

As part of our strategy we will implement the priority areas identified in the recent report Closing the Gap; priorities for essential change in mental health services to achieve parity between mental and physical health services.

(continues overleaf)



## IMPROVEMENT WORK STREAM FOUR: MENTAL HEALTH (cont.)

### **Aim: to improve the quality and integration of mental health services**

#### **Objectives**

- To redesign community services to reduce the reliance on inpatient care models
- To improve access by developing a single point of access for mental health
- To improve integration of services by implementation of RAID in SUHFT
- To focus on PbR as a way of improving outcomes and clarifying pathways based on need
- To focus on early intervention, personalisation and self-management through projects such as recovery colleges and personal health budgets
- To improve access and crisis pathway by system sign up to the Mental Health Crisis Concordat
- To improve outcomes by focussing on training and integration
- To deliver 155 service coverage for IAPT
- To ensure parity of esteem plan by working closely with public health to begin planning to narrow the gap in life expectancy

- To focus on improving experience
- To deliver care closer to home by improving our processes for individual placements

#### **Measurement**

- Measurement in IAPT service coverage and recovery rates
- Measurement of milestones on QIPP projects
- Measurement in dementia diagnosis rates
- Contractual KPI's with SEPT and other providers

#### **Governance**

The South Essex Joint Commissioning Strategy was developed by the 4 CCG's and 3 local authorities within south Essex. After one year of implementation the partners are reviewing current governance arrangements to decide the best footprint to deliver the next stages of delivery. Therefore the governance will evolve rapidly over the early part of the financial year to ensure timely and effective decision making.

This work stream contributes to the achievement of the following targets, standards and ambitions:

Other Measure: E.A.S.2: IAPT Recovery Rate; Other Measure: E.A.S.1: Dementia Diagnosis Rate; Quality Premium: E.A.3: IAPT Rollout; Outcome Ambition 1: E.A.1: Potential years of life lost from causes amenable to healthcare (per 100,000 population); Outcome Ambition 2: E.A.2: Health related quality of life for people with one or more long-term conditions; Outcome Ambition 3: E.A.4: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community; Outcome Ambition 6: E.A.7: Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community

## IMPROVEMENT WORK STREAM FOUR: MENTAL HEALTH (cont.)

### Mental health risk matrix

Risk	Mitigation
Cultural change – the implementation of the mental health strategy requires cultural change. It requires a change in the way services are delivered to patients by moving more care into primary and community with less reliance on inpatient services	The implementation plan is shared between provider and commissioner so both sides are committed to change
Stakeholders – the change requires wider stakeholder buy in. The south Essex system is complex with 3 health and wellbeing boards	Workshops to review the work programme and agree responsibilities and accountabilities
Joint working commissioners – the system changes require joint decision making	Workshops to review joint decision making and collaborative arrangements
QIPP challenge – the QIPP challenge for mental health is considerable	The plan is achievable through joint working and co-operation
The IAPT service coverage target is challenging. The current levels of referral are insufficient to support 15% service coverage	The IAPT transformation plan will target unmet demand by using innovative approaches to meeting diverse population needs

LEADS: S. WILLIAMS, DR K. NG, DR J. GARCIA

## IMPROVEMENT WORK STREAM FIVE: MEDICINES MANAGEMENT

Good medicines management means that all medicines prescribed across the local health economy will be carried out safely and cost-effectively using a strong evidence base.

This requires excellent communication between Primary and Secondary care, community pharmacists, community nursing and mental health teams. It involves both clinical staff who may diagnose, prescribe and review patient's conditions and non-clinical staff who may be involved in generating repeat prescriptions.

Good medicines management in Southend is crucial for our growing and ageing population. This aligned with new technologies and our ability to identify and treat diseases at an earlier stage will increase the pressure on the medicines budget.

There are already strong relationships with regard to medicines management across Southend. There is good clinical engagement and a strong track record of collaborative working which needs to be further developed if we are to achieve the high ambitions that we have set.

The CCG Medicines Management Team already work closely with existing clinical networks (respiratory, diabetes and cardiology) and have regular face to face meetings with the hospital dietetics and pharmacy teams. There is an established schedule of GP practice visits that has recently been enhanced by the inclusion of GP Leads on each visit as well as a prescribing leads network.

Some of the work that has been undertaken locally to improve services over the last year has been adopted regionally (prescribing of ostomy products and dietetic guidelines) and we are currently working with SUHFT to further enhance the anticoagulant clinic and identify those patients who might benefit most from newly introduced medicines.

Throughout 2014-16 we will be further strengthening these networks, updating and enhancing prescribing protocols and guidelines, ensuring medicines are considered and included in all clinical pathways and redesign and using contract levers with SUHFT to improve medicines management across this interface.

(continues overleaf)

## IMPROVEMENT WORK STREAM SIX: MEDICINES MANAGEMENT (cont.)

### **Aim: To ensure all prescribing is undertaken in a safe, evidence based and cost-effective manner**

#### **Objectives**

- To improve adherence to NICE guidance in relation to anti diabetes prescribing
- To improve adherence to British Thoracic Society Guidelines for asthma prescribing
- To make the prescribing of lipid lowering medication more cost-effective
- To review the prescribing of medicines within the Central Nervous System chapter
- To improve safety relating to the prescribing of high risk medicines
- To improve awareness and cost-effectiveness of prescriptions relating to Nutrition
- To reduce the number of inappropriate prescriptions for antibiotics

#### **Activities**

- Identify GP practice outliers and offer targeted support
- Practice nurse audits
- Time to learn sessions delivered by GP Leads and Medicines Management Team
- GP Practice visits attended by GP Leads and Medicines Management Team
- Prescription clerk audit of inhalers and nutrition

- GP practices to review and switch/stop prescriptions
- Benchmarking data to be analysed monthly by Medicines Management Team
- Develop a Quetiapine protocol in conjunction with SEPT
- Develop a Pregabalin protocol in conjunction with SUHFT
- Identify patients suitable for repatriation to SUHFT
- Discuss repatriation with hospital pharmacy team
- Repatriate using clear protocols
- Prescribing guidelines are communicated to all stakeholders
- Use of contract to improve discharge information

#### **Measurement**

- Number of practice nurses/clerks trained
- Audits completed by practices
- Spend on medicines prescribed by GP practices
- Benchmarking of prescribing costs with other CCGs
- Monthly monitoring of number and cost of prescriptions
- Number of prescriptions compared year on year

This work stream contributes to the achievement of the following targets, standards and ambitions: QIPP and Outcome Ambitions 1 & 2 and Quality Premium AE9

## IMPROVEMENT WORK STREAM SIX: MEDICINES MANAGEMENT (cont.)

**Aim: To ensure all prescribing is undertaken in a safe, evidence based and cost-effective manner**

<b>Medicines management risk matrix</b>	
<b>Risk</b>	<b>Mitigation</b>
Lack of clinical engagement with changes to prescribing	Clinical champions Prescribing Incentive scheme Practice support and training Developing stronger relationships with senior clinicians in acute setting Use newsletters and clinical meetings to clarify and reinforce messages about prescribing protocols
Patients unhappy with change	Patient information sheets Practice support Fostering clear communication between clinicians and patients

## IMPROVEMENT WORK STREAM SIX: CONTINUING HEALTHCARE

SCCG will continue to provide continuing healthcare for patients who require on-going health care and meet the eligibility criteria.

### **Aim: Embed quality and choice within CHC, ensuring commissioned services are safe, effective and provide value for money.**

#### **Objectives**

- Develop and support a culture of continuous improvement and patient choice
- Make effective use of data to support key quality improvements
- Improve patient choice
- Work within financial allocations
- Increase the percentage of patients reviewed annually from its current position
- Individuals have choice where possible of care packages
- Access to monthly CHC dashboard
- Collaborate with CHC/CSU team for access
- Quality visits at provider locations
- Work closely with local authority to investigate any issues or concerns
- Ensure national guidelines around reviews are adhered to.
- CHC Dashboard (new initiative)
- Investigation of complaints and concerns are addressed in a timely fashion

#### **Governance**

- Quarterly updates to QFP to also include forecasting
- CSU Performance Meetings (Monthly)
- fortnightly meeting with CHC & Quality Team
- CHC Steering Group monthly
- CHC Panels

#### **Measurement**

- Clinical audit of assessments
- Quarterly reports to CCG and assessors re findings
- 95% quarterly CHC reports are delivered in agreed timelines
- Percentage of complaints and concerns responded to within 21 days

#### **Activities**

- Monitor CQC website for reports from recent providers reviews and inspections
- Monitor NHS Choices for patient reviews
- Where care packages are not cost effective individual care packages will be reviewed.
- Work with partners to ensure right care package of care is delivered
- Effective use of CHC panels to agree care packages
- Work with CSU to ensure adequate staffing levels to meet requirements for reviews

This work stream contributes to the achievement of the following targets, standards and ambitions: Outcome Ambition 2: E.A.2: Health related quality of life for people with one or more long-term conditions

## IMPROVEMENT WORK STREAM SEVEN: CHILDREN'S SERVICES

The focus for the children's schemes is to improve quality and reduce utilisation on secondary care services, moving to a joint agency approach across health and social care to integrate key pathways, including meeting the national SEND reforms, putting the patient and family at the centre of their care.

### **Aim: Ensure children & young people have a positive start in life**

## IMPROVEMENT WORK STREAM SEVEN: CHILDREN'S SERVICES - improving quality and building capacity in local services

### **Objectives**

- To develop a local paediatric Dysphagia service
- To develop a local Autistic Spectrum Disorder (ASD) service and build local capacity
- To develop a shadow tariff for community paediatrics service and ensure value for money
- To re-procure the Child Death Rapid Response service

### **Activities**

Dysphagia service:

- Repatriation of tertiary activity to a local service
- Review/ develop joint commissioning arrangements in line with SEND agenda.
- Identification of referral rate and activity levels to inform the size, age complexity and scope of the caseload.
- Use of information to draw up detailed protocols and pathways

- Identify line management and governance structures and reporting methods
- Joint Strategy for SLT with LA, including pathway for communication aids
- Understand current level of need - review aspiration admissions at SUHT

ASD:

- Develop a process to ensure that patients in South Essex can access diagnostic testing for ASD from a local service with the development of the existing STAARS Service and repatriation of current tertiary activity for South East Essex.
- The immediate focus has been, resolving the short term issues facing the existing service due to their pressing urgency.
- The aim of this project is to ensure that all children are given the opportunity to attain and maintain their quality of life.

## IMPROVEMENT WORK STREAM SEVEN: CHILDREN'S SERVICES - improving quality and building capacity in local services (cont.)

- This will be achieved through adherence to NICE and NAPC guidelines:
- Timely identification, assessment, diagnosis
- Access to early interventions
- Review/ develop joint commissioning arrangements in line with SEND agenda.
- Joint Strategy for ASD with LA, including provision for after diagnosis
- Understand current level of need

### Shadow tariff:

- Phase 1
- Review of the centre focusing on:
  - Core business – activity, staffing, link between Acute & Community, service specifications, provision of equipment
  - Resource envelope
  - Future developments and opportunities
- Phase 2
- Work plan in year for 2014/15
- Benchmarking against other areas who are piloting a community-based tariff, such as Medway
- Month 6 - shadow tariff is rolled out

### Child death rapid response service:

- October 2013: Project Start
- January 2014: Board Sign off
- January 2014: Advert published with ITT
- March 2014: ITT bidder submission of completed response
- (no date) ITT Bidder interview (all bidders)
- April 2014: Complete ITT bid evaluation stage
- April 2014: Evaluation report to Project Board
- April 2014: CCG approval of recommendations
- May 2014: Contract/s award
- June 2014: Service Commencement

### Governance

- CCG Boards & Clinical Executive Group
- QIPP Performance & Finance Group
- Paediatric Clinical Engagement Group
- Equality & Diversity Review Group



## IMPROVEMENT WORK STREAM EIGHT: CANCER

South East Essex is in the second lowest quintile nationally for spend per 100,000 population on cancers and tumours and below the ONS cluster average. Cancer mortality is similar to the national average.

It is recognised that better prevention through tackling lifestyle behaviours and promoting screening can further reduce the need for admissions and resultant spend.

The level of mortality from cervical cancer in Southend is at the higher end of the spectrum and it is important that the uptake of screening programme offers is encouraged to improve outcomes from early detection and intervention.

The two week waiting times are generally better than target, but a steady increase in referrals is noted. The percentage of patients receiving treatment within two months compares favourably to the national average.

Improving outcomes for people with cancer is not just about higher survival rates. It is also about improving patients' experience of care and the quality life of cancer survivors.

### **Aim: To ensure a continued quality improvement for people with cancer and improve the patient experience of care by driving out variation in care pathways and reducing inequality of access**

#### **Objectives 2014-16**

Our objectives in 2014-6 will include:

- To engage in the East of England Strategic Clinical Network agenda through representation and membership of the Essex Cancer Forum
- Working collaboratively with CP&R CCG to deliver a uniform approach to patient cancer care across Southend
- Support the delivery of Improving Outcomes Guidance (IOG) compliance under the direction of the East of England Strategic Cancer Clinical Network
- To review and develop urology and anal cancer pathways with SUHFT to ensure IOG compliance
- To work with SUHFT to ensure appropriate capacity and resource to manage service demand for specialist urological cancer
- To support improvement of cancer outcome indicators against 2013 baseline
- To support improvement in the appropriateness and quality of referrals and engage with members in relation to their responsibilities around early detection
- To work collaboratively with public health to support and inform GPs on early detection initiatives
- To support initiatives to raise local awareness through participation in campaigns

(continues overleaf)

## IMPROVEMENT WORK STREAM EIGHT: CANCER (cont.)

- In addition to the constitutional measures, to monitor screening performance and uptake of screening programmes locally
- Based on guidance from the clinical network to ensure the improving outcomes guidance for children and young people is fully implemented locally, with streamlined access to specialist centres, supported by robust local MDT arrangements

This work stream contributes to the achievement of the following targets, standards and ambitions:

All constitutional measures on cancer waits; Outcome Ambition 1: E.A.1: Potential years of life lost from causes amenable to healthcare; Outcome Ambition 2: E.A.2: Health related quality of life for people with one or more long-term conditions; Outcome Ambition 3: E.A.4: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community; Outcome Ambition 6: E.A.7: Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community; Quality Premium: E.A.4: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community; Quality Premium: Local Measure Option: % of patients with long-term conditions who feel supported to manage their condition; Better Care Fund: E.A.4: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community; Better Care Fund: Local Measure Option: % of patients with long-term conditions who feel supported to manage their condition



# ACCESS



## Access

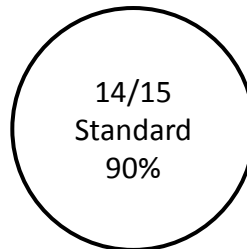
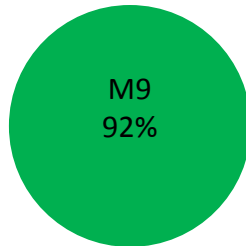
We are committed to the delivery of the NHS Constitution for the Southend population.

The following seven pages show our 2013/14 performance against the NHS Constitution measures and the actions we are putting in place to ensure that we meet all the required standards in 2014-16.

# NHS Constitutional Measures – Referral To Treatment

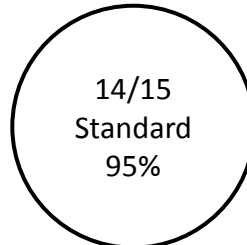
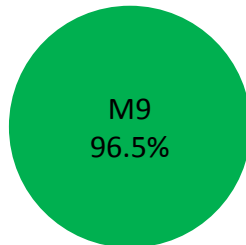
## Referral To Treatment waiting times for non-urgent consultant-led treatment (NHS Southend CCG)

Percentage of patients admitted to start treatment within a maximum of 18 weeks from referral



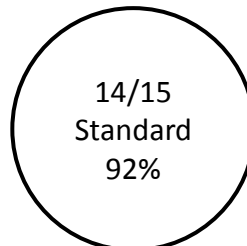
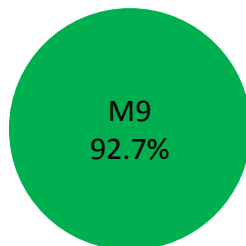
The CCG is working closely with SUHFT on actions to deliver improvements in the waiting times for patients at provider and speciality level. Compliance against this standard has presented challenges throughout the year to date, not least with the impact of the Oral Surgery backlog which was inherited from a backlog of non-admitted patients. The Trust has been working to reduce the number of patients on admitted pathways during 2013/14. Focus is now on speciality level compliance to deliver the required backlog reduction in Q4. This works in parallel with the Trust focus on tackling a number of data quality issues that have impacted since the introduction of a new PAS in early December 2013.

Percentage of non-admitted patients to start treatment within a maximum of 18 weeks from referral



Non-Admitted pathways have been compliant in all but two months of the year to date with the inclusion of oral surgery. Excluding oral surgery the Trust has consistently achieved non-admitted compliance each month of the past year. The CCG will continue to work with the Trust to deliver reduced waiting times in outpatients to provide greater sustainability to the overall pathway, thus mitigating against long waits in areas where conversions rates are more prevalent.

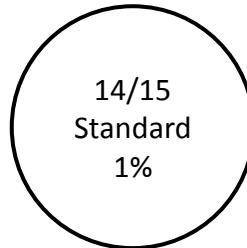
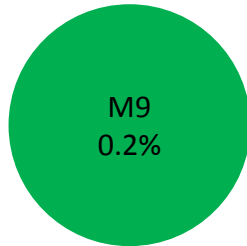
Percentage of patients on incomplete non-emergency pathways (yet to start treatment) who should wait no more than 18 weeks from referral



The Trust has delivered compliance against the incomplete standard of ensuring that 92% of patients have consistently waited less than 18 weeks. The work tail-gunning the admitted waits at sub-specialty level will support the assurance required by the CCG that patients are not waiting significant lengths of time whilst ensuring that the maximum combined backlog is 8% or less.

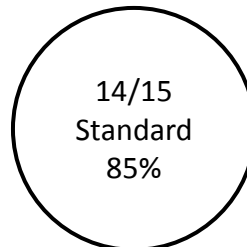
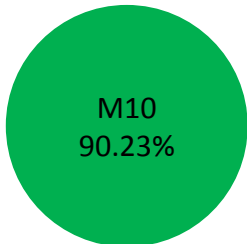
# NHS Constitutional Measures - Diagnostic test waiting times, Category A Ambulance Calls and A&E Waits (NHS Southend CCG)

Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral



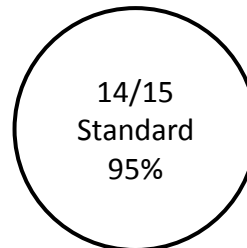
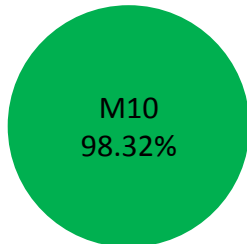
The Trust have consistently delivered compliance throughout the year against this standard with less than 1% waiting more than 6 weeks for a diagnostic test.

Category A calls resulting in an emergency response arriving within 8 minutes



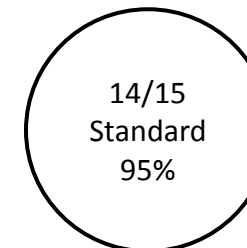
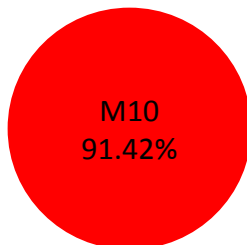
The Ambulance Services continues to exceed the national standards in the Southend CCG area. However, overall Trust performance is below standard against the suite of response indicators. This remains a key focus for the urgent care network of which EEAST are a key member.

Category A calls resulting in an ambulance arriving at the scene within 19 minutes.



As above.

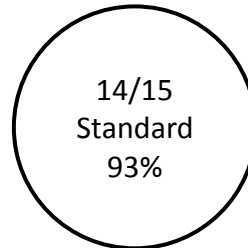
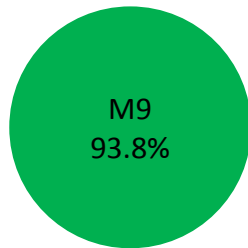
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department



January performance improved slightly on the M10 position with 91.42% recorded against the 4hr standard but with only 17 compliant days in the month presenting on-going challenge. Performance remains a significant concern and despite various actions in place within the Trust the required levels of change are slow to take hold.

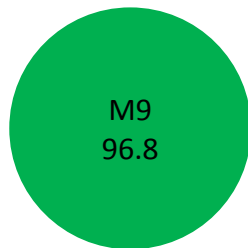
## NHS Constitutional Measures – Cancer Waits – 2 week wait (NHS Southend CCG)

Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP



Compliant

Maximum 2 week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected).



Compliant.

## NHS Constitutional Measures – Cancer Waits – 31 days

Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers

M9  
100%

14/15  
Standard  
96%

Compliant.

Maximum 31-day wait for subsequent treatment where that treatment is surgery

M9  
100%

14/15  
Standard  
94%

On the 31-day subsequent surgery standard the small numbers of patients treated each month presents a risk to compliance against the indicator as it only requires one patient of this small denominator to go beyond 31 days for the Trust to fail this target.

Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen

M9  
100%

14/15  
Standard  
98%

Compliant.

Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy

M9  
100%

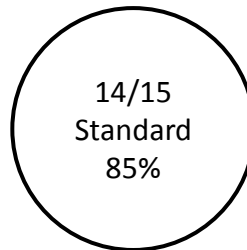
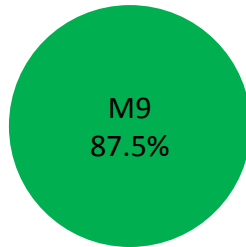
14/15  
Standard  
94%

Compliant.



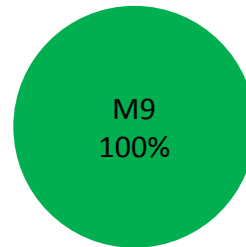
## NHS Constitutional Measures – Cancer Waits – 62 days

Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer



SUHFT has met the 62 day standard for Q3 and continues to consistently achieve the target for its own patients. Late referral from other providers continues to present challenge and the CCG has facilitated through the Inter-Provider Transfer policy a mechanism of agreement to mitigate against delayed referrals. It is recognised that compliance against this standard through Q4 will present a significant challenge, attributable largely but not limited to patient choice presenting delays in commencement of treatment during December.

Maximum 62-day wait from referral from a NHS screening service to first definitive treatment for all cancers

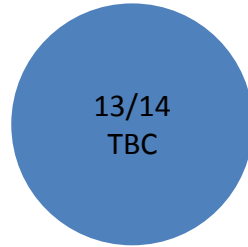


Compliant.

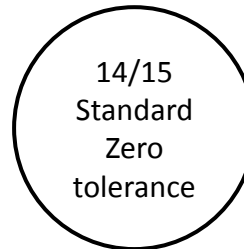
# NHS Constitutional Measures – Support Measures

## Mixed Sex Accommodation Breaches, Cancelled Operations and Mental Health

Mixed Sex Accommodation Breaches – Minimise breaches

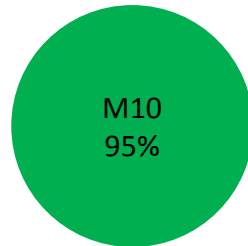


All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.



The Trust have experienced non-compliance against this standard with an increase in numbers during the third quarter. The Trust is formulating a formal response to the CCG's request for a recovery action plan which is also being compiled for the Trust Board.

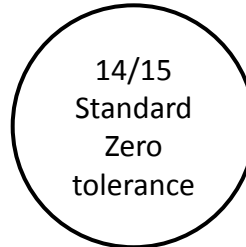
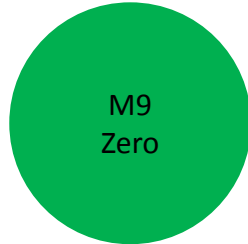
Mental health. Care Programme Approach (CPA): The proportion of people under adult mental illness specialities on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period.



Compliance is monitored on a monthly basis at contract performance meetings and any breaches are investigated to ensure that the provider has done everything possible to meet the standard and ensure safety of patients. We have also introduced a CQUIN to improve performance to follow up within 24 hours.

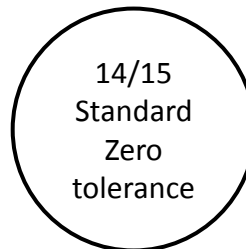
## NHS Constitutional Measures – Support Measures

Referral To Treatment  
waiting times for non-urgent consultant-led treatment. Zero tolerance of over 52 week waiters



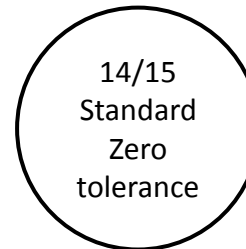
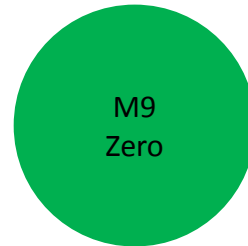
The CCG continues to work closely with the Trust to monitor and mitigate against long waiting times.

A&E Waits. No waits from decision to admit to admission (trolley waits) over 12 hours



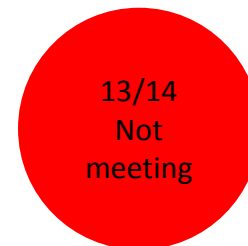
Clear system protocols and processes are in place to ensure early notification of patients at risk of breaching the standard are notified to the CCG – recovery plan to follow

Cancelled Operations  
No urgent operation to be cancelled for a 2<sup>nd</sup> time



The Trust have reported a compliant position each month to December 2013.

Handovers between ambulance and A&E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes.



Recovery plan to follow.

## Access for all: parity of esteem

Mental health is one of our key priorities and we are fully committed to delivering parity of esteem. We have made significant progress in a number of areas in 2013/14 and intend to build on this over the next two years.

The joint mental health commissioning strategy has driven key changes within Southend; the development of a GP crisis line, improving dementia intensive support services, piloting psychological therapies in long term conditions, developing shared care protocols, reducing delayed discharges and reducing admissions.

As part of our strategy we will implement the priority areas identified in the recent report *Closing the Gap*; priorities for essential change in mental health services to achieve parity between mental and physical health services.

The south Essex mental health commissioning economy is complex and one of our first tasks is to agree which aspects of the strategy are best delivered on a system perspective and which are best delivered within the CCG organisational boundary. We are focussing on the following areas:

- Improving service delivery through developments such as the single point of access and the community transformation programme
- Early intervention and self-management through developments such as mental health personal budgets and recovery colleges

- Improving access and developing the crisis pathway through developments such as adopting the national crisis concordat
- Training and integration through improving skills within primary and community care
- Improving experience through developing mental health specific friends and family tests
- Approach to prevention by ensuring that there are links between the mental health strategy and public health and wellbeing strategies

## ACCESS WORK STREAM ONE: PRIMARY CARE DEVELOPMENT

### **Aim: Support improvements in resilience, quality and access to primary care in Southend**

NHS Southend CCG commissions services on behalf of 36 GP practices, 19 of which are operated by a single GP.

We recognise that GPs are the cornerstone of the health system, and account for in the region of 80 per cent of all patient contact.

Although we do not commission GP services, it is a priority for us to work with our GP practices to help them improve their procedures and share good practice so that they are in a better position to respond well to demographic and contractual changes.

Primary care development is particularly important in Southend as it may be more difficult for smaller practices to respond to the recent changes to the national GP contract and the requirement to develop seven-day services.

We will focus on supporting improvements in the quality of primary care provided to the people of Southend. In particular, we will support the development of a GP federation in Southend, which will enable GP practices to work better together to achieve better patient outcomes.

(continues overleaf)

## ACCESS WORK STREAM ONE: PRIMARY CARE DEVELOPMENT

### Aim: Support improvements in resilience, quality and access to primary care in Southend

#### Objectives

- Support the development of a GP federation
- Support the development of seven day services in primary care
- Reduce unwarranted variation in GP practices
- Support GPs to improve patient experience of primary care

#### Activities

- Continue our programme of member practice visits, particularly focussing on supporting practices with specific need
- Support the Local Medical Committee to facilitate discussions with GPs about the development of a GP federation in Southend
- Complete D4 analytics pilot scheme, which uses innovative software to enable GPs to drive improvements, and widen the programme to use at scale upon successful completion
- Develop and implement mechanisms for member practices to apply for £5 transformation funding to improve access and services for over 75s
- Identify and work with interested practices to develop and implement 7-day services using transformation/ federation funding
- Utilise the GP member forums as a tool for education and innovation as well as networking and peer support

- Benchmark data from the GP patient satisfaction survey and distribute it to our practices
- Share benchmarked data with our practice patient participation group forum and agree how they can work within their practices to support improvements in access and patient experience
- Produce a 'how to' guide to improving access and experience for our member practices
- Target practices with poor patient satisfaction and offer them our support to implement the 'how to' guide

Primary care development risks matrix	
Risk	Mitigation
Lack of practice interest in establishing a GP federation or multiple federations being set up leading to complexity and confusion	Close working with LMC and member practices, support funding available Session held with practices in March to enable fact finding and to answer queries Funding to support establishment of federation based on outcomes
Lack of interest from practices to use D4 analytics software post pilot	Members forum session on benefits led by pilot practices Evidence of increase in practice efficiency and education received



**QUALITY**

## Quality

Quality is about delivering an excellent fit for purpose service as effectively as possible and is fundamental to all aspects of commissioning within Southend Clinical Commissioning Group.

We will ensure that high quality care is incorporated into all of our commissioned services for the people of Southend.

The NHS is facing unprecedented challenges and change. In order to deliver the best possible care to every patient in Southend, we will ensure that providers deliver the expected rights and pledges from the NHS Constitution and comply with national quality standards and guidance. This will ensure that quality improvement is always clearly aligned to any change and service delivery.

Over the past decade the role of commissioning as a key driver of quality, efficiency and outcomes for patients has become increasingly important to the health system in England.

At its simplest, commissioning is the process of planning, agreeing and monitoring services. However, securing services is much more complicated than securing goods and the diversity and intricacy of the services delivered by the NHS is unparalleled.

Commissioning is not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.

The safety of patients is our first priority. We will monitor our providers to ensure that they comply with national standards relating to safeguarding vulnerable adults and children.

We will ensure that safeguarding and promoting the welfare of children and vulnerable adults is given priority and is discharged effectively across the whole local health community through our commissioning processes.

We will continue to work with our providers to reduce hospital and community acquired infections such as MRSA and C.Difficile.

In the past year we have worked very closely with our providers and there have been no cases of MRSA bacteraemia reported.

It is recognised that we are now irreducible minimum level at which C.Difficile infections will occur, even where the best quality care is provided.

Our Infection Prevention & Control Team will continue to review any cases in order identify whether are any lapses in the quality of care to patients, and if so actions to address this with our providers.

We monitor and review the quality of healthcare provision for the people of Southend using a number of different methods including clinical audits, performance indicators, serious incidents, patient experience feedback and mortality and morbidity data.



## QUALITY WORK STREAM ONE: PREVENTING PREMATURE DEATHS

We are working with stakeholders and partners to prevent people from dying prematurely by promoting good health and discouraging decisions and behaviour that put health at risk.

Smoking is one of the main causes of premature morbidity and mortality, Southend has a higher prevalence of smoking and alcohol consumption than the national average.

We have identified a number of objectives which we will take forward with stakeholders.

### **Aim: To reduce the number of premature deaths for the population of Southend**

#### **Objectives**

- Drive down avoidable deaths within SUHFT.
- Optimise the detection and treatment of deteriorating patients.
- To improve access to preventative measures such as health checks within primary care.
- Improve participation of healthy living initiatives.
- Involving people in the planning of their end of life care
- Providing support to families & carers after death
- Obesity, smoking cessation, teenage pregnancy, alcohol & substance misuse
- Facilitate discussions to improve care delivery including uptake of contractual obligations such as Health Checks of LD patients in primary care
- Address all pathways in their entirety from prevention to end of life.
- Support providers to embed 6 C's
- 3 month pilot FFT to be rolled out in EoL
- E of L policy & pathway to be reviewed
- All staff familiar with standardisation tools such as EWS
- To support embedding to End of Life Care register.
- Continue to monitor VTE risk assessments from PTS
- Embed learning from serious incidents.
- To support SUHFT to achieve HASU
- Promote smoking cessation services
- Specialist support to pregnant women
- Offer spirometry as start of early intervention for smokers who maybe showing signs of COPD.
- Referral to health trainers.

#### **Activities**

- Embed findings of the Francis, Berwick, Keogh and Winterbourne into contracts.
- Implement dynamic methodology to share learnings from SUHFT and other providers across commissioned services.
- No harm event to be held date tbc.
- Linking with providers in North Essex on an annual basis.
- Use quality visits to ensure learning is embedded

## QUALITY WORK STREAM ONE: PREVENTING PREMATURE DEATHS (cont.)

- Referral to health trainers.
- Adult drug and alcohol services are being integrated into a single service in order to improve holistic care from 1st April 2014
- Blood borne virus interventions are being targeted at high risk injecting drug users.
- Southend CCG has been selected as to participate as one of the local action areas to focus on alcohol related health and crime matters.
- Work with SUHFT to develop a weight management pathway and commission a new Tier 2 Weight Management Programme

### Risks and mitigation

- Lack of clinical leadership & engagement
- Lack of collaboration with SUHFT stakeholders
- Poor quality data /documentation leading to poor outcomes
- Financial implications
- poor use of standardisation tools for acute illness severity such as EWS.

### Governance

- Clinical executive committee monthly
- CQRG – monthly
- Quality, Finance & Performance Committee – monthly
- Palliative Care MDT bi weekly
- MDT/GSF Practice Level (minimum quarterly)
- Community Geriatrician MDT - weekly

### Measurement

- Analysis of FFT Eof L data
- Report data from quality visits improving
- Report from quality visits yields action monitored by quality team reported up to quality & governance committee.
- Stroke outcomes measured nationally
- Monthly data reported to SNAP (Stroke National Audit Programme)

This work stream contributes to the achievement of the following targets, standards and ambitions: Outcome Ambition 1: E.A.1: Potential years of life lost from causes amenable to healthcare (per 100,000 population)

## QUALITY WORK STREAM TWO: POSITIVE CARE EXPERIENCE

Patient experience is a crucial part of quality healthcare provision, the NHS Constitution, the Outcomes Framework 2011/12 and the NICE Quality Standards for Experience and Mental Health Experience all reinforce the need for patient centred care.

Over the past few years, several documents and initiatives have highlighted the importance of the patient's experience and the need to focus on improving these experiences where possible.

The development of the NHS Constitution (2009–2010) was one of several recommendations from Lord Darzi's report.

The Constitution describes the purpose, principles and values of the NHS and illustrates what staff, patients and the public can expect from the service. Since the Health Act came into force in January 2010, service providers and commissioners of NHS care have had a legal obligation to take the Constitution into account in all their decisions and actions.

### **Aim: To ensure all people in Southend who access health services have a positive experience of care**

#### **Objectives**

- Improve patient experience in hospital.
- Improve patient experience of community care services
- Patient focused services are central to all delivery of care
- Patients have access to services seven days a week

#### **Activities**

- Work with providers to embed 6 C's
- Work with stakeholders to deliver customer care training
- Support launch of patient leader programme and other patient engagement programmes
- Promote awareness of FFT and response to data
- FFT Pilot for LD & EOL to role out
- SCCG quality visits to engage with patients contemporaneously for feedback

- Developing new approaches with partners initially focusing on urgent and emergency services.
- Hospital national pilot site for 7 day services
- SPOR will pilot 7 day working from April 2014 to support rapid response for admission avoidance
- Pilot 7 day A&E based social worker from June 2014 to enhance prevention offer through advice and guidance to appropriate care pathways, for example falls reablement, prevent carer breakdown through early identification.
- GP practice pilot – bid with CCG support
- Adopt skill mix models of delivery to address recognised staff shortages
- Workforce modelling to future proof services

(continues overleaf)

## QUALITY WORK STREAM TWO: POSITIVE CARE EXPERIENCE (cont.)

### **Risks and mitigation**

- Financial
- Not seen as priority for mandatory training.
- Releasing staff for training
- Timely accurate data
- National and local shortage of urgent care staff
- Shortage of GPs

### **Governance**

- CQRG monthly committee with acute provider.
- Monthly Quality, Finance & Performance Committee

### **Measurement**

- Reduced number of complaints relating to poor experience in hospital.
- Reduced number of complaints relating to poor experience of community services.
- FFT and Net Promote scores broken down by ward /team (data available from April 2013 to support trends and analysis)
- Benchmark data against other acute providers.
- Formal debrief with providers supported by written feedback within 3 working days.

This work stream contributes to the achievement of the following targets, standards and ambitions:

Outcome Ambition 5: E.A.5: Increase the proportion of people having a positive experience of hospital care

Outcome Ambition 6: E.A.7: Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community

Quality Premium: E.A.6: Friends and Family Test

## QUALITY WORK STREAM THREE: QUALITY AND SAFETY

Quality is about delivering an excellent, safe and fit for purpose service in an effective way as possible. This is fundamental to all aspects of commissioning within Southend Clinical Commissioning Group (SCCG) and we will ensure that high quality care is incorporated into all of our commissioned services for the people of Southend.

Safety of our patients is our first key priority and we will closely monitor the standards of healthcare associated infections such as Meticillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C.Diff), ensuring infection prevention and control element of patient safety quality and experience is embedded within the commissioning process.

### **Aim: Treating and caring for people in a safe environment and protecting them from avoidable harm**

#### **Objectives**

- Ensure collaborative approach to infection prevention and development of control strategies and actions (including continued reduction of CDiff and zero tolerance of MRSA infection and legionella monitoring) with clear accountability and assurance
- Secure compliance with NHS England's Safeguarding Assurance Framework working with local authority partners and community groups to safeguard and address the needs of vulnerable groups
- Ensure that infection control targets are included in all contracts with provider organisations
- Enable sharing of and learning from incidents and mortality reviews
- Ensure evidence based early warning systems are applied
- Support QIPP delivery
- Support learning from serious incidents and critical events
- For all services users to be free from avoidable harm from health care associated infections

#### **Activities**

- Representative from CCG attends SHMI Meeting
- Monitor information from Patient Safety Thermometer to ascertain themes and trends
- Attendance at Adult and Children Safeguarding Boards
- Attendance at relevant IPC Meetings
- Undertake Outcome 8 visits
- Quality Team undertake Quality Impact Assessments for all QIPP Plans
- Continued monitoring of providers through quality visits
- Use of contractual levers to encourage engagement with learning
- Patients cared for in clean environment that meets the NHS National Specification for Cleanliness 2007
- Zero tolerance for MRSA Bacteraemia
- Not to exceed trajectory CDiff.
- To be compliant with Health and Social Care Act Code of Practice for the Prevention of HCAI

(continues overleaf)

## QUALITY WORK STREAM THREE: QUALITY AND SAFETY (cont.)

### **Risks and mitigation**

- Harm caused
- Limited learning from incidents increase risk of harm
- Poor care and harm
- Poor patient experience
- Increased costs

### **Governance**

- Quality, Finance & Performance Committee – monthly
- CQRG
- Quality, Finance & Performance Committee
- CQRG - monthly
- MDT meetings – monthly or as required.
- Post infection review meetings for MRSA Bacteraemia and C.Diff. – as required.
- Attendance across the health economy at Infection Control Committee meetings.

### **Measurement**

- Follow up visits to ensure learning has been embedded
- Contemporaneous data received for MRSA & C.Diff, reviewed by IFL.
- Infection control leads attends monthly

This work stream contributes to the achievement of the following targets, standards and ambitions:  
Other Measure: E.A.S.5: Number of C.Difficile Infections (and Quality Premium Local Measure Option)

## QUALITY WORK STREAM FOUR: SEVEN DAY SERVICES

Patients need the NHS every day. Evidence shows that the limited availability of some hospital services at weekends can have a detrimental impact on outcomes for patients, including raising the risk of mortality. Southend CCG is working with providers and is committed to offering a more patient-focused service. Part of this commitment will be fulfilled by moving towards routine NHS services being made available seven days a week.

### **Aim: Develop seven-day services that will drive improved outcomes for patients**

#### **Objectives**

- Develop 7 day working across acute and community services and in primary care

#### **Activities**

- Southend Hospital is a national pilot for 7 day working – this will:
  - 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
  - Extend the current operational hours of SPOR and increase to 7-day working
  - Explore the development of 7-day working in primary care

#### **Measure**

- The number of services that are available 7 days a week
- No delay in treatment, therapy or discharge

This work stream contributes to the achievement of the following targets, standards and ambitions: XXXXXX

## Safeguarding

We have a responsibility to ensure that people accessing health services are protected from abuse.

Abuse is described as a violation of an individual's human and civil rights by other person or persons. Abuse may consist of single or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a person 'at risk' is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm, or exploitation of, the person subjected to it. Safeguarding is generally divided into two major areas: safeguarding adults at risk and safeguarding children.

**Safeguarding Adults:** An 'adult at risk' is someone who is 18 years or over who may be in need of community care due to a mental health problem, learning disability, physical disability, age or illness. As a result, they may find it difficult to protect themselves from abuse.

**Safeguarding Children:** The Children Act (2004) Section 11 places a statutory responsibility to safeguard children upon all NHS organisations. SCCG has a duty to ensure that it makes arrangements to safeguard and promote the welfare of children and young people that reflect the needs of the children in Southend.

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.

The following measures ensure that safeguarding and promoting the welfare of children and vulnerable adults is given priority and is discharged effectively across the whole local health community through commissioning arrangements:

- The CCG Clinical Chief Officer and Chief Nurse hold the Governing Body responsibility for ensuring that the CCG has safe systems in place for discharging its responsibility
- The CCG governing body receives a quarterly report on quality and performance which will include safeguarding issues for children and vulnerable adults and any exceptional issues are also mentioned in the monthly report to Quality, Finance and Performance Committee
- Executive level CCG membership of Local Safeguarding Boards ensures that safeguarding is at the forefront of service planning.
- CCG Clinical Chief Officer has membership of the Health and Wellbeing Board
- Close collaboration with the Local 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
- Ensuring that safeguarding children and adult strategies and associated policies are in place
- Ensuring that providers of services are held to account through regular review of safeguarding arrangements through quality scrutiny processes
- Designated Nurses and Doctors and the Lead for Adult Safeguarding are in post to offer professional expertise and advice regarding safeguarding matters



## Staff Satisfaction

The NHS Staff Survey is recognised as an important way of ensuring that the views of staff working in the NHS inform local improvements and input in to local and national assessments of quality, safety, and delivery of the NHS Constitution.

Outcomes from the recent staff survey undertaken by Southend CCG show that the majority of staff are happy with their work, the environment and feel supported. Areas for development include better communication, particularly with regard to the mission and goals of the organisation, personal growth advancement and recruitment and retention.

The roll out of the Friends & Family Test in September 2014 for NHS staff will provide another source to capture staff views.

**Aim: The primary aim of the staff satisfaction survey is to provide the organisation with a means to identify key employee concerns that may exist within the organisation.**

### Objectives

- Improve workplace satisfaction
- Improve recruitment & retention with stakeholders
- Improve life balance across the health economy
- Improve communication of organisational mission & goals.

### Actions

- Regular 1 to 1's
- Implement SMART personal development plans
- Exit interviews to establish any organisational concerns
- Cascade organisational newsletters, electronically and hardcopy in all staff areas.
- FFT applied to staff in the organisation

### Outcome/ Measure

- Annual staff survey
- Appraisal's
- FFT for staff
- Staff turnover
- Training needs analysis

### Risks & Mitigation

- Financial
- Increased staff turnover
- Skills and knowledge lost to the organisation
- Low morale amongst staff
- Increased risk of poor performance and associated costs
- **Governance**
- Staff survey monitored by Operational Executive meeting (weekly)
- FFT outcome data monitored by CQRG & QFP from from October 2014

## Commissioning for quality and innovation (CQUIN) schemes

We are using contractual levers (CQUIN schemes) to commission further quality from our providers, as follows:

### **Southend University Hospital Foundation Trust**

#### **National CQUINs 2014/15**

- Friends and family test – questions for staff and patients
- NHS Safety Thermometer – data on pressure ulcers, falls and UTI's
- Dementia – improvements in diagnosis and onward referral.

#### **Local CQUINs**

- Consultant Triage - for GP medical and frail elderly admission
- COPD – second year of embedding care bundle in all wards and in A&E
- Discharge Letters x 2; - 1) to cover letters being received within 72 hours and 2) for substantial quality improvement of discharge letter content
- Cancer Patients improved pathways – out of hours and within A&E
- Congestive heart failure – improvement in treatment plans for both GP and patient, information and training for patients
- Paediatric High impact pathway – re-modelling of paediatric pathway and embedding of practice
- SSKIN – improved pathways of care for pressure sore avoidance aligned with the community.
- VTE risk assessment – to improve VTE assessment uptake on wards by staff training and embedding of best practice.

### **South Essex Partnership Trust CQUINs 2014/15 – mental health contract**

#### **National**

- Friends and Family Test for Staff
- Friends and Family Test for Patients
- CMA – to demonstrate, through a national audit full implementation of process for assessing, documenting and acting on cardio metabolic risk factors.
- Dementia year 2 – competency based training for staff
- Patient Safety Thermometer – data on pressure ulcers, falls and UTI's

#### **Local**

- In patient discharge – development of new service to ensure following discharge all patients have a structured clinical telephone follow up 24 hours post discharge, seven days per week
- IAPT – improving access

### **South Essex Partnership Trust CQUINs 2014/15 – CAMHS contract**

#### **National**

- Friends and Family Test for Staff
- Friends and Family Test for Patients

#### **Local**

- Improving capacity in services in assessing and addressing mental health risk in children and young people.

## Commissioning for quality and innovation (CQUIN) schemes (cont.)

### South Essex Partnership Trust CQUINS 2014/15 – community contract

#### National

- National Safety Thermometer
- Friends and Family Test for Staff
- Friends and Family Test for Patients

#### Local

- Paediatrics – high impact pathways – asthma – management of the poorly controlled asthmatic child to enable timely and safe discharge to primary care
- GULP, Nutritional supplements – training and support to targeted care homes
- COPD unplanned care – increased proportion of recently diagnosed patients, informed, supported to manage their condition



**VALUE**



## Financial governance

Southend CCG's financial governance arrangements are built around the following key areas:

### **Robust Financial Procedures and Systems**

We have prime financial policies and detailed financial policies in place. We also have an effectiveness internal audit function reporting through the Audit Committee which has reviewed financial controls during 2013/14.

### **Effective Financial Reporting**

We present financial reports to the Quality, Finance & Performance Committee and the Governing Body.

The financial reporting is informed by subject matter experts, employed directly within the CCG, or through the support functions provided by Central Eastern CSU.

These reports are discussed in detail on a monthly basis, with specialist reports on key areas also being presented at the Quality Finance & Performance Committee.

### **Effective Financial Planning Arrangements**

The Financial Plan for 2014/15 and beyond has been developed through an iterative process.

The plan has been considered by the Quality, Finance & Performance Committee and informed by the Clinical Executive Committee.



# **BETTER CARE FUND**



# APPENDICIES