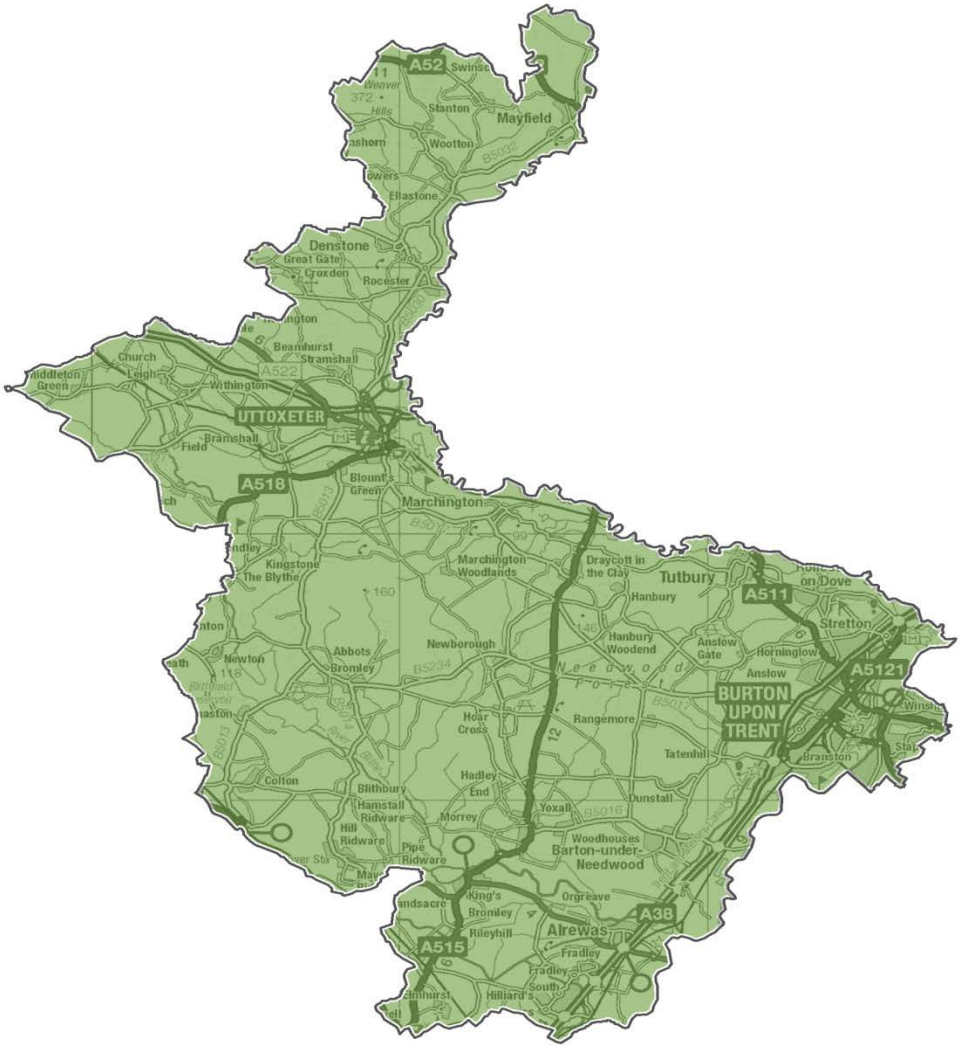
East Staffordshire Clinical Commissioning Group

East Staffordshire Delivery of Change Plan

2012 – 2016



Commissioning Quality Care for the People of East Staffordshire

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ESCCG Additional Evidence Signposting Sheet

Name of Document	East Staffordshire Delivery of Change Plan

Domain	Authorisation Threshold	Threshold Description	Signposting to Evidence (section and page references)
1	**1.1 A**	Mission, values and aims	Pg 14 - 15
1	**1.1 B**	Governance decision making and planning	Pg 12, pg 15 - 16
1	**1.1 C**	Measureable improvements	Pg 19 – 23
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2	**2.1.2 A**	Engagement with LA	Pg 98 - 101
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3	**3.1.1 B**	Clear credible plan	Whole document
3	**3.1.1. C**	Financial plans	Pg 108 – 114
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3	**3.1.1 E**	Support delivery of JHWS and integrated commissioning	Pg 98 -101, pg 103 - 104
3	**3.1.1 F**	Alignment with national strategies	Pg 55, pg 125
3	**3.1.2 A**	Process for developing plans	Pg 54 - 56
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3	**3.1.3 A**	Plan reflects JSNA etc	Pg 44 – 56
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3	**3.3 G**	Collaborative commissioning arrangements	Pg 98 – 102, Pg 122 -123
4	**4.2.3 B**	Opportunities to reduce inequalities	Pg 44 – 56, Pg 57 - 59
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5	**5.3 A**	Integrated commissioning	Pg 98 – 104
6	**6.2 C**	Clinical leadership in redesign	Pg 124

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Foreword from the Chair

Our vision is that by 2016 the people of East Staffordshire will live longer, healthier and happier lives.

I am very pleased to present the East Staffordshire Delivery of Change (ESDoC) document. This document sets out East Staffordshire Clinical Commissioning Group's Clear and Credible Plans for achieving our vision over the next three years and beyond.

Being a narrative of our strategy for the future, this Plan sets out where we are now, what outcomes we want to achieve by 2016, and how we plan to achieve them.

Key to this is our reason for being, or our "Mission Statement":

'***East Staffordshire CCG member practices will work together, and with stakeholders, sharing best practice and expertise. With this we shall strive for significant improvements in the overall health of the population we serve whilst at the same time achieve a sustainable local health economy and reduce health inequality.'***

In this Plan, we have set out how we intend to operate as a CCG and this is embodied in our values and our golden threads. We want to be a responsive and accountable CCG that genuinely works with patients and partners to achieve our shared outcomes for the people of East Staffordshire.

Also outlined, is a description of the resources available to us, together with a description of key risks. We have also included a profile of our collaborative partners and main provider organisations. We firmly believe that collaboration and joint working with all our stakeholders is the key to successful commissioning.

I am particularly proud to highlight the efforts we have made to engage with our patients and carers as well as stakeholders in the last year. We have used a variety of events to listen and obtain feedback about current health provision. This has allowed us to develop and refine our current commissioning priorities, described within this document.

We will continue to engage and improve relationships and communications with all our stakeholders as we develop our plans further over the next 3 years and we look forward to working in this new and exciting collaborative culture.

I am very excited to draw your attention to the eJSNA. (enhanced Joint Strategic Needs Assessment). This is a description of needs and resources for our population,

which extends beyond the usual dimensions of health. It describes housing, employment and other social profiles of the population we serve and recognises the impact these factors have on everybody's well-being.

For 26 years I have met with patients in my surgery and been frustrated by the fact that much of my patients ill health is influenced by factors I have had very little opportunity to do anything about. With the establishment of Clinical Commissioning and involvement with both the Health and Well Being Board and the Local Strategic Partnership, those opportunities are now at hand.

Through clinical commissioning, we can take the opportunity and the responsibility to influence and inform the strategies that will affect the well-being of the population we serve to a much greater extent. Equally important, we can take account of the priorities of Local Government and work together for the benefit of our patients.

Our strategy is to put in place commissioning intentions, which take into account the four aspects of QIPP (Quality, Innovation, Productivity and Prevention) and local priorities identified from numerous sources, to achieve our stated vision and outcomes.

We have excellent clinical leaders driving the CCG agenda and leading on key services development projects. Our practices are committed to this Plan and will be instrumental in delivering the outcomes we seek for our patients.

Please read this document. Be critical but also understanding of the complex and evolving environment within which we are now operating. The document is 'live' and will be regularly updated. Please use the feedback form at the end to tell us how we are doing and most importantly how we can do better!

Dr Charles Pidsley
Chair
East Staffordshire Clinical Commissioning Group (ESCCG)

Executive Summary

The East Staffordshire Delivery of Change (ESDoC) Plan sets out ESCCG's commissioning plans for health for the next 3 years.

This Plan has been created in real partnership with East Staffordshire GPs, our patients, the public and our major stakeholders and sets our direction for the next 3 years. It will involve further work with all stakeholders and continuous assessment of available resources and risks. It sets out clearly the health needs of the area, the work we have been doing to date to improve health and healthcare and our plans for the future.

Each year the Plan will be reviewed in the light of our progress and achievements, our financial health, new policy developments and the continuous feedback we receive from our patients and members.

A brief summary of each Chapter in the Plan is given below.

Chapter 1 - An Introduction to East Staffordshire CCG

This Chapter gives some background to the CCG; it describes who we are, what we are about and how we are organised.

Chapter 2 - Delivery to Date

Here we set out some of the changes to services we have made to date and our work programme in the current financial year 2012/13. Summary details about our current performance in terms of finance, delivery of efficiency gains and performance against targets are also provided.

Chapter 3 – Our Commissioning Cycle

Chapter 3 describes our Commissioning Cycle, our supporting 'Golden Threads' and our approach to commissioning for quality and outcomes.

Chapter 4 – The Health Needs of Our Population

In Chapter 4, we set out the key demographic and health profile information for the East Staffordshire population. This demonstrates some key challenges for the CCG not least a rapidly growing 'very elderly' population, worrying trends in obesity, alcohol misuse and use of emergency care and poor life expectancy in a number of ward areas.

Chapter 5 – Our Priorities for 2012 - 2016

This section sets out our key priorities for commissioning from now until 2016. At the present time, our main clinical commissioning priorities fall within 10 broad work programmes which are consistent with, and complementary to the priorities of the emerging Health and Well Being Strategy. They are:

1. Improving Life Expectancy
2. Giving Children the Best Start
3. Staying Well in Later Life
4. Promoting Healthy Lifestyles – in particular reducing obesity and harmful drinking
5. Urgent Care
6. Long Term Conditions – with a particular focus on stroke and diabetes
7. Mental Health
8. Primary Care
9. Outpatient Redesign
10. System Efficiency

Chapter 6 - Other Commissioning Intentions for 2013/2014

As well as our priority areas, there are a range of supplementary commissioning intentions for 2013/14 which we are currently sharing with our providers; these are set out in chapter 6.

Chapter 7 – Communication and Engagement

Communications and engagement with patients, carers, commissioning partners, providers and wider stakeholders is hugely important to us. We set out our approach to this in chapter 7 of our Plan.

Chapter 8 – Working in Partnership

We know we cannot commission without working constructively with all of our partners. In chapter 8, we set out the diverse range of partnership arrangements we are currently developing and those that are already in place.

Chapter 9 - Resources

Here we describe the resources available to the CCG to deliver this Plan including high level information about our workforce, finance, information technology and estates.

Chapter 10 – Future Risks and Challenges

In the final chapter, we highlight the future strategic risks and challenges as we see them and what we are doing to try and manage those risks and challenges.

Appendices & Glossary

Lastly, there are a range of Appendices and a Glossary that provide further details and links to additional resources, and we invite feedback on our Plan.

Set out below is a summary of the Plan – our ‘Plan on a Page’.

MISSION	**East Staffordshire CCG Member Practices will work together, and with stakeholders, sharing best practice and expertise. With this we shall strive for significant improvements in the overall health of the population we serve whilst at the same time achieve a sustainable local health economy and reduce health inequality**														
VISION	**Our vision is that by 2016 the people of East Staffordshire will live longer, healthier and happier lives**														
GOLDEN THREADS	**☑ Integrated Ways of Working; ☑ High Quality Compassionate Care; ☑ Improved Care Pathways; ☑ Focus on Prevention; ☑ Improved Health & Wellbeing; ☑ Evidence-Based Clinical Decision Making; ☑ Improved Communications & Engagement; ☑ Sustainable Local Providers of Choice**														
CONTEXT	**Early Years**	**Health Inequalities**				**Life Expectancy & Lifestyle Factors**				**Long-Term Conditions & Mental Health**				**Significant Financial Challenges**		
CCG PRIORITY	**Giving Children the Best Start**	**Primary Care**		**Promoting Healthy Lifestyles**		**Improving Life Expectancy**		**Staying Well in Later Life**		**LTCs**	**Mental Health**	**Diabetes**	**Stroke / TIA**	**O/P Redesign**	**Urgent Care**	**System Efficiency**
GOALS	Better Access	Better Access		Obesity Strategy		Reduce Mortality		Care Pathways		Risk Strat tool	↑ IAPT, CBT	Sanofi Review	Stroke Service Spec	Clinical pathways	Community pathways	More efficiency
	Education & Advice	2° to 1°		↑ activity		Increase Screening		Ageing Well		Integrated H&S care	Suicide Strategy	Audits + Pathways		Safe, VFM services	Team capacity	Support Providers
	NICE standards	Peer Reviews		↓ deaths, alcohol intake		Social Marketing		Falls Strategy		Dementia Strategy	Integrated, Responsive	Best Practice	Early supported discharge	Clinical support	Integrated Teams	Process improved
		PPI														
2013-14 PLANS	Service Reviews	Primary Care Develop-ment Plan		Retender Services		↑ Health-check (LES)		Evaluate Services		Service Reviews	Prescribing	Review LES's	Network review	Shift work to 1° care	New services	Variety of Secondary Care measures
	CQUINs			Alcohol Strategy				Patient Passports		*"Digital by Default"*	Service Reviews	Prescribing	New Spec	OP ratios in SLAs	VFM reviews	
	Maternity Tariffs	LES review		Teams reviewed		Work in 7 wards		Joint Models		Self-care Case Mgt	↑ access, integration	1° Care targets	Community Rehab	Specialty reviews	Integrated services	
	New KPIs	QP KPIs														
OUTCOMES	Increased Access	Improved 1° Care manage-ment of LTCs		↓ admissions		↑ uptake		↑ flu vaccs		↓ COPD admissions	↑ access	↓ LOS, admissions	ASI KPIs	↓ activity, spend	↓ admissions	Activity measures
	Less teen pregnancy			↓ deaths		↓ deaths		↓ falls admissions		↑ uptake	↓ 2° admissions	↑ care processes	↓ LOS, mortality	↑ efficiency		

East Staffordshire CCG – 2012 – 2016 - Plan on a Page

Chapter 1 – An Introduction to East Staffordshire CCG

1.1 Who We Are

East Staffordshire Clinical Commissioning Group (ESCCG) falls in the Staffordshire County Council area and is predominately covered by the area governed by East Staffordshire Borough Council with a small part of its population falling under Lichfield District Council.

The CCG serves a population of 134,200 residents and has been formed by the 19 general practices within the East Staffordshire Borough Council Boundary which includes Burton on Trent and Uttoxeter (see Figure 1 below).

The member practices together have had a strong identity, based on historical use of Queen's Hospital in Burton and have a long track record of working effectively together. Previous examples of this co-operative work are the former Burton Fundholding Group, the former GP co-operative for out of hours (OOH) provision "BURDOC", practice-based learning and the Burton-based GP training scheme. The current CCG has formed directly from the previous East Staffordshire Practice Based Commissioning Group.

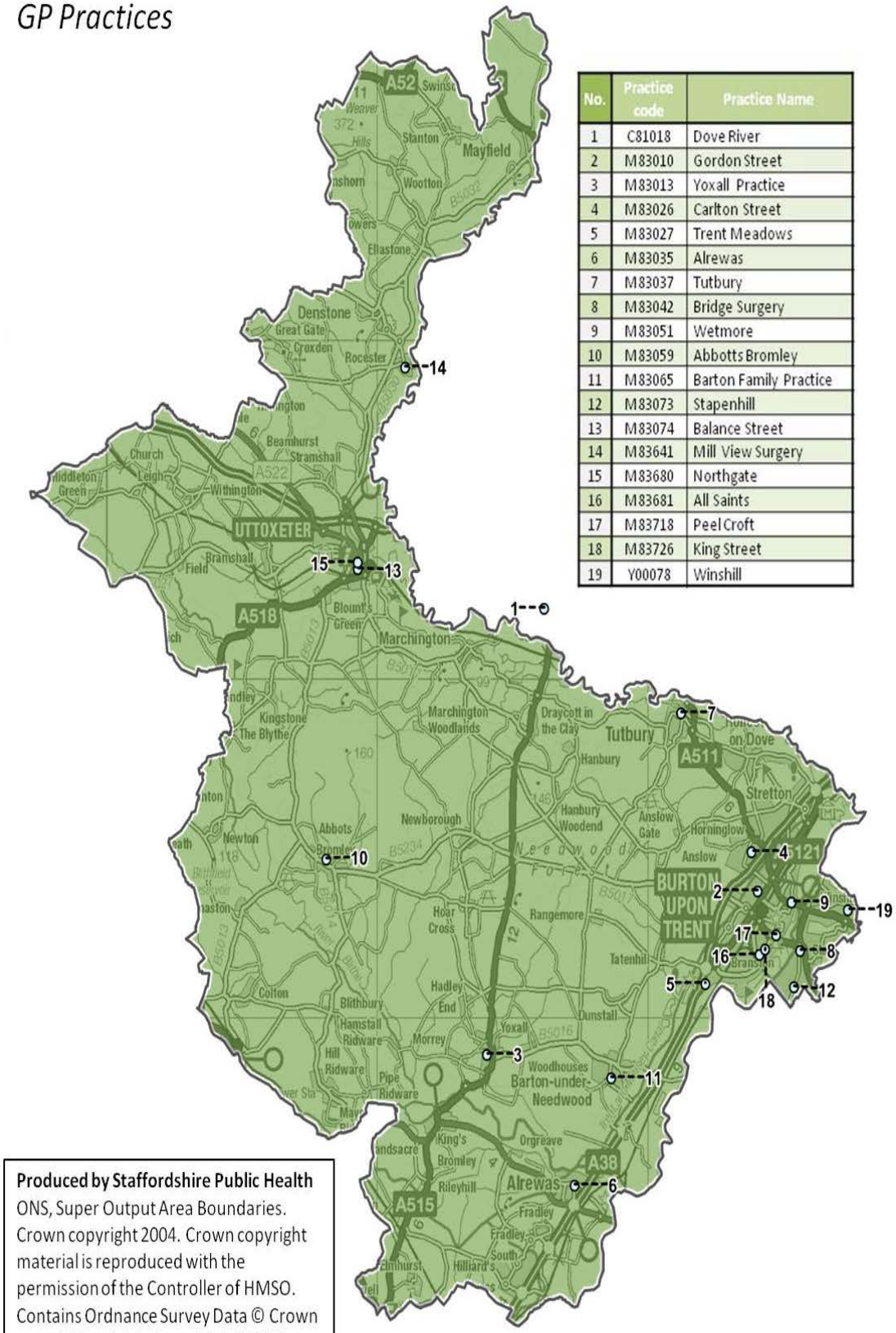
Each of our member practices is represented on our Steering Group; this group directs and empowers the CCG Board to act on behalf of the 19 practices. The group meets on a monthly basis in a formal governance role but also meets frequently at organised educational events; education and development is a hugely important element of the culture of ESCCG.

We believe that the specific health inequalities, health-related and wider needs of the local population and locality are quite distinct from those of the larger South Staffordshire area, and we work well as a clearly defined local health economy; for this reason we have decided to proceed to authorisation as an independent CCG with its own Governing Body.

We have the support of our PCT Cluster, Staffordshire County Council and East Staffordshire Borough Council to proceed, and in particular we want to capitalise on our geographical consistency with East Staffordshire Borough Council in order to focus on the shared areas of need in the population.

East Staffordshire CCG

GP Practices



No.	Practice code	Practice Name
1	C81018	Dove River
2	M83010	Gordon Street
3	M83013	Yoxall Practice
4	M83026	Carlton Street
5	M83027	Trent Meadows
6	M83035	Alrewas
7	M83037	Tutbury
8	M83042	Bridge Surgery
9	M83051	Wetmore
10	M83059	Abbotts Bromley
11	M83065	Barton Family Practice
12	M83073	Stapenhill
13	M83074	Balance Street
14	M83641	Mill View Surgery
15	M83680	Northgate
16	M83681	All Saints
17	M83718	Peel Croft
18	M83726	King Street
19	Y00078	Winshill

Figure 1: GP Practices in East Staffordshire CCG

1.2 Our Vision for ESCCG

Our vision is that by 2016 the people of East Staffordshire will live longer, healthier and happier lives.

To achieve this vision, East Staffordshire CCG will commission for a top class healthcare system that delivers integrated care services based on strong partnerships delivering locally agreed goals.

Over the last five years, female life expectancy in East Staffordshire has increased by over fourteen months and now exceeds the national average; we intend to repeat this success for men in the area.

By 2016 the people of East Staffordshire will:

- see a measureable reduction in health inequalities;
- be an integral part of the commissioning process to help us improve the quality of care;
- be enabled to take control of their own health needs wherever possible;
- know where to go for their health care and will understand what choices they have;
- have a health system with no duplication of services and “No Wrong Door” culture; all providers will work together demonstrating that compassion, quality and safety are at the core of service provision;
- avoid unnecessary hospital admission and prolonged length of stay once admitted;
- receive the highest quality care from the beginning to the end of their lives; and
- regard the CCG as a national exemplar that people want to work with and for.

1.3 Our Mission

Our mission statement describes our reason for being; why ESCCG exists:

East Staffordshire CCG member practices will work together, and with stakeholders, sharing best practice and expertise. With this we shall strive for significant improvements in the overall health of the population we serve whilst at the same time achieve a sustainable local health economy and reduce health inequality.

The CCG will also promote good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties.

1.4 Our Strategic Aims

The CCG's high level strategic aims are to:

- Use clinical skills to add value to patient care, concentrating resources on the basis of clinical need and improving patients' outcomes;
- Work in partnership with key local providers so they are the first choice for services for the patients of East Staffordshire;
- Work collaboratively with partner agencies to ensure the right care is given in the most appropriate setting;
- Embrace the QIPP (Quality, Innovation, Productivity and Prevention) agenda and to commission, and deliver, cost-effective care within the CCG's resources;
- Foster a partnership approach between member Practices, supporting each other in providing high quality primary care services;
- Demonstrate a strong commitment to openness and transparency, specifically in information and data sharing among member practices within the CGG;
- Develop integrated plans for continuous service and outcome improvement, based on sound prioritisation and benchmarking to deliver our mission, values and aims;
- Ensure patient safety and improve patient experience for those requiring our commissioned services; and
- Reduce the health inequalities of our population.

1.5 Our Core Values

The core values that lie at the heart of our CCG's work underpin our strategic aims and describe how the CCG wishes to operate in its day to day business. These values are an extension of the General Practitioner Committee's Fair Commissioning Charter and are as follows:

- Develop a culture of genuinely clinician-led commissioning, taking decisions in the best interests of the local population;

- Engage with patients and the public with respect to decisions taken about their health services;

- To ensure that all selected providers have the right level of capacity and capability to undertake the work specified by the CCG;

- Focus on quality first by emphasising the importance of *getting it right first time*. From this efficiency and productivity will follow.

- Establish and strengthen working relationships with Local Medical Committees, further enabling successful outcomes in commissioning; and

- To work in partnership with other CCGs, the Health and Wellbeing Board and local authorities to improve outcomes for our residents and to maximize efficiencies in commissioning and offer value for money services.

We also wish to confirm our intention to adhere to the values outlined in the NHS Constitution, which are complementary to our own core values, namely:

- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Working together for patients
- Everyone counts

1.6 Governance Structure of ESCCG

The governance structure of the CCG is shown in Figure 2 below.

The ESCCG Board is directed in its work by the 19 member practices that all sit on the Steering Group. The Board itself conducts its business through a range of formal sub-committees which are:

- The Audit Committee (statutory requirement)
- The Remuneration Committee (statutory requirement)
- The QIPP, Finance and Performance Committee
- The Quality Committee

Further detail about the CCG's governance arrangements can be found in the Constitution and the Integrated Governance Framework, both available on the CCG's website at www.eaststaffsccg.nhs.uk

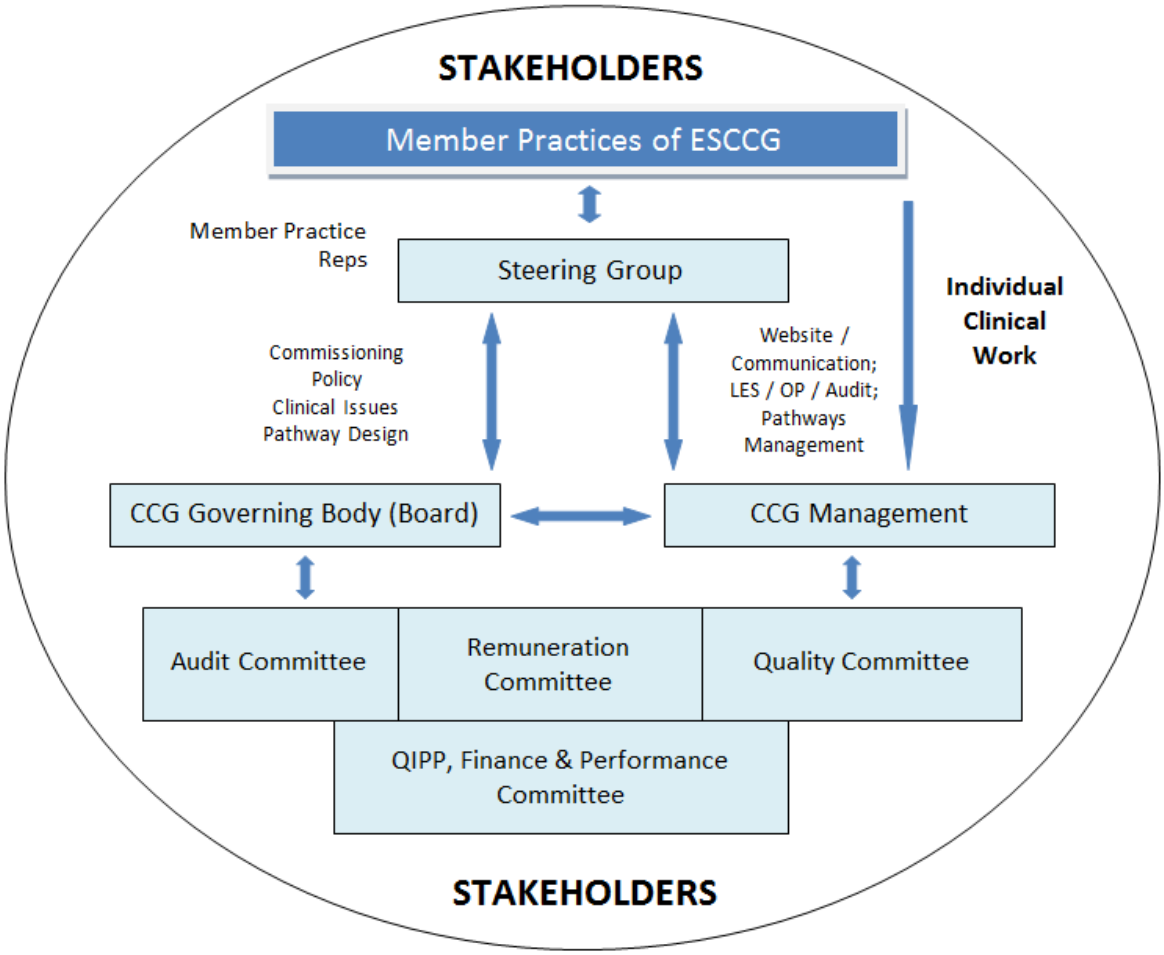


Figure 2: The ESCCG Governance Structure

1.7 The Governing Body (Designate Board)

In line with national guidance, the CCG has been working to put in place a designate Board pending formal authorisation. Recruitment to key posts has taken place over recent months and we are now pleased to confirm that we have a complete Board.

Our Board members are:

Dr Charles Pidsley, Chair, Bridge Surgery
Mr Tony Bruce, Accountable Officer
Dr Elizabeth Gunn, Vice Chair & Clinical Lead, Tutbury Surgery
Dr Catherine Faarup, GP Executive, Peel Croft Surgery
Dr John Cleary, GP Executive, Carlton Street Surgery
Dr John Tansey, GP Executive, Trent Meadows Medical Practice
Dr Wai Lim, GP Executive, Carlton Street Surgery

Mrs Michele Fildes, Practice Manager Executive, Trent Meadows Medical Practice
Mrs Heather Johnstone, Chief Nurse and Board Quality Lead
Professor Michael Chester, Secondary Care Doctor Executive
Mr David Harding, Lay Member for Governance & Audit
Mrs Ann Tunley, Lay Member for Patient and Public Involvement
Mrs Sarah Laing, Chief Operating Officer
Mrs Wendy Kerr, Chief Finance Officer

Pen portraits of each of the Board members can be found on the CCG's website at www.eaststaffsccg.nhs.uk

Chapter 2 - Delivery to Date

As described earlier, the practices in ESCCG have been working together for some time and have secured a wide range of improvements in service delivery through their commissioning efforts. The GPs have historically worked very well together under the remit of Practice Based Commissioning, have maintained a stable health economy and made a significant contribution to the efficiency of the South Staffordshire PCT area, having the lowest “pound per patient” spend across Staffordshire. However they recognise that much of their historical commissioning has been reactionary and they now aim to embrace the opportunities that working as a CCG brings and are looking forward to working in a more structured and strategic manner within the East Staffordshire health economy.

2.1 Progress in 2011/12

Our Annual Report for 2011/12 sets out our key achievements in the last financial year and some of the highlights that demonstrate our track record for delivery are given below.

Mental Health

The Crisis Resolution and Home Treatment Team mental health service was reviewed in 2011/12 by all ESCCG GP practices. The review found that in the main, the Crisis team offers a safe and effective service however further enhancements are being made in relation to communications between referrers and the team, and improved transfers of care between mental health professionals. Following the review, and as part of the planned bed reduction scheme, there has been enhancement of crisis resolution and home treatment services that included additional patient transport services. The outcomes of this have been significant with savings of £1.4 million, a reduction of 24 in-patient beds, and the closure of the Margaret Stanhope facility in September 2012. This is one of ESCCG exceptional success stories and we continue to lead on Mental Health contracting for all four CCGs within South Staffordshire.

Early Pregnancy Assessment Unit

The capacity of the Early Pregnancy Assessment Unit at Burton Hospital has been improved through the introduction of new referral protocols and clinical testing in primary care; this has minimised the number of unnecessary hospital attendances.

Improving Access to Services

New services for nail surgery, adult hearing and non-obstetric ultrasound have been commissioned through the Any Qualified Provider (AQP) programme. This will extend patient choice and drive up quality and the new services are due to be provided from October 2012.

Community Paediatrics

A comprehensive review of acute and a community paediatric service were undertaken by ES GPs which highlighted numerous gaps in local service delivery. A series of recommendations were made by ES GP clinical leaders in partnership with their secondary care specialist colleagues to develop a more integrated model of care for children's services. ESCCG has been leading on this thus far, but has now forged close working relationships' with South East Staffordshire CCG and under carefully managed and well governed collaborative arrangements SES CCG will lead on children's commissioning on behalf of ES. The CCG will continue to be a main driver of this agenda and it is envisaged that the paediatric services will be retendered in early 2013.

Eye Care

A review of low vision services was completed in 2011/12. Some adaptations to the service were agreed to ensure service resources where appropriately directed to patients from ESCCG, and the CCG Board committed to continue to fund both services, as they were seen to be beneficial to patients and demonstrate good value for money.

Alcohol Services

ESCCG has commissioned an Alcohol Liaison Worker service at Queens Hospital Burton, following a comprehensive review. The service has been redesigned with a clear focus on outcomes and is proving very successful in supporting people that attend the Emergency Department where alcohol consumption is a factor. Between July 2011 and March 2012 the service saw an average of 29 people every month and is showing some encouraging longer term results in terms of people who have reduced their alcohol consumption.

ESCCG has also been highlighted as a national exemplar for commissioning new services for alcohol detoxification**.** The CCG has commissioned two community detoxification beds in partnership with the Burton Addiction Centre. The contract monitoring process identified that in the first three quarters of last year the 38 dependent drinkers referred were successfully detoxified, 37 went on to undertake

rehabilitation, 7 were referred onwards to other services and 24 successfully graduated from the rehabilitation programme as abstinent drinkers.

Dermatology

A new community dermatology service provided by Assura (an independent provider) was introduced in October 2011. The service improves access and the patient journey by providing an additional choice for patients, reducing unnecessary hospital appointments, reducing waiting times and producing savings for the local health economy. By the end of March 2013 the service will have treated approximately 500 patients and will have saved at least £20,000. We expect the service to save up to £70,000 in future years.

Urgent Care

During 2011/12, a new model of care for an Integrated Urgent Care Centre (IUCC) was successfully piloted. The IUCC uses a senior, highly motivated and well-trained GP, with rapid access to diagnostics, to assess and manage patients who may be prevented from being admitted to hospital. The service was implemented fully on 1st April 2012. To date, it has had a positive impact on achievement of quality targets within A&E and early indications suggest a downward trend in the medical admission rate for Burton Hospital, despite rising demand.

Medicines

Working with GP Practices, the ESCCG Medicines Management team reviewed prescribing activity in 2011/12 and made £175,000 in savings through simple switches of medication, without any reduction in quality.

Community Intervention Team

The CIT is a seamless 24 hour rapid response and time limited service to manage people safely in their own homes. The service provides clinical and social intervention to maximise independence, prevent acute admission and the need for long term care, and facilitates hospital discharge. The Community Intervention Team rapidly responds to GP referrals to put services in place to reduce the need for hospital admission. It enables people to:

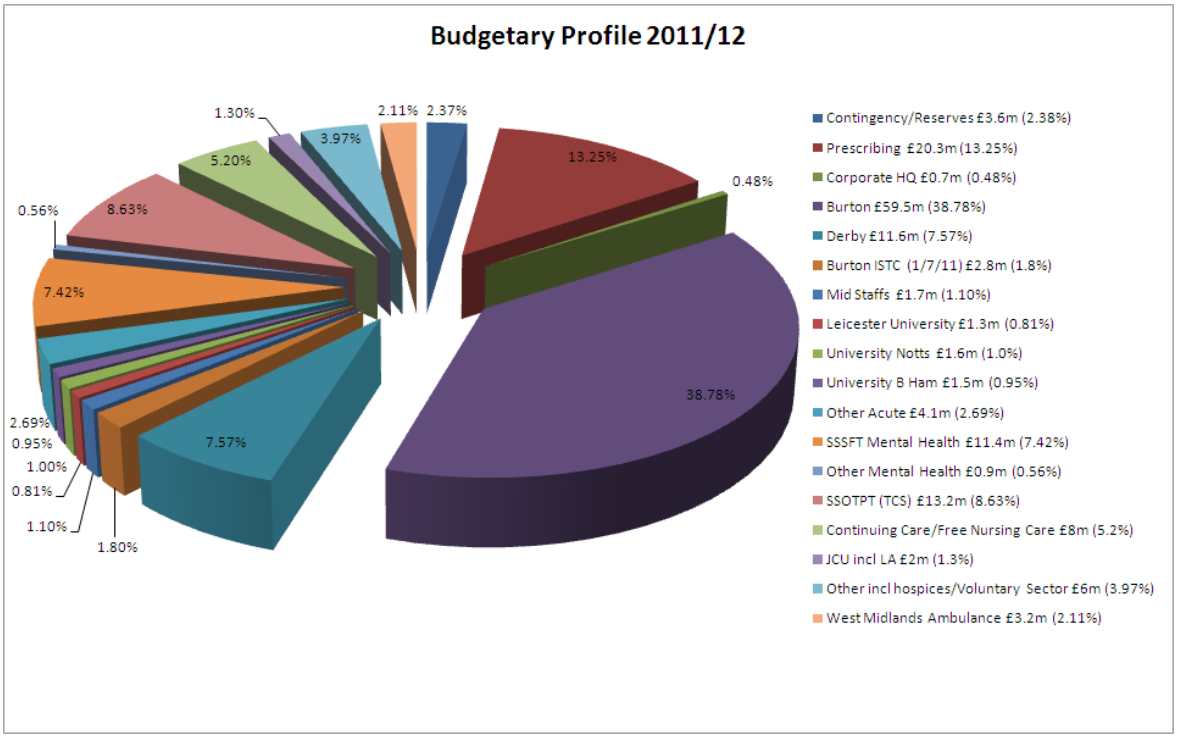
- be as independent as possible, living their life their way and managing identified risk;
- influence and to take personal responsibility for their own programme of care;
- reduce or avoid their dependence on services; and
- receive care closer to home – the right place, the right time, and with the right care.

2.2 Financial Performance in 2011/12

In 2011/12 ESCCG had a devolved budget of £153.363m and took responsibility for prescribing budgets, CCG corporate budgets and all hospital and community health Services with the except for:

- Specialised Services.
- Countywide Substance Misuse.
- Primary Care – excluding GP secondary care services provided in primary care.
- PCT Surplus.

The distribution of the CCG's 2011/12 budget is illustrated below:-



At the end of 2011/12, the CCG had an outturn expenditure position of £153.342M and generated a small surplus of £21,000.

This position was achieved while developing services as appropriate, for example:-

- Investments in acute services to support sustainable 18 weeks referral to treatment target delivery; reducing backlogs for both inpatient and outpatient activity to levels that accommodate achievement of the target, and funds to assist in dealing with winter pressures.

- Investments in integrated support workers and extending the current Nursing Home pilot to support the care outside of hospital initiative and the end of life

strategy;

- Piloting the integrated urgent care centre to identify, assess and treat patients with a view to redirecting into more appropriate community services;

- Investments in Mental Health services (Mac UK) dementia services;

- Investments in community services such as palliative care integrated support workers and community dermatology services;

- Investments in social care provision and early discharge schemes, including stroke and community intervention teams to improve discharge and avoid hospital admissions, primarily over the winter period;

- Investments in primary care services to encourage locality commissioning, with the focus on admission avoidance; and

- Investments in sexual assault services and a range of screening services for breast, bowel and aortic aneurism.

The successful outturn position for 2011/12 with a relatively small surplus, reflects the challenges within the South Staffordshire health economy and demonstrates how tightly expenditure has had to be managed to ensure delivery. Clinical engagement in this process has been key in enabling a greater level of clinical input and influence into commissioning. CCG clinicians have established strong relationships with secondary care clinicians thereby facilitating service change.

The 2012/13 contracting round was formally led by the CCG and as a result it established its own commissioning intentions to be incorporated into the 2012/13 contracts. An element of this was undertaken collaboratively with our associate commissioners due to the nature of the relationship with our Host providers and neighbouring CCGs. The focus for 2012/13 was based on areas of high costs, procedures of limited therapeutic value and clinical pathway changes agreed by the CCG Steering Group and Executive Board. We acknowledge that a more robust process of prioritisation needs to be developed moving forward into 2013/14 and we are currently developing a process in collaboration with public health colleagues and other key stakeholders.

2.3 Our Priorities for 2012/13

Some of the work initiated in 2011/12 has been continued into 2012/13. A brief summary of some of the current commissioning work programme is set out below.

Long Term Conditions (LTC)

The management of long term conditions is a key priority for 2012/13 onwards. The CCG is working with partners to develop services and interventions that prevent the development of long term conditions, provide integrated pathways of care for patient and support greater self-management to improve outcomes and patient experience. A key plank of this work is the identification of those patients at high risk of deterioration through a risk stratification process and implementing personalised care planning through a coordinated approach across health and social care. Specific priorities have also been identified around diabetes and dementia in adults as well as asthma in children.

GP Out of Hours

The out of hours contract is due for renewal and work is being undertaken during 2012/13 to develop a robust service specification for the new service to be implemented in April 2013. This will be done in conjunction with the launch of the new national non-emergency NHS number, 111.

Falls Service

A Community Falls service was commissioned by ES GPs in 2010 and this is now being reviewed. A clinical case note review will inform the redesign of future pathways and education sessions in 2012/13.

Outpatient Services

As part of a major review of outpatient activity at Burton Hospital, work has already commenced on redesigning pathways for cardiology and urology and there is future work planned for ophthalmology and orthopaedic outpatient services.

End of Life Care

In April 2012 the East Staffs End of Life (EOL) Programme Board was set up. The Board's aim is to improve the care of patients and their carers at end of life by providing strategic direction to service redesign and facilitating integrated working across provider and commissioner organisations. Work streams will focus on improving the quality and productivity of services within community, primary and

secondary care provision. This includes working with providers to increase the number of patients who die in their preferred place of death, and implementing an Electronic Palliative Care Coordination System (EPaCCS).

Care of Frail Older People

The frail elderly population has been a priority area in East Staffordshire for a number of years. As part of a programme of work to deliver care outside of hospital, the CCG has funded a half-time Community Geriatrician. During the course of 2011/12 and into 2012/13, East Staffordshire GPs have worked with Burton Hospital to shape the role of the geriatrician, daily GP liaison has been implemented and it is expected that weekly clinic sessions and domiciliary support will be in place by December 2012. The CCG will also be working with the Hospital and South East & Seisdon CCG to establish a Frail Elderly Board to define models of care and to further develop the role of the Community Geriatricians by integrating with urgent care services and community teams.

Perinatal Mortality

In previous years we have had an issue with infant mortality in East Staffordshire, and thanks in part to effective partnership working, the infant mortality rate in East Staffordshire is now no worse than that in other parts of the country. We are not complacent however and with the help of the public health team, we will be working to tackle wider perinatal mortality issues that still exist. As part of this programme we are working to develop the Family Nurse Partnership programme.

Enhanced Services in Primary Care

The commissioning of Local Enhanced Services in primary care is transferring to CCGs from 1st April 2013. As a result, the CCG is conducting a review of existing services in 2012/13 to inform CCG decision-making prior to this handover. There are opportunities to refine some services whilst reviewing provision, cost and quality of services to patients. The following services will be prioritised for review in 2012/13 as they have the highest potential for increased quality or efficiency: minor surgery, minor injuries, near patient testing / shared care prescribing / anti-coagulation, drug misuse, suture removal and wound care, insulin Management and glucose tolerance testing.

Home Oxygen Services

A new Home Oxygen Assessment and Review Service will be commissioned from the 1st October 2012. This service will commence in line with a new Home Oxygen Supply Contract and will ensure that all patients who currently receive or need home oxygen in the future receive a full assessment and on-going reviews from an

appropriately qualified specialist. This will improve quality and safety for those patients, ensuring that oxygen is clinically indicated for every patient utilising it.

Medicines Management

The Medicines Management priorities for 2012-13 include:

- Focussing on Quality and Outcomes Framework targets to improve the treatment of acute asthma through audit and training events;
- Audit and review of prescribing initiatives against national QIPP targets including new indicators;
- Local initiatives identified through benchmarking against local and national data including maximising benefits of patent expiries and generic prescribing;
- Medicines optimisation contributing to risk stratification for patients with long term conditions;
- Repatriation of the prescribing of erythropoietin's to specialist care;
- Increasing Clozapine provision in treatment resistant schizophrenia;
- Community based initiatives working with provider organisations in wound care, continence, sexual health, rheumatology and diabetes.

2.4 QIPP Progress to Date

Our priorities to date have also been influenced by our QIPP (Quality, Innovation, Productivity and Prevention) programme.

ESCCG has made an encouraging start to QIPP during 2012/13 and recognises that over the last 12 – 18 months the QIPP programme has been driven by the overarching requirement to deliver financial balance across Staffordshire as a whole. Therefore, some of our QIPP schemes have involved joint working with other CCGs in particular South East Staffordshire and Seisdon CCG.

We intend to make QIPP savings of £2.8 million in 2012/13. Summary details of the current QIPP programme are shown in Table 1 below.

ESCCG, together with partner stakeholders, continues to focus on how we can make further improvements as we can no longer being able to rely on year-on-year growth in NHS budgets and spending. ESCCG recognises the need to address increasing costs and further demand arising from the fact that we have both a growing and an ageing population. Identifying efficiencies allows us to free up resources which can be used to treat more patients more efficiently, whilst continuing to deliver year on year quality improvements.

Whilst this undoubtedly represents a significant challenge, there is good evidence to suggest that by concentrating on delivering high quality care, prevention and early intervention, we can improve efficiency and save NHS resources. We are therefore endeavouring to create a culture that focuses on ‘getting it right first time’ which will both improve quality and reduce costs.

Maintaining financial balance will continue to be a key requirement for the CCG, however, our strategy to on-going financial stability from 2013/14 is to put in place commissioning intentions which drive the QIPP agenda whilst at the same time whole-heartedly support and address ESCCG key priorities.

Quality will remain our key over-riding principle. The CCG Board and member practices are keen to shift the focus of QIPP from being purely a financial initiative, to one which is genuinely about improving quality, outcomes and experience; this will more readily encourage the engagement of local clinicians and other stakeholders in moving our priorities from plans to delivery. Supporting bold measures in system changes to improve quality and reduce cost will be a key requirement for us all.

ESCCG recognises its role in leading and galvanising the whole health and social care system in making shared strategic plans for long term sustainability for East Staffordshire services. To this end, the CCG will be seeking to initiate a sustainable and partnership approach to on-going QIPP delivery from 2012/13 through the establishment of the East Staffordshire Health Economy Forum.

Table 1 : Summary of QIPP Schemes in 2012/13

Summary ESCCG QIPP Schemes 2012/13			
Scheme Name/Overview	**Planned Outcomes/Quality improvements**	**Efficiencies Identified**	**RAG Rating Green/Amber/Red**
Mental Health Service Redesign			
Closure of Margaret Stanhope and reinvestment in Crisis Resolution Community Teams and Dementia Services.	Reducing premature death in people with serious mental illness. Enhancing the quality of life for people with mental illness and dementia. Improving experience of healthcare for people with mental illness, focusing on community mental health services.	£176k	Green - Fully implemented in September 2012.
Medicines Management			
Implementation of savings identified in the East Staffs Medicine Management Business Plan 2012/13, supporting National prescribing QIPP and local prescribing priorities.	Ensuring patients are on the most appropriate and cost effective medications. Ensuring patient safety. Ensuring prescribing in line with National QIPP and local agenda. Ensuring prescribing is in line with NICE guidance.	£235k	Amber - Savings identified, requiring full implementation by practices.
Home Oxygen			
Review patients on the CCG home oxygen list to increase quality and patient safety and reduce spending through ensuring that there is a clinical benefit for those patients who are in receipt of home oxygen.	Reduction in number of patients who are prescribed home oxygen inappropriately. Adjustment/removal of home oxygen for patients who are non compliant or where no clinical benefit is derived.	£46k	Amber - Reductions shown Year to Date covering months 1 to 4.
Integrated Urgent Care Centre at BHFT			
Identify, assess and treat patients with a view to redirecting where appropriate into community services. Reduce inappropriate admissions,facilitate timely discharge from A&E. Improve the patient experience. Improve primary, secondary care interface and joint working, also benefiting ambulatory care pathways, and appropriate use of care pathways.	Reduction in admissions rate for BHFT (overall and specific ICD-10 Codes), which is higher than national average, achieve 4 hour A&E target, improve hospital flow, rapid diagnostics, better outcomes for patients and reduced re-attendance rates.	£21k	Amber - Improvement in the A&E 4- hour wait target between April and August (ytd). Overall the IUCC is maintaining a low admission rate and contributing to a reduction in the overall medical admission rate,
Outpatient Redesign - Various Specialties			
To ensure that each outpatient attendance has a clinical need and is delivered in an appropriate setting by an appropriate clinician.	Patients only referred where primary care cannot care for the patient. Redesign pathway ensuring efficiencies whilst ensuring patients receive a quality service. Appropriate plans for when patients discharged from secondary care. Improving patient experience of outpatient care.		Amber - Various specialties at different stages of implementation. A number of pathways are to be approved at September/Octobers steering group for
Specialties			
Cardiology - First and Follow Up		£63k	
Ophthalmology - First and Follow Up		£84k	
Orthopaedics -First and Follow Up		£151k	
Urology- First and Follow Up		£52k	
Rheumatology Follow Ups		£194k	Implemented in 12/13
ENT - First and Follow Up		£48K	
Gynaecology - First and Follow UP		£47K	
Bed Closure (21 beds) at BHFT			
Bed closures on the Geoffrey Hodges unit at BHFT. The Geoffrey Hodges Unit is a rehabilitation unit; closure of these beds will result in improved outcomes for patients following illness or injury and support care closer to home.	Enhancing quality of life for people with LTC, reducing time spend in hospital, and supporting people to self manage conditions. Improving the experience of care for people at the end of their lives. Helping people to recover from episodes of ill health or injury, improving the proportion of older people (65 and over) who were offered rehabilitation following discharge from an acute or community hospital.	£660k	Red- Awaiting feedback on the recent bed modelling review undertaken by STHA. However work continues to be undertaken by CCG with regard to LTC and Frail Elderly to support reductions in bed capacity and care closer to home.
Other Schemes - actioned within 12/13 contract rd	Savings identified resulting from 11/12 QIPP	£1,052K	Implemented in 12/13 contra
	schemes and Value for Money challenges.		
	Total QIPP Savings	£2,829k	

2.5 Our Use of NHS Resources

In line with our QIPP aspirations, we want to get the best value and optimal outcomes for the money we have to spend on care in East Staffordshire. On the whole, compared to others CCGs, ESCCG spends less money for average outcomes across a range of disease areas; it is our ambition to spend average money for better outcomes.

Comparative national data that we have for the CCG up to and including 2011 shows that our referral rates for first outpatient appointments are lower than the average for the country, as is our growth in referrals. Growth in ESCCG was 16% from 2007 – 2011 compared with 21% for the country as a whole. However, even though we compare well, this is still an enormous increase in activity and demand continues to rise.

For the same period, elective (planned care) admission rates and growth in this area are at or about national averages. Growth in ESCCG is 17% compared with 16% nationally; again this is creating greater demand in the system as a whole and is highlighted as a priority area of work going forward.

For non-elective care (urgent and unplanned care) ESCCG is seeing admissions growth of 16 % (2007/08 – 2010/11) compared with 7% nationally. A&E attendances as a percentage of practice list size are 33% in ESCCG compared to about 20 % nationally and the proportion of those people that then go on to be admitted is 25.81% in ESCCG (in 2012/13) whereas national rates are at least 5% lower. However, it should be noted that the impact of the IUCC will not yet be showing in these national datasets. Nevertheless, growth in non-elective care is a major concern for the CCG and our partners.

ESCCG has made major improvements in the management of the prescribing budget over the past three years and continue to see successes. A highly skilled medicines management team with dedicated clinical leaders work proactively with both practices and providers to strive for improvements. We have seen no growth in prescribing expenditure between 2007 and 2011 compared with national growth of 3%.

Spending on prescribing is now close to the national average at £80,245 per 1,000 patients compared to £79,662 nationally, however, this is not standardised for age; as discussed later in Chapter 4, ESCCG has a rapidly growing elderly population and this may account for some of the difference. Our biggest areas of spend in primary care prescribing are for circulatory disease, respiratory disease,

endocrinology (in particular in relation to insulin prescribing for diabetes) and mental health.

We spend less money on primary care services overall than the Staffordshire and England average.

We spend more than the average CCG on circulatory disease services and yet we have higher than average death rates for circulatory disease.

We have slightly higher numbers of deaths caused by gastrointestinal disease and neurological conditions. There is higher prescribing spending in these areas but less spend on both elective and non-elective care.

Those areas where the CCG is performing below the national average in terms of spend and/or outcomes will be key areas of focus over the next few years and these are detailed later in Chapter 5.

Data is routinely shared with member practices about their use of NHS resources. To date this has covered inpatient, outpatient and A&E data. Practices will be able to access their own data remotely from late autumn 2012 as the CCG is implementing an IT system called ‘Budget Manager’. The system is currently being rolled out and all practices will be ‘live’ by early 2013; this will enable benchmarking and data sharing to be embedded into the culture of the CCG.

2.6 ESCCG’s Performance in 2012/13

Table 2 below gives a snap shot of South Staffordshire PCT performance for the year 2012/13 up to and including August 2012 against a range of national targets and measures. Burton Hospital Foundation Trust (BHFT) figures are shown wherever possible.

Comprehensive CCG level data will not be available until 2013/14.

On the whole, local performance against national targets is good. Those areas that are not at the required target level have agreed action plans for improvement which are monitored routinely via contract meetings and clinical quality review meetings with providers.

Table 2: Local Performance Against National Targets as at 31 August 2012

National Target	Required Rate	Performance
Ambulance Category A response times	75% < 8 minutes	**75.4%**
Cancer Waits: from referral to treatment	85% < 62 days	**87.1%**
Cancer Waits: from assessment to treatment	96% < 31 days	**98%**
Cancer Waits: from referral to assessment	93% < 14 days	**93.9%**
Mental Health Care Programme Approach	95% < 7 days	**97.4%**
Referral to Treatment: admitted patients (PCT)	90% < 18 weeks	**85.9%**
Referral to Treatment: non-admitted patients (PCT)	95% < 18 weeks	**96%**
Referral to Treatment: admitted patients (Burton)	90% < 18 weeks	**91.8%**
Referral to Treatment: non-admitted patients (Burton)	95% < 18 weeks	**98.4%**
Diagnostic Tests Waiting Times (PCT)	99% < 6 weeks	**97.8%**
Diagnostic Tests Waiting Times (Burton)	99% < 6 weeks	**100%**
A&E Waiting Time: total time in department (Burton)	95% < 4 hours	**97.4%**
A&E unplanned re-attendance rate (Burton)	< = 5%	**6%**
Mixed-Sex Accommodation Breaches (PCT)	0	**8**
Mixed-Sex Accommodation Breaches (Burton)	0	**1**
Incidence of MRSA: number of cases (PCT)	6	**4**
Incidence of MRSA: number of cases (Burton)	0	**1**
Incidence of C.Difficile: number of cases (PCT)	53	**70**
Incidence of C.Difficile: number of cases (Burton)	11	**10**
VTE risk assessment: inpatient admissions (Burton)	90%	**96.6%**
Delayed discharge: days delayed / occupied beds (Burton)	< = 3.5%	**2.3% (6 patients)**
Occurrence of “Never Events” (Burton)	0	**0**
Hospital-acquired Pressure Ulcers: grade 2 (Burton)	n/a	**46**
Hospital-acquired Pressure Ulcers: grades 3+4 (Burton)	n/a	**18**
Cancelled Operations (Burton)	61 (Q1)	**56**
Patients spending 90% of time on a stroke unit (Burton)	80%	**84.5%**

2.7 Overview of Contractual Performance in 2012/13

ESCCG intends to inherit a stable local health economy. The 2011/12 year end contract position at BHFT was almost as planned with a relatively small over-performance of £125K for the year.

Table 3 below shows contract performance at Month 5 (August) in 2012/13 which is the latest available position for contract monitoring data provided by NHS Providers.

Good financial management by the CCG in 2012/13 will provide a good platform on which to move forward into 2013/14. The CCG must not be complacent due to the potential for additional pressures to develop in-year, such as increased prescribing costs, winter pressures etc. which could have an adverse financial impact. Therefore any identified mitigating actions should be acted upon to support generation of additional contingency funds which may be required in the later part of the financial year.

The BHFT contract is currently over-performing, mainly relating to other CCG's not ESCCG, as we are reporting an under spend. However the recurrent underlying position for ESCCG is showing over performance on non-elective and outpatient procedures, which in 2012/13 is being masked by use of Strategic Change monies allocated to BHFT to offset an element of over performance as per the contractual agreement. There are a number of outpatient redesign schemes planned and in progress that should aid recovery of this position later on in the financial year as schemes come into full effect, in addition to further mitigating actions being identified.

Table 3: Contract Performance to Month 5 (April 2012 - August 2012)

Type	M5 Plan (£000s)	M5 Actual (£000s)	Variance () = +	Annual Plan (£000s)	Forecast Outturn	Variance () = +
Acute	35,044	34,723	(320)	84,019	83,708	(312)
Mental Health	5,117	5,178	61	12,174	12,431	257
Community	4,249	4,020	(229)	10,252	9,825	(427)
Other	6,929	7,008	80	16,511	16,867	356
Total	**51,339**	**50,930**	**(409)**	**122,957**	**122,832**	**(126)**

2.8 How We Measure Our Performance

The CCG considers performance management as an inter-connected set of learning activities necessary for measuring, monitoring and challenging specific aspects of both the CCG's performance and that of other organisations, in important areas of delivery.

Performance management will be a steady routine of sustained implementation against rigorous and transparent standards that are expected to deliver specific outcomes.

There will be three further dimensions to the CCG's approach:

- Ensuring that care is safe;
- Ensuring that care is both efficient and effective; and
- Ensuring that it provides patients with the most positive experience possible.

Our vision is to place continuous performance improvement across all dimensions and at the heart of everything we do, because delivering the best quality of care will yield the best value from the system. Fundamental to this is good intelligence, not only to both assess and report performance, but also to ensure that interventions are put in place properly to remedy any poor performance and to ensure that learning occurs.

The CCG has established a QIPP, Finance and Performance Committee that has delegated powers as a sub-committee of the CCG Governing Body. This group has agreed Terms of Reference and meets on a monthly basis to provide the CCG Board with assurance about performance management, QIPP delivery and financial management.

Similarly, there is a Quality Committee, another sub-committee of the Board that has responsibility for quality of care, patient safety and patient experience.

Further details can be found in the Constitution and the Integrated Governance Framework available at www.eaststaffsccg.nhs.uk

Chapter 3 - Our Commissioning Cycle

3.1 The ESCCG Commissioning Cycle

We have recently developed our commissioning cycle with staff and local CCG clinical leaders. This has helped us to clarify best practice and the roles and functions of the individuals involved in each stage of the cycle.

The Cycle consists of four main steps with associated activities; there will be flexibility in applying these and each step will be proportionate to the scale of what is being commissioned.

PLANNING

DOING (Procurement)

REVIEWING (Contract Management)

ANALYSING (Assess & Review)

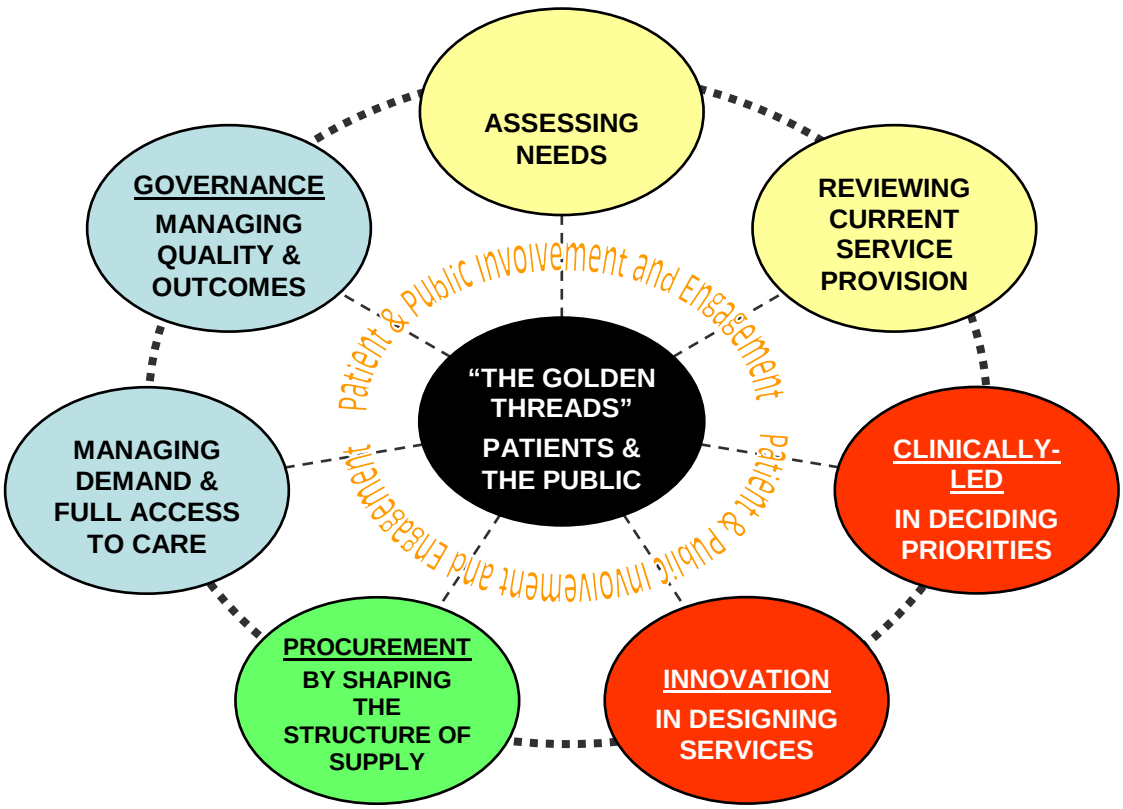


Figure 3: The ESCCG Commissioning Cycle

CCG staff and member practices will decide how best to design our commissioning processes by adapting / adopting common activities to those matching the preferred ways of working locally.

However the essential features are:

- **Patients + the Public** are fully engaged, at the heart of our compassionate Cycle
- **Lean, non-bureaucratic** processes, where permissible within regulatory requirements
- **Innovative** Commissioning: quickly turning good ideas into commissioned services
- **Integrated** Commissioning: with local authority, other CCGs to pool resources, risk share
- **Focussed** on delivering QIPP and excellent outcomes within financial resources

Our Cycle has been developed so that all Member Practices, CCG staff and stakeholders:

- Understand each element of the Cycle and their roles / the roles of others;
- Understand the implications of it and its impact on how business is managed;
- Understand our Stakeholders - where engagement must or should occur; and
- Understand the tools to commission effective services & when to use them.

Our “Golden Threads” are cross-cutting, common elements of all parts of the Cycle and we aim to ensure that the threads are considered in whatever work we are doing. The majority of these golden threads were also highlighted at the recent stakeholder events as overarching principles for our commissioning activities:

- ✓ Patient and Public Involvement at the Core of our Commissioning
- ✓ Commissioning with, and for, Compassion
- ✓ Improved Care Pathways
- ✓ Focus on Prevention
- ✓ Improved Health & Wellbeing
- ✓ Evidence-Based Clinical Decision Making
- ✓ Integrated Ways of Working
- ✓ Improved Communication & Engagement
- ✓ Sustainable Local Providers of Choice

3.2 Commissioning for Quality and Outcomes

The NHS Next Stage Review, led by then Health Minister Lord Darzi, culminated with the publication of *"High Quality Care for All"* in November 2008. This report provided the primary focus for the current national context for quality improvement in the NHS (Darzi 2008). It stated that whilst the past decade of NHS reform was about increasing *capacity*, the future reform will focus on increasing *quality*. According to the review, centrally determined targets based on *process* (e.g. how many?), must give way to locally determined targets based on *quality* (e.g. how good is it and how was the outcome for our patients?).

The review considered seven key aspects to improve the quality of services:

- Bringing clarity to quality
- Measuring quality
- Publishing quality performance
- Recognising and rewarding quality
- Raising standards
- Safeguarding quality
- Staying ahead

The Darzi review went on to define quality in terms of three key areas:

1. Patient Safety;
2. Patient Experience; and
3. The Effectiveness of Care.

In order to achieve our quality aspirations, East Staffordshire CCG is establishing robust processes and systems to monitor, measure, reward and safeguard quality in order to ensure safe and effective care which provides a positive experience for all patients.

The overarching quality objectives for East Staffs CCG are to:

- Embed quality into the commissioning cycle ensuring that services being commissioned are safe, effective and provide patients with a positive experience. This will ensure that associated outcome benefits are being realised and the CCG has the ability to take action if the safety and/or quality of commissioned services is compromised.
- Develop and support a culture of continuous improvement in the quality of commissioned services.
- Identify and utilise benchmarking data to support key quality improvements.
- Review and extend the current mechanisms for monitoring patient experience.

- Shift the emphasis of quality activity from quality assurance through counting data to quality improvement as a result of improved monitoring, measuring and reporting of outcomes for patients.

These objectives will be delivered via a robust process of reviewing best available evidence on quality improvement programmes and through the implementation of best practice to deliver high quality services. This will be achieved by working in partnership with provider organisations to ensure clear quality improvement systems exist and that there are clear measures of evidence based quality of care and patient experience.

3.3 CQUINS (Commissioning for Quality and Innovation)

One of the ways we currently commission for quality is through the use of CQUINS which are contract payments for quality and innovation initiatives.

Examples of CQUINs in 2011/12, where local Trusts made quality improvements were:

- the implementation of a Paediatric Early Warning System (PEWS) which scores routine observations; an increasing score indicates deteriorating health and enables early intervention;
- 90% of all adult in patients had a VTE (Venous Thromboembolism) risk assessment on admission to hospital using the national clinical assessment tool;
- completing a dementia strategy and delivery of dementia training to staff;
- improvements in the provision of physical healthcare for patients with a learning disability; and
- improvements in the care of patients with continence issues.

Our CQUINs for the current year include

- improvements on the Patient Experience score;
- giving treatments to prevent VTE for those patients identified at risk;
- implementation of the ‘safety thermometer’ an initiative that aims to eradicate 4 harms (falls, grade 3 and 4 pressure ulcers, VTE and catheter associated UTI).

3.4 Clinical Quality Review Meetings

There is an established programme of clinical quality review meetings for all key providers. ESCCG will establish and implement a strong governance structure to drive improvements in the clinical quality review meeting process and during 2012/13

will work to ensure that the contract is used to its full capacity to ensure that standards of safety are continuously reviewed and raised.

The clinical quality review meetings will continue to receive data from all providers in relation to key quality measures and planned improvements in relation to each dimension of quality. Significantly next year there will be a shift from reporting numbers to increasing the requirement to report patient outcomes. Furthermore, there will be an additional change in approach through moving from the meetings being a discussion about numbers to one of themed clinical discussions, sharing outcomes and feedback on what are important issues for patients. The programme for these will be agreed with each provide, with some scope to change if circumstances require urgent consideration of a particular issue.

3.5 ESCCG Quality Strategy

The East Staffordshire CCG Quality Strategy has been developed and outlines the key aims and objectives for driving the quality agenda forward over the next three years. The key objectives in the quality strategy are outlined below in Table 4.

Progress on delivering the Strategy will be monitored via the ESCCG Quality Committee.

The full strategy can be found at www.eaststaffsccg.nhs.uk

3.6 Research and Innovation for Quality Improvement

The importance of improving the quality of clinical treatment and care is widely recognised. It is equally important to improve the effectiveness of interventions designed to prevent disease. We will demonstrate clinical effectiveness by measuring performance in relation to:

- The continuous improvement and innovation in the safety and quality of commissioned services.
- Implementation of NICE guidance and standards
- Reduction of variation in practice (commissioning for quality)
- Equity of access
- National Quality Outcome Framework and Clinical outcomes
- Value for money
- Research/ audit
- Staff competencies & training uptake rates
- Workforce metrics
- Public Health information

ESCCG is committed to continuous quality improvement through these various routes many of which depend upon the use of research and innovation. The CCG recognises that for quality to improve, changes to current and previous systems will be required. It is also recognised that these changes may, at times, appear challenging to staff and to patients who use our services. With patient safety first and foremost, ESCCG will work to achieve the following:

- We will encourage innovation from Practices through a locally agreed prescribing incentive scheme to drive improvements in the quality of care. Recognising and rewarding improvements in practice.

- ESCCG will continue to develop and promote clinical guidelines to ensure that referrals from GPs to secondary care are consistent with local protocols and of a consistently high quality.

- ESCCG will engage not only with GP practices but also with the wider clinical community to ensure that we make best use of the clinical expertise and experience within our health economy to drive improvement in quality.

- ESCCG will develop and implement a research and development strategy which will focus on driving quality improvements through local projects.

- ESCCG will remain committed to meeting the requirements of the Research Governance Framework (DH, 2001)

- ESCCG will continue work with the Primary Care Research Network to support increased practice involvement in research activity.

- ESCCG will look outwards for examples of best practice and seek to learn from other organisations.

Table 4: Summary of the ESCCG Quality Strategy

Our Ambitions	Actions / Projects to support our ambitions	Measure of success (at March 2013)	Measure of Success (at March 2015)
To embed quality throughout the CCG	1. Responsibility for quality to be included in all CCG role descriptions, all committee terms of reference, service specifications, contracts and other CCG documentation 2. Strong leadership for quality at all levels of the organisation. 3. (Consider) quality newsletter (or section in main newsletter) for member practices, highlighting key quality indicators e.g. complaints, patient experience, key serious incidents etc. to ensure wide awareness and shared learning.	1. Wide acceptance and ownership of the quality agenda evidenced in all reports and associated documentation. Staff supported to develop individual roles and contribution to quality agenda. 2. Quality is seen as organisational not individual responsibility. 3. Member practices aware of key risks, quality issues arising in main providers or nationally where appropriate and able to feed into established process where concerns are identified.	1. Evidence of CCG wide involvement in Quality work programmes, quality explicit in all commissioning activity. 2. As above 3. Communication route for key quality issues is clear, responsive and functioning effectively
To demonstrate continuous quality improvement	1. Quality strategy developed, central to the key indicators i.e. patient safety, patient experience and clinical effectiveness	1. Strategy clear, objectives in place and communicated to members, partners etc. 2. Reports to Governing Body focus on all three key areas, working towards achievement and evidence of continuous improvement in the three key areas.	1. Continuous quality improvement is evident and Governing Body is assured that systems and processes to support CQI are effective. 2. Improved outcomes for patients are reported across the organisation.

Our Ambitions	Actions / Projects to support our ambitions	Measure of success (at March 2013)	Measure of Success (at March 2015)
To develop a new way of working to improve quality	1. Establish CCG quality committee as the forum through which key quality activity is agreed, monitored and developed to assure CCG Governing Body and external bodies e.g. Cluster, SHA.	1. Quality Committee established and operating effectively to monitor quality whilst working differently to previous PCTS	1. Quality committee functioning effectively and continuing to provide assurance to governing body.
	2. Establish collaborative quality forum as agreed during stakeholder event.	2. Collaborative forum working effectively to eliminate duplication and drive up joint quality improvements across the health economy.	2. Collaborative quality forum continuing to drive up joint work programme on quality improvements, evidence of previous year's collaborative success reported.
	3. Revise current quality schedule to reflect the need to evidence continuous quality improvement and improved outcomes for patients whilst still monitoring statutory requirements.	3. New contract contains all KPIs plus indicators relevant to outcomes rather than performance.	3. Monitoring of KPIs is routine, effective and responsive. New schedule reflects outcomes focussed approach to commissioning for quality.
	4. Work collaboratively to revise current format of Clinical Quality Review Meetings (CQRM) to ensure that these become a forum conducive to evidencing the changes above and are reflective of what matters to member practices and our patients.	4. CQRM operating more effectively, KPIs monitored but focus of meeting on outcomes for patients and acting on/ learning from previous experience.	4. CQRM operating as a responsive, joint and effective forum focussing primarily on evidence of improved outcomes whilst still meeting contractual requirements.
	5. Change approach to quality improvement to introduce more proactive quality improvement methods rather than relying heavily on responsive reviews	5. Proactive quality improvement plan in place including work to develop core standards and expectations aligned to the Total Quality Management model	5. New approach operational, responsive and working effectively to TQM model.

Our Ambitions	Actions / Projects to support our ambitions	Measure of success (at March 2013)	Measure of Success (at March 2015)
To use soft intelligence and other forms of patient feedback to drive quality improvements	1. To establish new system for monitoring, acting upon and feeding back to patient feedback (links to wider involvement and engagement work) 2. To establish an open, responsive and effective culture, through a system for recording the concerns of health care staff 3. To establish "spotter practices" and mystery shopper programmes to support ad hoc and wider feedback mechanisms.	1. Insight web based feedback system providing sufficient information on patient feedback to enable responsive commissioning and action where needed. Action is taken as a direct result of patient feedback. 2. Evidence that concerns are taken seriously, considered and investigated fully and action is taken as a result of staff concerns 3. Spotter practices established and information from these and mystery shopper programme being used to influence change.	1. Evidence of change as a direct result of patient feedback is seen at relevant committees. Timely feedback is given to all forms of soft intelligence and patient feedback. 2. Continued evidence of improvements in this area and confidence in respect of action taken to address concerns. 3. Spotter practices and mystery shopper programme proving effective route for feedback and responses to findings clearly evident.
To respond to opportunities to learn from others to improve quality	1. Respond to recommendations from Francis Inquiry when published (now likely to be January 2013) ensuring that key lessons for commissioners are embedded at all levels of the CCG.	1. Self-assessment against recommendations will highlight gaps which will be addressed. 2. Action plan to address recommendations is developed, agreed and approved. Implementation underway, strategy amended to reflect as required.	1. Continued evidence of change and on-going monitoring.

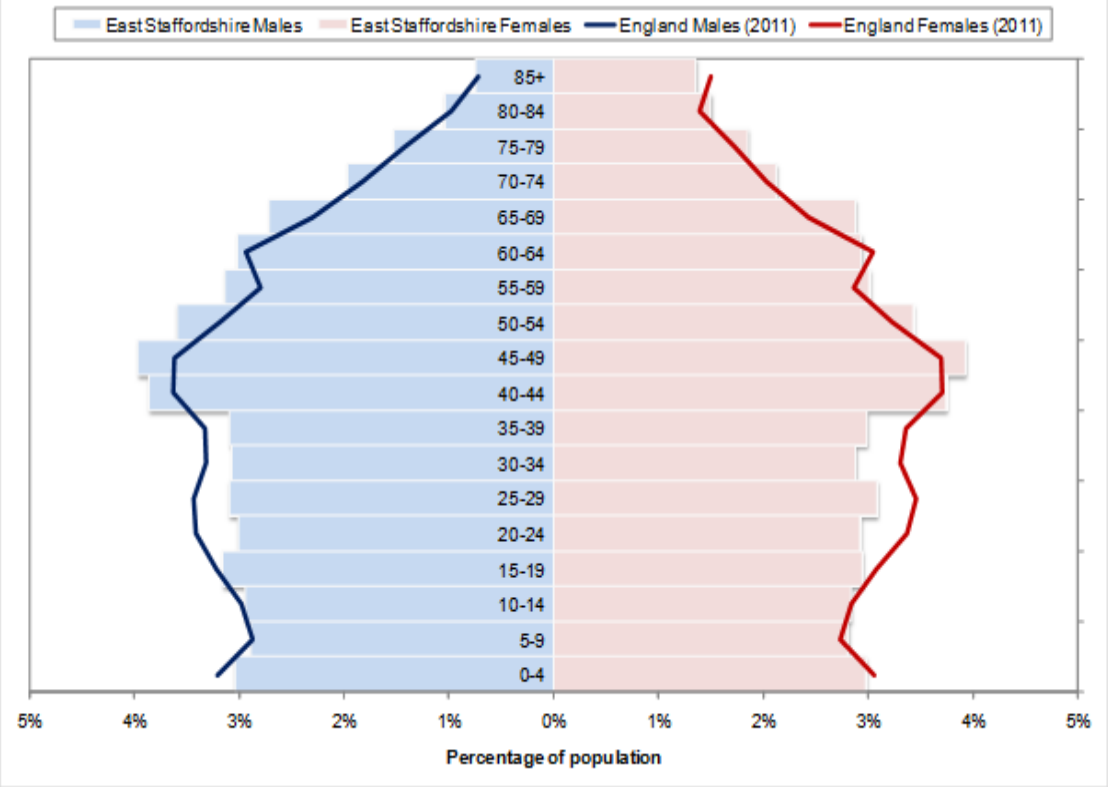
Chapter 4 - The Health Needs of Our Population

The following section of our Plan summarises the key health issues facing the population of East Staffordshire. Further detail can be found in the Priorities section of this document and in the Staffordshire Joint Strategic Needs Assessment April 2012 and the Health and Wellbeing Profile for East Staffordshire Borough Council, May 2012 both of which can be found at http://www.staffordshireobservatory.org.uk/IAS/jsna/2012 .

4.1 Demographic Profile

The population of East Staffordshire CCG is projected to grow by 20% between 2011 and 2035 and whilst population increases will be across all age groups the biggest rise and the biggest impact will be in people aged 65 and over. Forecasts indicate that there will be a 75% growth in over 65s and 99% growth in over 75s between 2011 and 2035. The over 75s age group is growing faster in East Staffordshire than the average for the rest of the country. There are also local plans to build 7000 new homes in East Staffordshire which would have a significant impact on ESCCG. We will continue to work closely with ESBC and commission accordingly.

Figure 4: Population age structure of East Staffordshire CCG (2012) compared with England (2011)



Source: GP registered populations 2012 and 2011 Census, Office for National Statistics, Crown copyright

2009 estimates reveal that 8% of the population are from minority ethnic groups, lower than the national average of 13%, with the largest single minority group being Pakistani (4%). The minority population of East Staffordshire live predominately in the Burton area.

Data from both National Insurance Number registrations to migrant workers and GP registrations reveals significant increases in the number of migrants living and working in East Staffordshire, mainly from Eastern Europe.

Over a quarter of the East Staffordshire population is classified as rural (slightly higher than Staffordshire overall and England) and the area is characterised as a relatively affluent area, however, there is a real split between Burton and the rural areas of the CCG and ESCCG recognises the serious inequalities in healthcare across the patch and will continue to strive to address this.

Table 5: Population projections for East Staffordshire CCG (percentage change from 2011)

	2011	2015	2020	2025	2030	2035
0-14	23,240	24,510 (5%)	26,150 (13%)	26,870 (16%)	26,640 (15%)	26,400 (14%)
15-24	16,080	15,360 (-4%)	14,390 (-11%)	15,100 (-6%)	16,550 (3%)	17,160 (7%)
25-49	45,070	45,300 (1%)	45,600 (1%)	46,110 (2%)	47,960 (6%)	49,030 (9%)
50-64	25,640	27,040 (5%)	29,910 (17%)	30,330 (18%)	28,220 (10%)	27,090 (6%)
65-74	12,480	14,130 (13%)	14,930 (20%)	15,430 (24%)	17,660 (42%)	19,290 (55%)
75+	10,490	11,760 (12%)	13,600 (30%)	16,690 (59%)	18,710 (78%)	20,830 (99%)
0-15	**24,910**	**26,060 (5%)**	**27,620 (11%)**	**28,530 (15%)**	**28,460 (14%)**	**28,210 (13%)**
16-64	**85,130**	**86,150 (1%)**	**88,430 (4%)**	**89,870 (6%)**	**90,920 (7%)**	**91,460 (7%)**
65+	**22,970**	**25,890 (13%)**	**28,530 (24%)**	**32,120 (40%)**	**36,370 (58%)**	**40,130 (75%)**
All ages	**133,000**	**138,100 (4%)**	**144,580 (9%)**	**150,530 (13%)**	**155,740 (17%)**	**159,800 (20%)**

Note: Numbers may not add up due to rounding

Source: 2011 GP registered populations and 2010-based sub-national population projections 2010-2035, Population Projections Unit, Office for National Statistics, Crown copyright 2012

4.2 Health Inequalities

There are 12 Lower Super Output Areas (LSOA), sub-ward areas averaging approximately 1500 people, in the most deprived quintile (20%) of the country, this equates to 17% of the total population of East Staffordshire; a further 17% live in the second most deprived quintile. There are also 10 LSOA in the most deprived quintile (20%) for child wellbeing which equates to 18% of the child population (3,800 children).

The most deprived areas in the CCG are Eton Park, Stapenhill, Shobnall, Winshill, Horninglow, Anglesey and Burton. Four of these areas have higher levels of people living with limiting long-term illness (Burton, Stapenhill, Horninglow and Shobnall) and all seven have fertility rates higher than the England average. Teenage pregnancy is also higher in Burton, Eton Park, Heath and Stapenhill.

16% of children living in the CCG area live in income deprived households compared with 22% across England. In terms of older people living in income deprivation, the proportion for the CCG is 16% compared with 18% across England. Again these mask pockets of deprivation within the area, for example, the range between practices for children living in income deprivation is 7-32% and 9-25% for older people.

A third of the CCG's population is defined as being in the most disadvantaged quintile for geographical access to services. This is due to the rural nature of some of these areas.

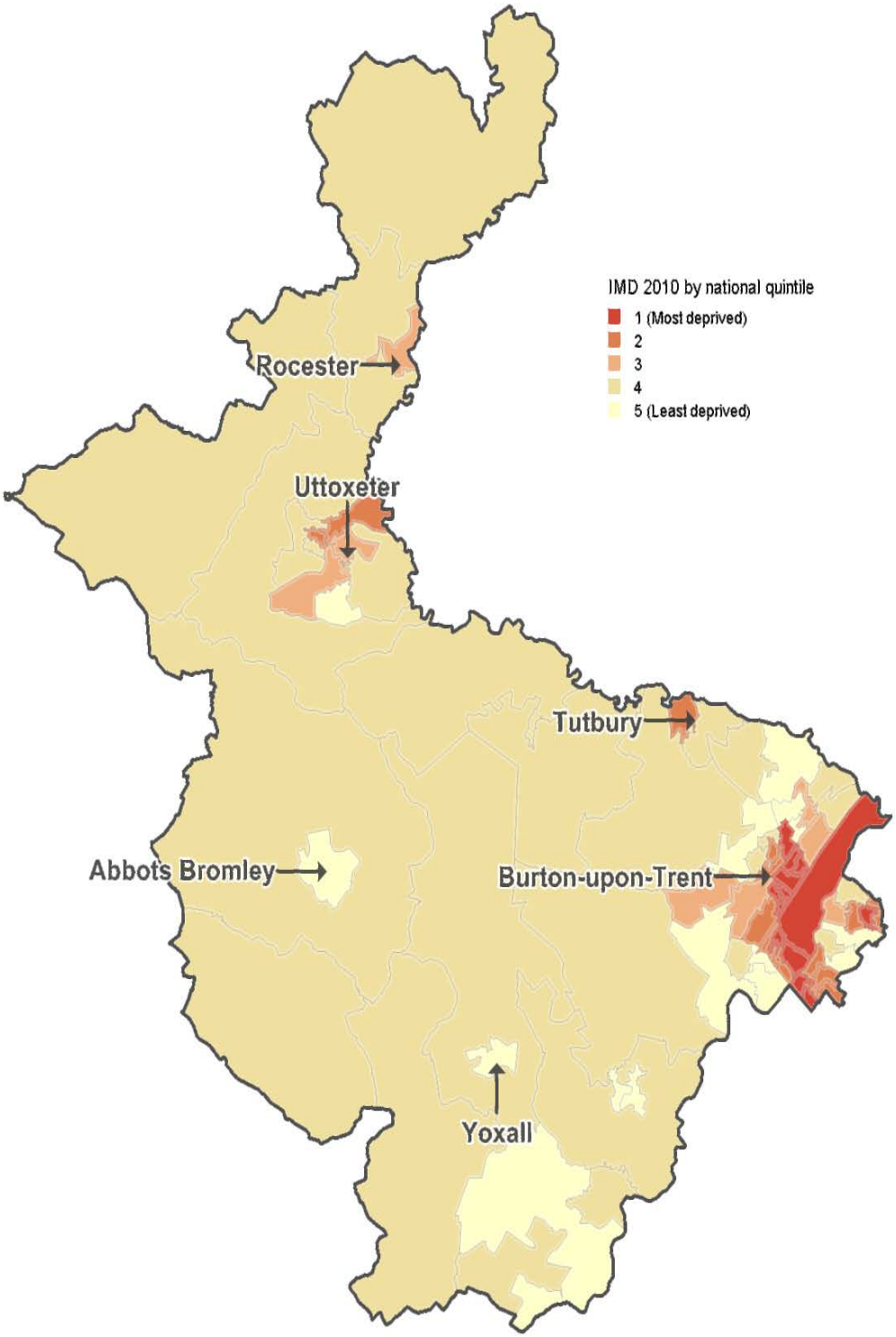
Figure 5 below shows the geographical spread of deprivation across ESCCG.

4.3 Life Expectancy

Life expectancy for men is 14 months lower in East Staffordshire than the England average; this is largely due to lower life expectancy in areas of Burton and this is likely to be rooted in the wider determinants of health, inequalities and lifestyle factors.

We have been hugely successful in reversing the trends in infant mortality (five years ago East Staffordshire saw some of the highest rates nationally) and through a multi-agency partnership approach these are now reduced to less than England average. We had also had an issue with still birth rates as trends had been steadily increasing since 2003-2005, however, our most recent data shows the CCG is at the England average for still birth. These are areas that the CCG will continue to monitor.

Figure 5: Deprivation in East Staffordshire CCG

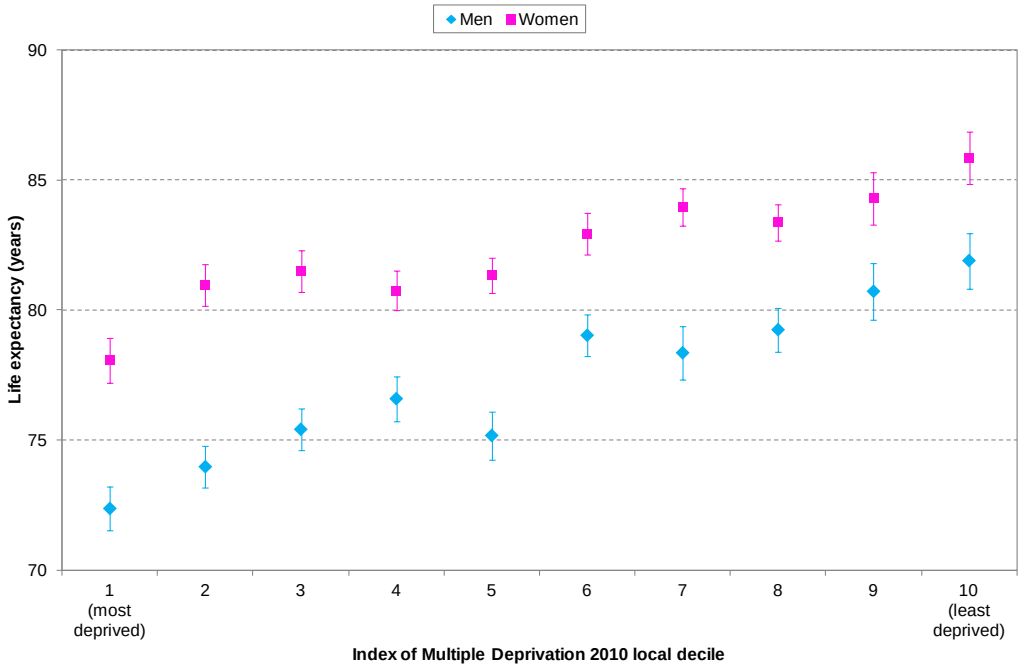


Source: Indices of Deprivation 2010, Department for Communities and Local Government, Crown copyright 2011ONS, Super Output Area Boundaries. Crown copyright 2004. Crown copyright material is reproduced with the permission of the Controller of HMSO
Contains Ordnance Survey Data. Crown copyright and database rights (2011). Licence number 100050850

There are very significant health inequalities in East Staffordshire and the difference in life expectancy between the best and worst ward is 10 years for men and 8 years for women. Seven wards have a higher All-Age All-Cause Mortality (AAACM) rate than the England average and overall premature mortality rates are higher than the England average in Eton Park, Horninglow, Shobnall, Stapenhill and Winshill wards.

This is illustrated in Figure 6 below which shows the difference in life expectancy in population deciles (i.e. the population divided into tenths); 1 is the most deprived decile and 10 is the least deprived decile. The gap between the best and the worst deciles is likely to be rooted in the wider determinants of health, inequalities and lifestyle factors.

Figure 6: Life expectancy in East Staffordshire CCG by Decile (tenths), 2006-2010

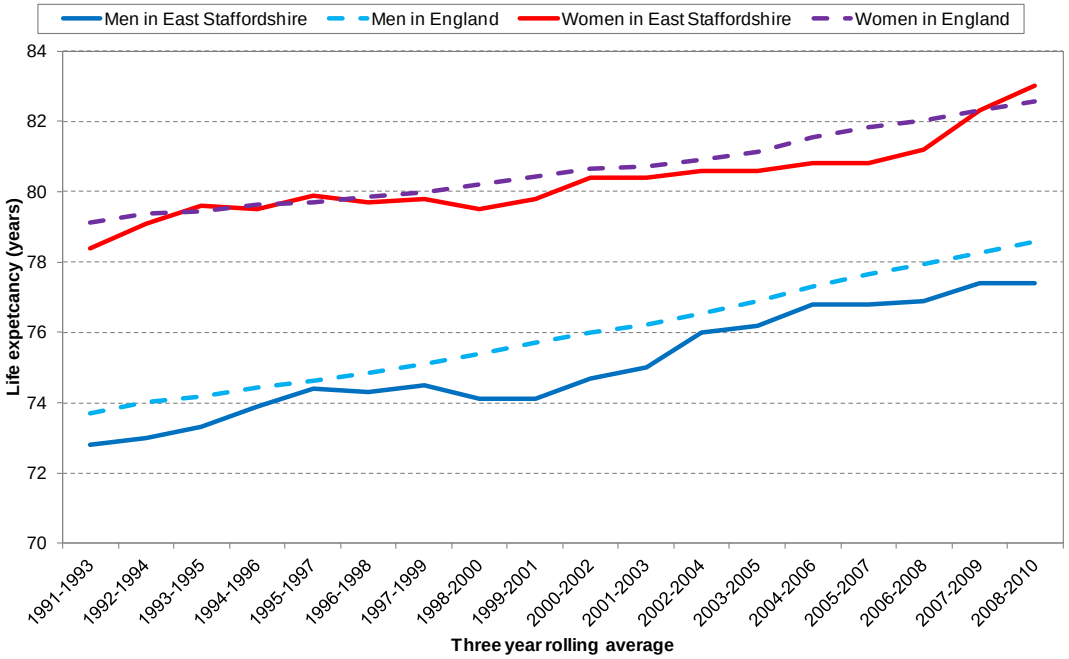


Source: Death extracts, Office for National Statistics, Mid-year population estimates, Office for National Statistics, Crown copyright and Indices of Deprivation 2010, Department for Communities and Local Government, Crown copyright 2011

Figure 7 below shows the trends in life expectancy in East Staffordshire when compared with the England average. The chart shows that women's life expectancy in East Staffordshire is now longer than that for England whereas men's life expectancy is shorter and the gap between the two is increasing.

However, the trend across the CCG area continues to be positive in that the rate of people dying prematurely (before 75 years) has declined over the last 15 years.

Figure 7: Trends in life expectancy for men and women



Source: Compendium of Population Health Indicators (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

Table 6 below shows how some of the inequalities can persist as health inequalities in old age as poor life chances lead to unhealthy lifestyles which lead to early onset of disease, severe disease and death. The table illustrates the differences in life experience and health outcomes between the most deprived and least deprived areas of the CCG.

On average we see approximately 1200 deaths per year in East Staffordshire; of the people who die in East Staffordshire every year the causes are circulatory disease (33%), cancer (27%) and respiratory disease (13%), all of which will be tackled through our strategic plan.

We also have higher than expected mortality for suicide and undetermined injury, circulatory disease and gastrointestinal disease.

The good news is that across the CCG area, the rates of people dying prematurely before the age of 75 has continued to decline over the past 15 years. However premature mortality rates are still higher than the England average in Eton Park, Horninglow, Shobnall, Stapenhill and Winshill wards.

Table 6: Health inequalities: comparison of babies born in the least deprived and most deprived areas in East Staffordshire CCG

		Least deprived	Most deprived	East Staffordshire
Health	Claim incapacity benefit	1.0%	4.2%	2.2%
	Have a limiting long term illness	12%	21%	17%
	Smoke	14%	28%	21%
Education	Get a least five GCSEs A*-C	69%	28%	54%
	Claim free school meals	5%	37%	14%
Work	Become a professional or manager	36%	13%	25%
	Are employment deprived	4%	17%	9%
	Live on benefits	6%	25%	13%
Home and family	Live in poverty as a child	5%	38%	17%
	Live in income deprived households	4%	28%	12%
	Go home to a council house	1%	18%	8%
	Are part of a lone parent family	3%	10%	6%
	Have no access to a car or van	9%	44%	22%
Experience of crime	All crime	3%	14%	6%
	Anti-social behaviour	1%	7%	3%
	Burglary	0.2%	0.4%	0.2%
	Deliberate fire	< 0.1%	0.3%	0.1%
And finally	Live alone as a pensioner	10%	17%	14%
	Live in poverty when they are aged 60 and over	7%	31%	14%
	Live to the age of (for men)	79.9	72.1	76.8
	Live to the age of (for women)	83.6	78.2	81.6

Data analysed and compiled by Population Health Intelligence, Staffordshire Public Health

4.4 Giving Every Child the Best Start

Fertility rates in East Staffordshire are higher than the national level. During 2010/11 the proportion of pregnant women accessing a health and social risk assessment before 13 weeks gestation was lower than the West Midlands average. Provisional data indicates that levels in 2011/12 have increased and the proportion is now similar to the West Midlands average. Inequity in access between wards however remains an issue.

The proportion of women who smoke throughout pregnancy in East Staffordshire is lower than the England average. However, similar to the national picture, levels of young pregnant women smoking remain high.

Breastfeeding initiation and prevalence rates at six to eight weeks for East Staffordshire are considerably lower than the England average.

The proportion of low birth weight babies in East Staffordshire is similar to the England average.

Levels of obesity for children in reception were 8% in 2010/11, similar to the national average. Levels of obesity for children in Year 6 are much higher (20%) and have increased significantly over the last two years. There is also variation at ward level; Shobnall has a high proportion of children who were obese in reception whilst Anglesey has high levels of obese children in Year 6. We have implemented a Childhood Obesity programme and have commissioned a specific team to tackle this problem.

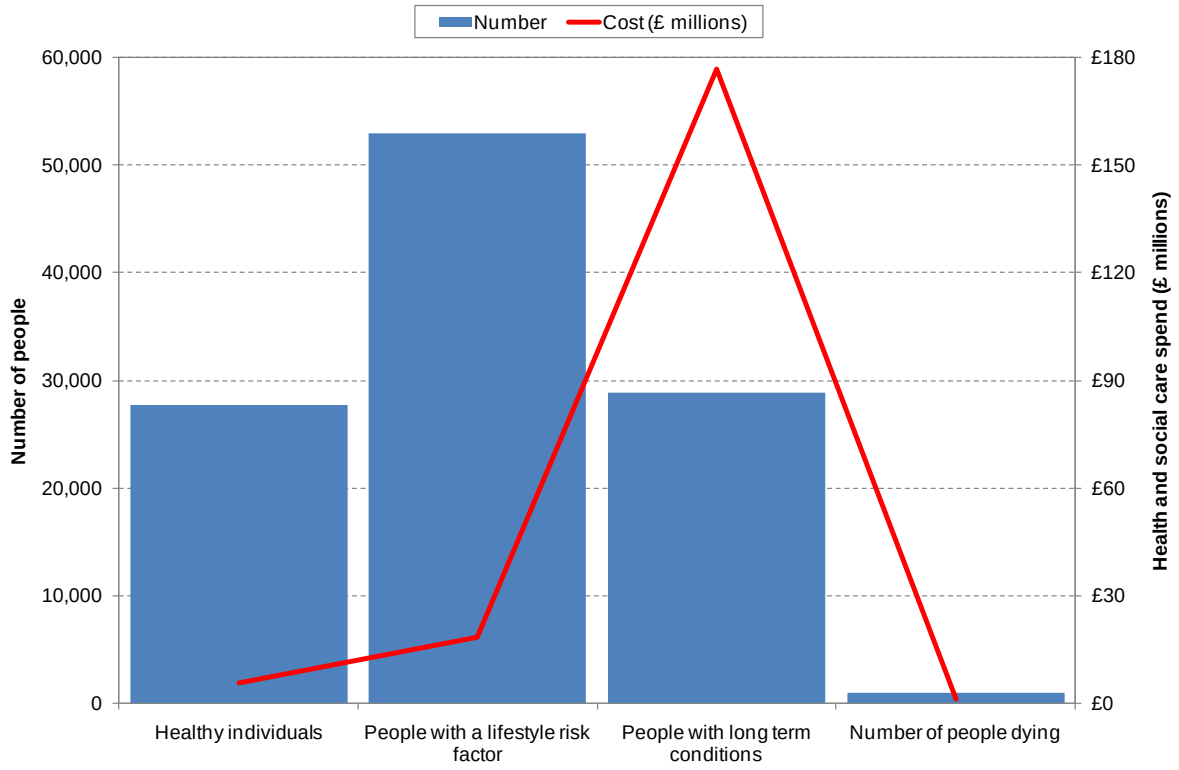
Teenage pregnancy rates in East Staffordshire are similar to the England average, although parts of the CCG area have high rates. Burton, Eton Park, Heath and Stapenhill wards had high teenage pregnancy rates in 2008-2010. The CCG is part of a teenage pregnancy working group and we have seen rates of teenage pregnancy in inner Burton decline; this is a promising start and we must now concentrate on those areas that are indicating a rise.

4.5 Long Term Conditions

The pathway from good health to severe disease and death is shown in Figure 8 below. This shows estimates of the numbers of CCG residents in each stage in the pathway. Whilst the numbers towards the right of the diagram are a small proportion of the population i.e. numbers of people with severe disease, Figure 8 also shows that the amount of the NHS and social care budget spent here is very high (about £200 million across East Staffordshire CCG).

Analysis of 2008 data from a number of practices reveal that at least one in four people have a long term condition (LTC) with one tenth of the population having more than one condition.

Figure 8: Distribution of health need and spend across the disease pathway in East Staffordshire CCG, 2010/11



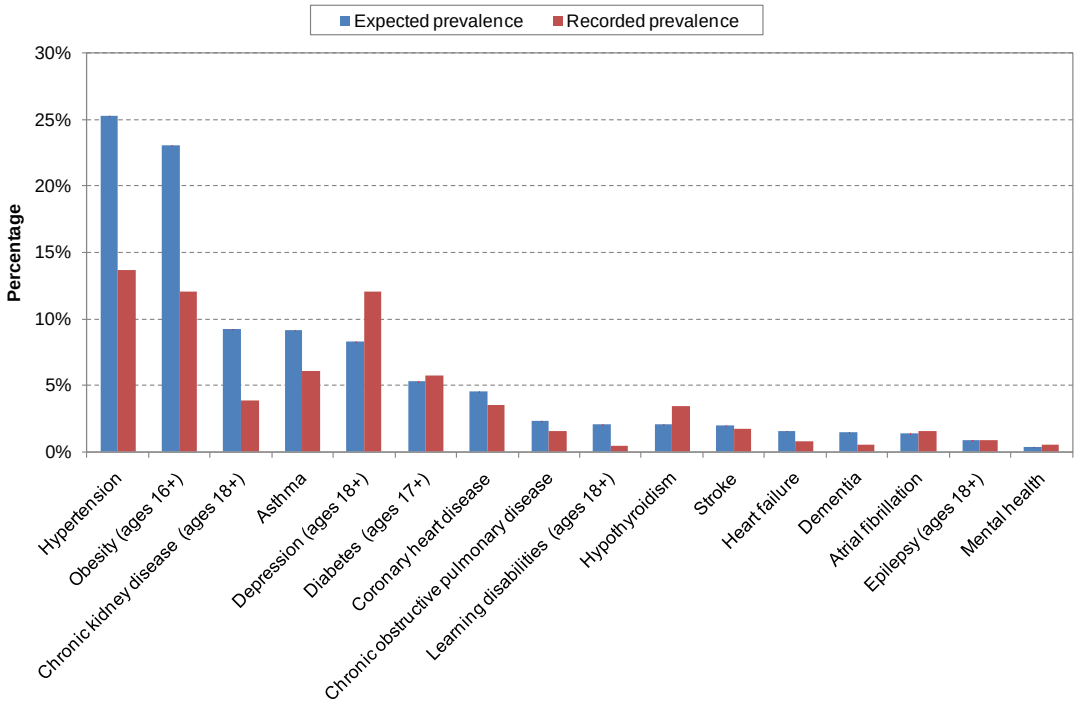
Analysed and compiled by Population Health Intelligence, Staffordshire Public Health

The numbers of patients recorded on GP disease registers are lower than expected for chronic kidney disease, dementia, heart failure, hypertension, learning disabilities and obesity (Figure 9). This means that there are potentially large numbers of patients who are unrecorded, undiagnosed and untreated for these conditions.

The NHS Health Check programme is one way of increasing the identification of people with undiagnosed disease. Performance across the CCG area had been poor, however, the CCG is now the best performing CCG in the South Staffordshire area and recently patient uptake has doubled.

With an ageing population, the CCG is predicted to see an increase in the number of people with LTCs. This will place an increasing burden on health and social care resources.

Figure 9: Recorded and expected prevalence for selected long-term conditions in East Staffordshire CCG, 2010/11



Source: GP registered populations, Disease prevalence models, Public Health Observatories in England, http://www.apho.org.uk/diseaseprevalencemodels, accessed February 2012, NHS Comparators, NHS Doncaster QOF Benchmarking Tool, Quality and Outcomes Framework (QOF) for April 2010 to March 2011, Quality Management and Analysis System (QMAS) database - 2010/11 data as at end of July 2011, Copyright 2011, The Health and Social Care Information Centre, Prescribing and Primary Care Services. All rights reserved

4.6 Lifestyle Factors

Both premature death and LTC are linked to preventable lifestyle risk factors, for example a third of patients with LTCs are obese, 14% are smokers and 19% are ex-smokers.

21% of the adult population in East Staffordshire smoke. Significantly more smokers are from routine and manual groups across the CCG contributing to increases in health inequalities. East Staffordshire also has high smoking-related admission rates compared with England. The CCG also has low four week quit rates per 1,000 smoker compared with national levels.

Burton on Trent is historically a brewery town and alcohol has a high profile here. Our ambitions are high and we continue to work with Public Health on a Staffordshire wide service redesign programme and are members of the Alcohol strategy

implementation board. We have seen big successes at the Burton Addiction Centre (BAC) and will continue to support the BAC O Connor centre to further develop services.

Approximately 20,700 adults consume alcohol at 'increasing risk' and a further 5,700 at 'higher risk'. In addition there are estimated to be around 4,000 dependent drinkers across the CCG, with a gap in structured alcohol treatment places across the Staffordshire area. Estimates also suggest that 22,300 adults aged 16 and over are binge drinkers. The rate of increase in alcohol-related admissions across East Staffordshire is higher than England.

Adult obesity levels in the CCG (25%) are similar to the England average (24%). However the range is between 22% and 28% in general practice. Levels of obesity are coupled with poor diet and low physical activity levels across the CCG. The CCG is working closely with the public health team to implement a new weight management service specification delivered through the lifestyle team.

Hospital admission rates from unintentional injuries in East Staffordshire are higher than the national average. Rates of people aged 65 and over in East Staffordshire who are admitted to hospital for a fall-related injury are also higher than the England average.

4.7 Mental Health

Suicide rates are similar to the England average across the CCG however, self-harm admission rates in the CCG are higher than national levels. Self-harm is often an expression of personal distress and there is a significant and persistent risk of future suicide following an episode of self-harm.

Levels of severe mental illness (schizophrenia, bipolar disorder and other psychoses) recorded in GP disease registers are significantly lower than for England as a whole. The CCG wishes to investigate this further as we suspect that this means that patients have not been identified as having a mental illness and therefore may not be receiving the care that they need.

The number of dementia cases suggests significant under recording across the CCG and a new dementia strategy is currently being developed. It is recognised that further investments will be needed within dementia services to improve provision.

Clearly, this population health data presents some significant challenges to the CCG and this has been reflected in the range of priorities and commissioning intentions that have been set out in the next sections of this Plan.

Chapter 5 - Our Priorities for 2012 - 2016

In order to produce a meaningful, integrated and strategic plan, ESCCG have engaged with the local community and with all major stakeholders. We have recently established an East Staffordshire Health Economy Forum with representation at executive leader level from all main providers and relevant CCGs; this will provide a forum for oversight of the delivery of this Plan and should generate “buy in” from our main providers. The next steps will be to include those CCGs that sit outside of the Staffordshire Cluster but who also utilise BHFT our main acute provider of care.

We have embraced the QIPP agenda and pride ourselves in the fact that we do not own any projects that are not QIPP schemes. All of our work is either increasing quality, saving money or preventing ill health; in some cases it is also highly innovative or at the very least adopting best practice.

Our project management process has been designed to support QIPP and to ensure we take account of our commissioning cycle golden threads, including ensuring that equality and diversity factors are considered. Our project documentation is complementary with PRINCE2 methodology, which supports good governance of our projects and allows for flexibility depending on time constraints and/ or the value/ importance of the project.

With our public health colleagues, we are currently in the process of developing a robust and transparent priority setting framework that can be used in all our future planning and commissioning processes. This framework will be designed with input from our practices, the public, our patients and our partners and will draw on existing best practice.

From 2013/14 we will use this framework to assess and prioritise our service development and commissioning activities.

This next section of our Plan sets out the key areas that the CCG will be focusing on over the next 3 years. It does not attempt to include every area of commissioning activity that we are involved in and the absence of a particular service area / patient group does not mean that we are not working in that area. However, it is really important to us that we are clear about our ‘top’ priorities.

For this Plan, engagement has been high on our agenda and for the first time East Staffordshire CCG’s priorities have been clearly identified and agreed through a variety of sources.

We believe that in prioritising these areas of work, we will improve health and healthcare and reduce health inequalities in the East Staffordshire area.

Other key documents that have influenced the priorities are:

- The ESCCG QIPP Programme
- The NHS Outcomes Framework 2012/13
- The NHS Operating Framework 2012/13
- The emerging ESCCG Primary Care Development Plan
- The legacy cluster of PCTs “Integrated System Plan 2012/13”

Our priorities are also highly consistent with the proposed NHS Commissioning Outcomes Indicators for CCGs for 2013/14; these are the health outcome targets we are likely to be measured against (see Appendix 4).

We have also engaged with our patients and our partners in helping to shape these priorities through stakeholder events in July and October 2012. We will continue to do this annually to ensure that our work plans remain relevant and responsive.

Our stakeholders have told us that they want us to:

- Establish integrated ways of working
- Ensure high quality compassionate care
- Improve communications channels
- Focus on prevention
- Establish meaningful engagement
- Ensure fair funding levels
- Ensure there is a sustainable local hospital
- Improve mental health services
- Improve pathways

We have reflected this feedback in our priorities, in our commissioning cycle and our golden threads.

Our clinical commissioning priorities for 2012 – 2016 fall within 10 key work programmes which are:

1. *Improving Life Expectancy*
2. *Giving Children the Best Start*
3. *Staying Well in Later Life*
4. *Promoting Healthy Lifestyles* – with a particular focus on obesity and alcohol
5. Urgent Care
6. *Long term conditions* – with a particular focus on diabetes and stroke
7. *Mental Health*

8. Primary Care
9. Outpatient Redesign
10. System Efficiency

Those priorities shown in italics significantly overlap with the priorities of the Health and Wellbeing Board and are currently being consulted upon for inclusion in the Joint Health and Wellbeing Strategy.

Within each Programme area there may be a number of priority projects; a high level summary of each programme area is set out in this section.

Each summary plan covers:

- The key issues in that area;
- What work has been going on to date;
- The target patient group(s) e.g. men, older people, teenage girls;
- The high level objectives we are trying to achieve;
- The outcomes targets we will measure ourselves against – these will be agreed with partners over the next few months;
- Our commissioning intentions in this area for 2013 – 2014;
- How the work will contribute to our QIPP programme; and
- Who our key partners are in this area of work.

More detailed plans for each priority are currently in development; these will set out the project governance arrangements, key actions required, milestones, targets and financial information. Investments and efficiencies relating to these priorities are set out in Chapter 10 of this Plan.

The top 10 priority work streams have been shared with, and built upon, by our stakeholders at our most recent engagement event in October 2012.

All 19 of our GP practices have formally signed up to, and are working on, these priority programmes. They are working with the CCG team to commission improved services from our local providers and they are also seeking to deliver improved primary care services from their own practices.

We have also identified clinical leaders for all of our work streams (see Appendix 3) and our aim is to not only further increase the level of individual GP engagement in specific clinical projects, but to increase the level of understanding around the whole commissioning agenda.

Priority Programme 1 – Improving Life Expectancy

Key Issues

- Higher rates of mortality for circulatory disease, gastro-intestinal disease and unintentional injury.
- ESCCG has around 10 suicides per year similar to average for England (2008/10 data), however, admissions for self-harm (a predictor of suicide) in 2010/11 were the highest in Staffordshire and higher than England and west Midlands averages.
- Men live shorter lives that the England average by 14 months.
- The difference in life expectancy between the best and the worst wards is 10 years for men and 8 years for women.
- Higher rates of still birth until recently.
- In 2011/12 in South Staffordshire PCT, 4.2% coverage of eligible population for health checks compared with the best performing PCT in the West Midlands achieving 19%.

Work to Date

- A primary care delivered NHS health check programme has been in place since 2011 via a Local Enhanced Service (LES) in GP practices; this intervention aims to prevent vascular disease (heart disease, stroke, diabetes and kidney disease) by offering all adults between the ages of 40 and 74 a check to assess their risk, and give them advice and support to reduce their risk.
- Take up of the LES from practices in ESCCG is amongst the best in the county; only 3 of our practices are not currently offering the service; however, uptake by patients is very variable.
- Simplified data collection and performance management and appropriately increased the price paid per check to reflect the work required to undertake health checks.
- Public awareness campaign planned for 2012/13.

Target Groups

The populations of the 7 most deprived areas of East Staffordshire CCG i.e. Eton Park, Stapenhill, Shobnall, Winshill, Horninglow, Anglesey and Burton.

Adults between the ages of 40 and 74 and men in particular.

Objectives

- Reduce mortality rates for circulatory and gastrointestinal disease and from suicide and unintentional injury.
- Improve uptake of screening services in particular bowel screening.
- Target social marketing and positively discriminate towards patients in the 7 wards.
- Support people to get back to work.
- Promote healthy lifestyles especially in the 7 wards.
- Identify opportunities to deliver dedicated men's health services.
- Reduce the gap between actual and expected prevalence rates on primary care disease registers.

Outcomes Targets

- Reduce the life expectancy gap between the best and the worst wards.
- Reduce deaths from circulatory disease.
- Reduce deaths from gastrointestinal & liver disease.
- Reduce premature deaths (under 75) from circulatory disease.
- Reduce admissions for self-harm.
- Reduce rates of still birth.
- Improve uptake of bowel screening.
- Increase the numbers of 'fit notes' in primary care.
- Men's health services are accessible in all 7 wards.
- Increase the % patient uptake of NHS Health checks in primary care.

Commissioning Intentions 2013/14

Support practices to maximise the patient up take of NHS health checks especially for those resident in the 7 ward areas.

Target communications and social marketing to at risk groups.

Work with public health team to commission alternative services to fill any gaps in provision.

Work with a wider range of partners (employers, CAB, Housing Associations etc.) to target social marketing, health messages and promote NHS health checks.

Contribution to QIPP

Prevent early and unnecessary deaths.

Improve the ***quality*** of access to primary care health checks.

Partners for Delivery

Local employers	Job Centre Plus
Local Authorities	Screening services
Citizen's Advice Bureaux	Debt Advisory Services
Trent and Dove Housing Association	Practices
Public Health	

Priority Programme 2 – Giving Children the Best Start

Key Issues

- Fertility rates are higher than the national average and especially high in 7 wards in Burton (Anglesey, Shobnall, Burton, Eton Park, Stapenhill, Winshill and Horninglow).
- Rates of stillbirth have been higher than the national average until very recently.
- Lower access to maternity services within 13 weeks of pregnancy.
- Higher rates of smoking in pregnancy and slightly higher low birth weight babies.
- Breast feeding initiation rates are low compared with the England average.

Work to Date

- Review of attendances at Burton Hospitals' emergency pregnancy assessment unit (EPAU) for bleeding in early pregnancy. In 2011, BHFT highlighted that highlighted that 35% of patients attending the EPAU for early bleeding were not actually pregnant. The CCG has invested in practice pregnancy testing and worked with Burton Hospital to develop a new pathway for referral. A recent audit has demonstrated that this has improved referrals from general practice to the EPAU but referral to scanning time is delayed in some cases.

- Supporting the expansion of the Family Nurse Partnership with ES Borough Council and NHS Commissioning Board.

- Public Health team are developing a Midwife Support Worker project to focus on reducing Smoking in Pregnancy.

- Inpatient obstetric activity was expected to reduce as a result of reconfigured Community Midwifery workload however, this has not occurred to date.

Target Groups

Young girls / teenagers in the 4 wards of Burton, Eton Park, Heath and Stapenhill.

All pregnant mums.

Objectives

- Improve intelligence about stillbirths.
- Develop a collaborative information and awareness campaign with partners.
- Target education and advice in schools.
- Improve access to early maternity care and advice (pre 13 weeks).
- Re-establish the maternity service liaison committee
- Improve access to family planning advice and support including termination of pregnancy services.
- Improve rates of breast feeding and uptake of smoking cessation services.
- Implement the new NICE standards for ante-natal care.
- Support and influence the School Nurse review that is being led by Public Health.
- Working with the NHS Commissioning Board (NCB) ensure delivery of the health visitor “call to action” work increase numbers of health visitors.
- Increase awareness of pregnancy symptoms/care in all women, but especially young girls and older women (who may mistake menopause symptoms) through social marketing campaigns.
- Recognise the potential impact of early confirmation of pregnancy (or not) on subsequent issues e.g. infant mortality, smoking in pregnancy etc.

Outcomes Targets

- Maintain the current trajectory of reduced Teenage Pregnancy rates (2008-10 = 39.4 per 1000 / England = 38.1 per 1000)
- Improve access to early stage maternity services from 81% to 90% over the next 2 years.
- Improve breast feeding initiation rates from 47% to the England average of 74%.
- Reduce smoking in pregnancy from 16.9% (July 2009 - Sept 2011 Data) to England average of 13%.
- Reduction in interventions such as
  - C sections
  - Use of ventouse and forceps
  - Episiotomies
- Reduction in tears during delivery

Commissioning Intentions 2013/14

- Full maternity service review in 2013/14 including review of community maternity service specification; ensure that key quality markers are identified and monitored including links to primary care.
- Develop and negotiate a maternity based CQUIN to encompass all aspects of maternity including community.
- Ensure all Maternity Matters indicators are being met.
- Providers to promote the baby friendly initiative.
- Improve the availability of information about family planning, emergency contraception, and pregnancy and termination services in general practice, community pharmacy and schools.
- Review health visiting support to mum's and target services to the 7 most deprived wards.
- Providers to collect and report patient level activity data for community midwifery services.
- Implement new maternity pathway tariff from 2013/14.
- Extend the provision of targeted Stop Smoking and Pregnancy support to all Staffordshire 'hotspot areas' where prevalence rates for smoking during pregnancy are higher than the England average.
- Extend the Breast feeding Support Helpline across all of Staffordshire.
- Extend the School Nurse Administration Team Role across Staffordshire.
- Increase of capacity within EPAU to improve referral to scanning time.
- Explore the potential for vending machines for pregnancy test.
- Provide guidance on what to do with a positive pregnancy test.

Contribution to QIPP

Improve access to high ***quality*** maternity care.

Prevent teenage pregnancies.

Prevent smoking in pregnancy, low birth weight and still births.

Prevent disability at birth.

Partners for Delivery

Schools and school nurses
Family planning services
Community pharmacies
Public health team
Youth services
Burton FT maternity services
GP Practices
NCB

Priority Programme 3 - Staying Well in Later Life

Key Issues

- Predicted 75% growth in over 65s and 99% growth in over 75s between 2011 and 2035.
- 13 of the 21 wards in East Staffordshire have high proportions of older people and the older population is expected to rise; this will have an impact on all services.
- Hospital admissions from falls in the over 65's are high.
- Flu vaccination rates in the over 65's is lower than the England average.
- BHFT has relatively high rates of mortality for community acquired pneumonia (which largely affects older people).
- BHFT is currently only achieving 2 of 4 elements to the CQUIN for pressure ulcers; one indicator is unrecoverable in 12/13 as the Trust has exceeded the maximum number of hospital acquired ulcers for 2012/13 (target 7 reported 9).

Work to Date

- There has been an initial audit of fall and hip fractures admission rates by practice in the CCG. Work has also begun to look at patient level information at two practices; this will inform the development of the 'Falls Aware Strategy'.

- A CQUIN has been commissioned from Staffordshire and Stoke on Trent Partnership Trust (SSOTP), "Safety Express" which aims to maintain the focus on the prevention of falls, as well as pressure ulcers, and community acquired UTIs (urinary tract infections) in patients receiving care from the SSOTP. (This was a local precursor to the Safety Thermometer.)

- The CCG has funded a half-time Community Geriatrician who will work closely with practices, Burton hospital and community services. The CCG will also be working with the Hospital and South East & Seisdon CCG to establish a Frail Elderly Board to define models of care and to further develop the role of the Community Geriatricians by integrating with urgent care services and community teams.

- A CQUIN for pressure ulcers has been commissioned in the BHFT contract.

Target Groups

People aged over 65

Older people from BME groups

Objectives

- Develop Strategic Plan with H&WB partners for ageing well in East Staffordshire.
- Develop robust pathways and models of care for the management of frail elderly patients.
- Focus on cross-agency preventative care.
- Harness the large body of good will and voluntary expertise in the community.
- Provide integrated case management for patients at risk of hospital admission.
- Develop and deliver a 'Falls Aware' strategy.
- Improve quality of care in relation to pressure ulcers.
- Improve access to interpreting services for older people and their families from BME groups.
- Reduce social isolation through the development of community schemes.

Outcomes Targets

- Reduce the number of admissions in over 65s for falls and hip fractures to a level that is lower than south Staffordshire group of CCGs average by 2014/15.
- Improve flu vaccination rates to at least the England average for over 65s.
- All patients identified via the risk stratification tool have a case manager identified.
- Increase the number of complex geriatric assessments completed.
- Eliminate avoidable grade 3 & 4 pressure ulcers.

Commissioning Intentions 2013/14

- Agree plan for improved provider performance on Safety Thermometer indicators i.e. falls and pressure ulcers.
- Extend the requirements of the current SHA ambition to eliminate pressure ulcers by December 2012 to include improved healing rates.
- Medicines management reviews for all patients over 65 on multiple medications.
- Pharmaceutical needs assessment of all patients admitted via A&E following a fall.
- Revisit falls pathways, evaluate and re-specify the current community falls service
- Audit admissions for falls from nursing homes.
- Support work with community geriatrician and practices to manage patients with complex needs.

- Establish the Frail Elderly Board with key partners.
- Work with the Public Health team and primary care to agree a strategy for improving flu vaccination rates.
- Develop local publicity campaigns for flu vaccination.
- Integration of the Community Geriatrician with Community Intervention Team and Falls Team to ensure Complex Geriatric Assessments are completed in the community, in patients' homes and nursing homes, wherever possible.
- Review access to interpreting services.

Contribution to QIPP

Improve the ***quality*** of care for older people.

Prevent falls, flu and pressure ulcers.

Partners for Delivery

Community services including falls team, intermediate care team, district nursing and community geriatrician

Local Authority Partners	All local NHS providers.
Nursing and residential homes	Public health
Age UK	Interpreting services

Priority Programme 4 - Promoting Healthy Lifestyles

Key Issues

- 26% obesity in adults compared with 24% nationally.
- Increasing levels of obesity in children in Year 6.
- Smoking attributable hospital admissions higher than England average.
- Alcohol related admissions increasing.
- 51% of men and women are 'inactive'.

Work to Date

- During the past year the public health team and CCGs have been reviewing how we commission lifestyle services and subsequently the Lifestyle Service is being changed to focus on Adult Weight Management.

The new Adult Weight Management service will still be managed by Stoke on Trent and Staffordshire Partnership Trust and will still offer a single access point, but the new focus will be obesity and weight reduction. The Lifestyle Services previously supported people to lose weight and this was the main reason that people accessed the service. The new focus on obesity is expected to enable the service to really focus in on outcomes for clients.

- There are a range of other services that support people to make healthy choices including Stop Smoking Services; a Child Weight Management Service, and a Physical Activity Team. We will continue to review and adapt these services to meet the needs of the local population.

Target Groups

Over weight and obese adults and children
Smokers of all ages
Drinkers of all ages
Asian population in relation to dietary advice

Objectives

- Implement the Staffordshire wide obesity strategy.
- Improve healthy eating through improving cooking skills, advice to new mums, links to supermarkets, support for food planning and reducing reliance on fast food.
- Extend opportunities for lifestyle support.
- Improve smoking quit rates e.g. through working with schools and employers.
- Improve levels of physical activity
- Reduce alcohol consumption, and deaths related to alcohol (gastrointestinal disease and liver failure)
- Exploit opportunities to work with other partners in social marketing e.g. Burton Albion.

Outcomes Targets

- Quit rates at 4 weeks.
- Reduce rates of admission for smoking related causes.
- Reduce rates of admission for alcohol related causes.
- Reduce death rates for gastrointestinal disease.

Commissioning Intentions 2013/14

- Commission new community dietetic services.
- Continue to lead the H&WBB alcohol strategy work.
- Improve access to alcohol / drugs services
- Decommission the services provided by the Physical Activity team.
- Adhere to policy framework – Making Every Contact Count – ensure that all healthcare staff are trained and recommendations are implemented.
- Re-tendering of alcohol services including the alcohol liaison service in A&E to ensure early intervention and sign-posting.
- Key outcomes from the adult weigh management service pilot to be incorporated into the lifestyle service provision for Staffordshire.
- Extend the Lifestyle Service for adults to provide a service for the population of East Staffordshire.
- Child Weight Management Services to be re-modelled to address early intervention, Tier 3 and Healthy Kid 5 for the population of Staffordshire.
- Work with Burton Albion football club to promote healthy lifestyle messages.
- Target prevention of taking up smoking in young people.
- Provide 'easy access' stop smoking services e.g. in the work place.
- Establish robust monitoring of quit rates.

Contribution to QIPP

Prevent early death due to obesity, smoking and alcohol consumption.

Prevent obesity.

Prevent admissions for smoking and alcohol related causes.

Improve access to high ***quality*** weight management services.

Partners for Delivery

Local Authorities
Leisure services
Burton Albion
Primary care mental health teams
North Staffordshire Alcohol Liaison Team
Trading Standards (alcohol)
Weight management services
Public health team
All our main providers
Police (in relation to alcohol)

Priority Programme 5 – Urgent Care

Key Issues

- BHFT not achieving national A&E 4 hour target (recognised this is a 'system' issue)
- Non-elective admissions growth between 07/08 and 10/11 was 16 % for ESCCG compared with 7% nationally
- A&E attendances as % of list size are 33 % in ESCCG compared to about 20 % nationally
- Proportion of A&E admissions admitted as a % of A&E attends is 25.81% in ESCCG in 2012/13 – national rates are at least 5% lower.
- Admission rate as a proportion of list size is 6.21% compared to 6.01% nationally
- Higher rates of admission for falls, smoking and alcohol related conditions, unintentional injuries, self-harm, children with epilepsy, childhood asthma
- Admissions for ambulatory emergency care conditions i.e. conditions that could be managed in the community are high compared with national figures
- Increasing rates short stay admissions (0-2 days)
- Very short stay admissions (less than 8 hours) for under 19 year olds cost £1.5 M between April 2011 and June 2012.

The top 10 causes of admission via A&E in 2011/12 were:

Symptoms, signs and abnormal clinical and laboratory findings	1830
Injury, poisoning and certain other consequences of external causes	1644
Diseases of the respiratory system	1029
Diseases of the circulatory system	994
Diseases of the digestive system	855
Diseases of the genitourinary system	641
Diseases of the musculoskeletal system and connective tissue	277
Diseases of the nervous system	243
Infectious and parasitic diseases	200
Diseases of the skin and subcutaneous tissue	194

Work to Date

- In 2011/12 the CCG piloted an Integrated Urgent Care Centre (IUCC) and a revised service specification was implemented from 1st April 2012. The service aims to improve hospital flow, reducing the number of medical admissions and improving quality of care. A senior diagnostic GP assesses and treats patients in

A&E who have been sent for clarification of provisional diagnosis and management of potentially serious conditions. The service aims for all non-trauma patients, with a moderate likelihood of discharge, to be seen promptly by a senior decision-making clinician with a view to early discharge back into the community thereby reducing unnecessary admission to hospital.

- The IUCC is also responsible for the development of Ambulatory Emergency Care pathways that are then embedded throughout the rest of the Emergency Department; to date, the impact of these pathways has been very low.

- The CCG plans to refocus urgent care work under new programme board that will be launched in January 2013.

Target Groups

Patients with long term conditions
Frail older people
Patients with ambulatory emergency care conditions who require acute hospital care but without an overnight stay in hospital

Objectives

- Ambulatory emergency care pathways developed and in use for upper GI bleed, childhood epilepsy, childhood asthma
- Ensure that community intermediate care team have sufficient capacity for step up and step down care.
- Implement paediatric assessment unit at BHFT
- Implement integrated care teams within the community to deliver case management and provide care closer to home.
- Implement ambulatory emergency care pathways to ensure only patients who require an overnight stay in hospital are admitted.
- Improve the quality and effectiveness of patient information on admission an on discharge (to patients and professionals).
- Develop a greater range of alternatives to admission.
- Improve inter-provider understanding, awareness and signposting.
- Improve effectiveness of OOH care and communications.
- Improve systems to allow access to information about ‘live’ provider capacity.
- Improve patient information systems between providers to improve quality and efficiency.

Outcomes Targets

- Reduce the overall Non- elective (NEL) admissions rate for BHFT in line with national average.
- Reduce NEL admissions rate for patients with ambulatory emergency care conditions.
- Reduction in under 19 rates of unplanned admission for asthma, diabetes and epilepsy.
- Reduce admissions for alcohol related liver disease, smoking related conditions and self-harm.
- Reduce numbers of readmissions.
- Reduce conversion rates of A&E attendances to admissions.

Commissioning Intentions 2013/14

- Commission new Out of Hours service from April 2013.
- Integration of out of hours services with the national 111 service.
- Evaluate the outcomes achieved by the IUCC revised specification.
- Comprehensive audit of non-elective data sets.
- Commission Paediatric Assessment service at BHFT and integrated services to support with discharge including community paediatrics.
- Review effectiveness of current shared urgent care commissioning arrangements with Stafford and Cannock CCG.
- IUCC expansion to include:
  - 7 day working
  - integration with Frail Elderly model to support admissions avoidance; and
  - GP liaison for advice and rapid access diagnostics in A&E.
- Review of NEL admissions at BHFT to include GP referred admissions and all short stay spells i.e.0-2 day LOS.
- Reducing NEL across trust to national average.
- Review the pricing mechanisms in the urgent care pathway.

Contribution to QIPP

Rapid access to high ***quality*** care without the need for admission.

Prevent unnecessary hospital admission.

Productive use of NHS unplanned care resources including related commissioning resource.

Innovative use of IUCC and elderly care.

Partners for Delivery

All local NHS providers.
Local authority.
Out of hours and 111 providers.
Social care teams.

Priority Programme 6 – Long Term Conditions

Key Issues

- Higher spend and poorer outcomes for circulatory disease when compared to England and SHA averages.
- High rate of exception reporting in primary care for atrial fibrillation.
- 70.96% of CHD patients on a beta blocker compared with 73.53% nationally.
- 86.39% of COPD patients with a record of FeV1 in last 15 months compared with 88.86% nationally.
- Only 49% of estimated cases of dementia are reported (QOF).
- Only 66% of estimated cases of COPD are reported (QOF).
- High no of drug items for Parkinson's disease.
- BHFT has comparably high mortality rates for COPD.

Work to Date

There is a lot of work on-going for Long term Conditions that began as part of the national QIPP programme and much of which is applicable to all long term condition disease areas.

This includes:

- Working with partners to identify at risk patient groups using risk stratification tools and developing integrated care teams, self-care programmes and intelligence systems to support LTC management.
- Established a multi-disciplinary Long Term Conditions programme board lead by CCG Clinical Lead for LTC
- Inclusion of a CQUIN with SSOTP to produce 1000 – 1500 care plans across East Staffordshire for patients identified at risk
- Identification of diabetes, COPD, dementia as key pathways to address

There are some very specific areas of work required for in particular for stroke / TIA

and diabetes and so these are set out separately as key projects in the programme of work.

Target Groups

- All patients identified via the risk stratification tool
- Patients with respiratory disease, dementia, diabetes and CVD

Objectives

- To implement recommendations from the dementia strategy led by Cannock and Stafford CCGs.
- Implement the risk stratification tool across East Staffordshire.
- Commission integrated health and social care teams.
- Commission self-care and expert patient programmes.
- Re-commission home oxygen services

Outcomes Targets

Increase patient uptake of CVD risk assessment.

National QIPP target - reduce NEL admissions for LTCs by 20% for patients with long term conditions by March 2014 (from 2008/09 baseline levels).

Reduction in under 19 rates of unplanned admission for asthma, diabetes and epilepsy.

National QIPP target - 25% reduction in length of stay for LTCs by 2013/14 compared to 2008/09 baseline levels.

Commissioning Intentions 2013/14

- Review the pulmonary rehabilitation service
- Commission a CQUIN for CVD risk assessment
- Implement the Digital by Default recommendations (an initiative which aims to use technology to improve quality and access to care).
- Implement the recommendations from current integrated care pilots including case management and self-care.
- Providers to increase the role of tele-healthcare in the management of Long Term Conditions
- Review options for provision of exercise services for patients with Parkinson's disease

Contribution to QIPP

Commission high ***quality*** integrated care for patients with LTC.

Prevent unnecessary admissions for patients who have a LTC.

Deliver ***innovative*** LTC services through the use of Digital by Default and telecare.

Partners for Delivery

Public Health
All local NHS Providers
Telecare providers
GP Practices
National QIPP programme

Priority Project 6A – Stroke and TIA

Key Issues

- Low proportion of patients admitted directly to an acute stroke unit within 4 hours of hospital arrival; BHFT is 50 % (target is 90%)
- BHFT also below national Accelerating Stroke Improvement indicators for Joint Care Planning, Swallowing Screening within 4 hours, and % receiving anti-platelet (24hrs)
- BHFT scored below the national average on 7 of 9 indicators in the National Sentinel Stroke Clinical Audit 2010
- 91.72% of patients on appropriate medications following TIA and stroke compared with 93.72 nationally
- Burton Hospital is actively seeking support to become a hyper acute stroke unit (HASU).

Work to Date

- From April 2012 ESCCG has been working with the Shropshire & Staffordshire Heart and Stroke Network, BHFT and other local CCG's to consider and support the implementation of the new NHS Midlands & East Stroke Service Specification. ESCCG has also worked with BHFT and other Staffordshire CCG's to consider the implications of BHFTs application to become a HASU.

- Atrial fibrillation (AF) is a major risk factor for stroke. All ESCCG have been made aware of and offered support in the use of the GRASP Atrial Fibrillation

Tool kit (Guidance on Risk Assessment and Stroke Prevention for Atrial Fibrillation). The GRASP AF Tool kit is an audit tool used in primary care to aid the risk stratification and effective management of AF patients. Practices also assess stroke risk by working to the QOF AF indicators around identification of AF patients, risk stratification and management using the CHAD2 scoring tool (CHADS2 - Congestive heart failure, hypertension, Age (>75), Diabetes mellitus, prior Stroke).

Target Groups

People who have had or are at risk of having a stroke or TIA

Patients with AF

Objectives

Implementation of the NHS Midlands & East Stroke Service Specification

Ensure all relevant health professionals deliver Pulse Checks, to identify patients with AF.

Ensure there are sufficient services available so that those identified as at risk of stroke (via pulse check, health checks, etc.) can have their risk of stroke reduced.

Outcomes Targets

Improvement on agreed Accelerating Stroke Indicators to achieve national targets

Mortality within 30 days of hospital admission for stroke.

Substantially reduce patients' length of stay in stroke rehab beds at Burton Hospital.

Commissioning Intentions 2013/14

- Continue to work with stroke network as part of the NHS Midlands and East Stoke Services review to develop appropriate models of care for the East Staffordshire area
- Implement the NHS Midlands and East Stroke Service Specification.
- Review of the current early supported discharge team service specification and resourcing.

- Reduce the need for hospital based stroke rehabilitation through the commissioning of community provision for Stroke Early Supported Discharge and review the charging mechanisms for rehabilitation.

- Implement the locally agreed service specification to enable increased community-based stroke rehabilitation.

- Increase the use of the GRASP toolkit in primary care.

Contribution to QIPP

Primary and secondary ***prevention*** of stroke and TIA.

Improve ***productivity*** and ***quality*** of stroke services through early supported discharge and decrease length of stay in hospital.

Access to high ***quality*** primary care services for the management of AF.

Partners for Delivery

Burton Hospitals Foundation Trust
SSOTPT – Community Providers of Stroke Services
Shropshire & Staffordshire Heart and Stroke Network

Priority Project 6B – Diabetes

Key Issues

- Hospital admission rates for unstable blood sugars in diabetes are higher than England averages.
- High costs of insulin treatment per patient on diabetes register.
- Glucose testing strips are a high spend area.
- QOF Hba1c performance is poorer than the national average at 54%.
- Low number of spells for amputations but high costs; average length of stay for amputations is high.
- Proportion of GP admissions to emergency care is high.
- High number of patients with multiple admissions.
- Variations across primary care in prescribing, costs, admission rates and outpatient costs.

- Diabetes exception reporting in QoF is higher than national rates.
- Proportion of patients with a record of retinal screening in the last 15 months is 90.8% compared with 91.4% for Staffordshire and 91.6 % for England.

Work to Date

- Diabetes identified as a key area for review by the long term conditions programme board.
- Working in partnership with Sanofi, benchmarked primary (QOF data), Secondary Care (NEL admissions and inpatients) and prescribing data.
- Reviewed patient outcomes against costs.
- Stakeholder event arranged for November 2012 to present data and to identify agree key actions.

Target Groups

All patients with diabetes on GP registers (Type 1&Type 2 diabetes)

Patients at risk of developing diabetes

Objectives

- Agree recommendations for implementation from the Sanofi review.
- Hold a 'Diabetes Summit' to agree a strategy with partners.
- Benchmarking exercise against evidence and best practice to highlight gaps in service and inform future commissioning
- Deep dive/audit into the cause of long LOS for amputees.
- Development of integrated pathways of care between primary and secondary care.
- Supporting general practice to reduce variations in care.
- Review of local diabetes service provision/pathway.
- Implementation of a long term self-care model for patients and carers that educates & empowers individuals to manage their condition more effectively.
- Improve access to high quality structured patient education for patients, their families and carers.

Outcomes Targets

- Improve rates of people with diabetes who have received 9 care processes.

- Maintain rates of identification and diagnosis of diabetic patients.
- Reduction in the number of non-elective admissions for diabetic related conditions.
- Reduction in the average length of stay for patients admitted for amputations.
- Increased self-management and confidence of patients with diabetes through provision of patient and carer education/support at all stages across the pathway of care.
- Reduce exception reporting in QoF.

Commissioning Intentions 2013/14

- Agree targets with GP practices for diabetes management in primary care.
- Review of insulin management LES and GTT LES.
- Specify prescribing parameters in contract for specialist diabetes services.
- Commission provision of standardised Blood Glucose Testing Strips following tendering process.
- Comprehensive review of all diabetes services across providers.

Contribution to QIPP

Improve access to high ***quality*** diabetes care in primary, community and secondary care.

Reduce ***costs (productivity)*** of prescribing and testing strips.

Prevent admissions for diabetes and reduce lengths of stay.

Partners for Delivery

Staffordshire and Stoke on Trent Partnership Trust
Burton Hospital Foundation Trust
Diabetes UK
GP Practices
NHS Diabetes
Public Health

Priority Programme 7 – Mental Health

Key Issues

- Low prevalence rates for SMI on GP registers
- 83% of patients have a comprehensive care plan compared with 89% nationally
- Mortality rates for undetermined injury higher than England average
- Mental health spend relatively low
- High admission rates for self-harm

Work to Date

The Crisis Resolution and Home Treatment Team mental health service was reviewed in 2011/12 by all ESCCG GP practices. The review found that in the main, the Crisis team offers a safe and effective service however further enhancements are being made in relation to communications between referrers and the team, and improved transfers of care between mental health professionals.

Following the review, and as part of the planned bed reduction scheme, there has been enhancement of crisis resolution and home treatment services that included additional patient transport services.

The outcomes of this have been significant with savings of £1.4 million, a reduction of 24 in-patient beds, and the closure of the Margaret Stanhope facility in September 2012.

The redesign of crisis services is one of ESCCG exceptional success stories and we continue to lead on Mental Health contracting for all four CCGs within South Staffordshire.

ESCCG is currently working with partners to develop the South Staffordshire Dementia Strategy.

Target Groups

Adults with severe mental illness (SMI) especially those not currently on GP registers

Adults with dementia

Objectives

- Increase access to psychological therapies including CBT in primary care.
- Contribute to the development and delivery of the Suicide Strategy for Staffordshire with key partners, the local response to the 'Preventing suicide in England' strategy.
- Develop and commission comprehensive and responsive mental health services.
- Contribute to the development and delivery of the dementia strategy.
- Improve numbers of patients on GP registers that have a comprehensive care plan.
- Promote positive mental health and provide access to comprehensive patient information and advice via websites and other social media.
- Increase GP education in mental health.
- Improve support for carers of patients with dementia.
- Maximise the use of the voluntary sector.

Outcomes Targets

- Access to crisis services.
- Reduce inpatient episodes.
- Increase early diagnosis of dementia and rapid access to dementia assessments.
- Reduce in numbers of patients with dementia prescribed anti-psychotic medication.
- Reduce non-elective admissions, length of stay and readmissions particularly for those detained under MH Act.
- Review of CAMHS (East) to include better integration with social care and children's services.

Commissioning Intentions 2013/14

- Audit the use of drugs in dementia and prescribing of anti-hypnotics
- Benchmark practices across east Staffordshire to review access to services.
- Patient passports in use in secondary care settings for patients with dementia.
- Improve access to memory clinics
- Develop an investment plan for dementia care
- Audit of crisis and primary care mental health services
- Review CAMHS in particular tier 1 and 2.
- Work with practices to improve recording on QoF registers

- Re-tender for diagnostic and intervention services for children with ASD.
- Review of neuropsychology service.
- Review crisis management / psychiatric liaison in A&E.

Contribution to QIPP

Improved access to high ***quality*** adult and child mental health services in primary and secondary care.

Prevention of inpatient admissions.

Partners for Delivery

South Staffordshire & Shropshire MH FT
Public Health team
Local Authorities
BHFT
GP practices
Age Concern
Alzheimer's Society

Priority Programme 8 – Primary Care

Key Issues

- Low prevalence rates on disease registers for palliative care, chronic kidney disease, dementia, heart failure, hypertension, learning disabilities and obesity; potentially large numbers of patients who are unrecorded, undiagnosed and untreated for these conditions.
- Low spend on primary care services through GMS and PMS contract compared with national average.
- High levels of demand reported by practices.
- Need to demonstrate shared decision making and choice in primary care.

Work to Date

- The commissioning of Enhanced Services in primary care is transferring to CCGs from 1st April 2013. As a result, the CCG is conducting a review of all existing enhanced services in 2012/13 to inform CCG decision-making prior to this

handover. There are opportunities to refine some services whilst reviewing provision, cost and quality of services to patients. The following services will be prioritised for review in 2012/13 as they have the highest potential for increased quality or efficiency: minor surgery, minor injuries, near patient testing / shared care prescribing / anti-coagulation, drug misuse, suture removal and wound care, insulin Management and glucose tolerance testing. Where services remain the responsibility of the NCB, we will work with the Local Area Team as appropriate.

- Implemented Budget Manager in practices to support monitoring of activity against plan; practice performance will be reviewed monthly and outlying practices will be supported to meet their contractual plans.

- CCG is represented on the Local Professional Network (LPN) for Eyecare and has developed strong links with the LOC. Local Optometrists have commenced training to provide a Primary Eyecare Acute Referral Service (PEARS) that will reduce referrals to secondary care outpatients.

- QP indicators agreed for emergency admissions redesign are development of a catheter policy, development of frail elderly pathways and development of a paediatric pathway for viral illnesses.

- As part of the QOF QP work, practices have developed pathways for urology, cardiology, orthopaedics, ENT and ophthalmology, all of which aim to increase the management of patients in primary care.

The Medicines Management business plan for 2012-13 includes:

- Quality and Outcomes Framework targets to improve the treatment of acute asthma through audit and training events;
- Audit and review of prescribing initiatives against national QIPP targets including new indicators;
- Local initiatives identified through benchmarking against local and national data including maximising benefits of patent expiries and generic prescribing;
- Medicines optimisation contributing to risk stratification;
- Repatriation of Erythropoietin's to specialist care;
- Increasing Clozapine provision in Treatment Resistant Schizophrenia;
- Community based initiatives working with Provider Trust on wound care, continence, sexual health, rheumatology and diabetes.
- Reduce NSAID prescribing

Further medicines priorities for 2012-13 have been identified as part of the CCG planning process and include a review of the governance procedures regarding

prescribing decisions, shared care and individual funding requests and to ensure effective governance systems are in place for NPSA and MHRA alerts, and NICE implementation.

Target Groups

All patients who use primary care services

Objectives

- Move low level work from secondary care to primary care where appropriate.
- Improve primary care access to certain community based services e.g. dietetics, physiotherapy and CBT.
- Ensure that there is equitable access to primary care services (and sufficient capacity).
- Practices can evidence engagement and involvement with patients and the public.
- Benchmarking across member practices of healthcare needs indicators, interventions, and patient outcomes.
- Commitments to openness about data and mechanisms to enable information sharing.
- Clear approaches to peer review and discussions across member practices.
- Clear plans for commissioning of medicines management, dental services and community pharmacy.
- Clear plans for ensuring shared decision making and choice in primary care
- A primary care quality dashboard will be developed as well as an additional local enhanced service to support the additional workload in primary care as a result of newly commissioned pathways and guidance. Part of the routine monitoring of this will be a programme of practice visits.

Outcomes Targets

(to be finalised in the revised Primary Care Development Plan, currently under development)

Reductions in secondary care outpatient appointments, particularly in dermatology, ophthalmology, orthopaedics, cardiology, urology.

Improve recording in QoF registers.

Commissioning Intentions 2013/14

Further detail about plans and commissioning intentions for Primary Care will be set out in the Primary Care Development Plan.

The summary is as follows:

- Practices have expressed an interest in a community-based service for ENT in preparation for 2013/14 QP indicators.
- Commission enhanced optometric services in the community.
- Review all current Enhanced Services.
- Review access standards in primary care.
- Develop a practice quality dashboard.
- Re-introduce the practice nurse development role to ensure appropriate use of nurses and extended skills where appropriate to support increased primary care workload.
- Implement the Prostate Cancer LES for increased community provision to improve access and reduce secondary care activity.
- Use of Digital by Default in primary care

Contribution to QIPP

Improve access to high ***quality*** primary care services.

Efficient use of prescribing budgets ***(productivity).***

Maximising the ***productivity*** of QoF and LESs.

Innovative use of technology in primary care services.

Partners for Delivery

LMC, LPC, LOC and LDC	GP Practices	NCB
Community Pharmacies	Dental practices	Optometrists

Priority Programme 9 – Outpatient Redesign with BHFT

Key Issues

Current provision of outpatient services at Burton Hospital is not as efficient and effective as it might be.

Issues include:

- Too many patients in clinics.
- Insufficient time to spend on more complex consultations.
- Unnecessary referrals with significant degree of inter-regional clinical variation in referral and follow up.
- Attendances that have no clinical value.
- Physical visits to receive results which could be provided by other means.
- Referrals for expert advice that could be provided by other means.
- Referrals to meet patient expectations rather than clinical need.
- QIPP indicators demonstrate that bringing spend in line with the national average will produce significant savings.

Work to Date

From March 2012 ESCCG GPs have been working with Consultants from BHFT and Primary care providers to improve outpatient services for East Staffs patients. To date work has concentrated on Urology, Cardiology, Ophthalmology and Orthopaedics, with further work planned for ENT and Gynaecology.

Work to date has resulted in redesigned pathways for Raised PSA, Recurrent UTI, Dipstick Haematuria, Atrial Fibrillation, Paroxysmal Atrial Fibrillation and Palpitations.

Target Groups

Patients attending for specified outpatient services.

Objectives

- Patients who need a consultant opinion receive that within agreed timescales.
- Clinical support to GPs when referring for a consultant opinion.
- Clinical pathways to ensure patients only have to attend a hospital when it is clinically appropriate.

- Ensure clinical pathways are as seamless as possible.
- The local health economy will provide safe, quality and value for money clinical services.

Outcomes Targets

A reduction in inappropriate outpatient attendances.

A reduction in overall spend on Outpatient Appointments.

Commissioning Intentions 2013/14

- Continue to work with primary care providers including GP practices and Optometric practices to explore the feasibility of moving activity from secondary to primary care where clinically appropriate.
- Agree pathway refinements with BHFT and GP practices to ensure all attendances have a clinical value and are sent to the hospital with the appropriate work up.
- Support one stop shop outpatient activity and agreement of fair cost tariffs.
- Commission specific outpatient follow-up ratios pending development of jointly agreed clinical pathways.
- Review nurse-led clinics.
- Review community physiotherapy provision, reduce demand for direct access diagnostics where this has not been necessary and reduce demand on the direct access physiotherapy service at Burton Hospital.
- Develop a community-based model for GPwSI-led ENT service and move activity to this service as appropriate.
- Review Gynaecology outpatient services.
- Use of digital by default in outpatient settings where appropriate.

Contribution to QIPP

Improve access to high ***quality*** outpatient services.

Prevent unnecessary outpatient appointments (***productivity***).

Innovative use of technology in outpatient services**.**

Partners for Delivery

Burton Hospitals Foundation Trust
GP Practices
Local Optometrists / LOC
Local Professional Network for Eye care

Priority Programme 10 – System Efficiency

Key Issues

- Population increases in East Staffordshire are expected to grow at a faster rate than any other part of Staffordshire, this will have an impact on local services
- There is limited access to rapid assessment and diagnostics services
- Delayed discharges have been a problem and discharge information is not of a consistently high quality
- Post discharge support in the community following discharge has been identified as an area for improvement by local GPs
- Need to make better use of comparative benchmarking information e.g. Better Care Better Value / NHS Comparators / Right Care profiles / Programme budgeting & SPOT information

Work to Date

- The CCG has been actively involved in the Staffordshire QIPP programme particularly in relation to services at BHFT
- Review of the early supported discharge (non-stroke)
- Outpatient redesign programme with BHFT
- Participation in the bed modelling work at BHFT

Target Groups

All our providers

Objectives

- To achieve at least “better than England average” performance in nationally recognised benchmarks.

- Improve efficiency in secondary care including reducing the need for admission, reducing lengths of stay and expeditious discharge.
- Improve day case rates for certain procedures – e.g. cholecystectomy
- Support BHFT to examine the causes of delayed discharges.
- Work with CHC team to explore how processes can be improved

Outcomes Targets

Final targets to be agreed but improvements will planned for in the following areas:

- Day case rates
- Cancelled procedures
- Readmission rates
- Zero day LOS

Commissioning Intentions 2013/14

- Ensure all recording of activity is accurate e.g. for non-elective care.
- Prescribing formularies in place and adhered to in all trusts; wound care, feeds and continence products are priority areas.
- Work with BHFT to improve waiting times for x-rays and scans including reporting.
- Implement proven improvement methodologies e.g. productive ward, productive theatre.
- Improve quality of hospital discharge letters.
- Improve rapid access to secondary care advice and “hot clinics”.
- Review the local policy of procedures of limited therapeutic value.
- Maximise use of day case activity.
- Maximise use of the SSOTP Single Point of Access service in order to facilitate discharge and prevent inappropriate admissions.
- Control equipment costs across the Health Economy.
- Use of digital by default.

Contribution to QIPP Improve the ***productivity*** and efficiency of the local health system. ***Prevent*** unnecessary use (waste) of health care resources.
Partners for Delivery All local providers All commissioning partners

Chapter 6 - Other Commissioning Intentions for 2013/14

There are a range of other commissioning intentions that we have for 2013/14, that are either more generic or do not fit neatly into priority programme areas as described in Chapter 5.

It should be noted that all of our commissioning intentions are shared with providers on the understanding that the CCG has a fixed financial envelope within which to operate and therefore all of the outcomes of these commissioning intentions need to be affordable.

In addition, the Staffordshire public health team have contributed to the development of commissioning intentions for all Staffordshire CCGs; some of that input is included here and some is included in Chapter 5.

6.1 All Providers

For all Providers we have highlighted in our commissioning intentions the requirements to:

- Implement the recommendations of the Francis Inquiry when it reports;
- Comply with locally agreed prescribing formularies and NICE guidance;
- Agree to the provision and submission of key data sets and finance information for contract and performance monitoring;
- Work with all partners to support the transformation agenda and to deliver efficiencies in the wider system;
- 'Make every contact count' for the promotion of health messages and signposting to appropriate health and care services;
- Increase flexibility, innovation and personalisation in QIPP schemes;
- Identify patients suitable for palliative care pathways and ensure appropriate decision making with the involvement of patients and family;
- Ensure that any service changes are considered in the light of the effects on other partners and the wider health economy;
- Consider the use of tele-healthcare solutions in all pathway redesign;
- Address any emergent quality issues as a result of proposed service changes;
- Ensure that all services have the required service specifications detailed in contracts; and

- Have complete clarity on all activity, contracts values and costs.

6.2 Staffordshire and Stoke on Trent Partnership Trust

In our negotiations for our 2013/14 contract with our community service provider, we will be highlighting our intentions to work with them to:

- Review the community contract to ensure best value and ensure full rebasing of contract activity at specific CCG level;
- Have the provider develop a comprehensive directory of services;
- Develop and agree service specifications and eligibility criteria for drug boxes for those patients on the end of life pathway;
- Review District Nursing service specifications and ensure that all district nurses have received end of life training;
- Decommission the nursing home support service;
- Commission a single point of access for intermediate care and rapid response;
- Participate in and facilitate a review of the equipment service;
- Review community physiotherapy services;
- Review the use of enteral feeds;
- Review Allied Health Professional services for Children and Young People;
- Review stoma services and agree service pathways between acute and primary care; and
- ensure smooth and effective integration of services in all our on-going work.

6.3 Burton Hospitals Foundation Trust

In addition to the intentions outlined earlier, the CCG will also be highlighting in its commissioning intentions for 2013/14:

- the need to be fully involved in the Clinical Services Strategy of BHFT to be assured that quality of its services and financial stability are sustainable in the future;
- the requirement for BHFT to continue to work in partnership with local CCGs and major stakeholders to facilitate clinical engagement between BHFT Consultants,

GPs and other significant providers to ensure effective locally agreed clinical pathways that reflect the economic and clinical needs of the population;

- the need to share information arising from clinical trials that might have an adverse cost impact on the introduction of new drugs;
- improved pathways for end of life care to be provided;
- the intention to review the range of services provided at the community hospitals; and
- a review of the services provided and drugs delivered through "Homecare" services.

6.4 South Staffordshire & Shropshire Healthcare FT

Some of the intentions listed below are our shared intentions with the Joint Commissioning Unit who act on our behalf for some areas of commissioning.

In our negotiations for our 2013/14 contract with our mental health and learning disability service provider, we will be highlighting our intentions to work with them to:

- review mental health services in acute settings including CPN services in the community;
- improve rapid access to urgent mental health services;
- progress ‘care clustering’ as part of the PbR work;
- review CHC arrangements;
- continue to develop a single point of access for CAMHS services;
- review of services for neurological disorders and acquired brain injury;
- review assertive outreach pathways between community and tier 4 CAMHS; Retender the Sustain service (mental health support for looked after children with an attachment disorder);
- participate in and support the development of a single shared strategy for specialist Learning Disability services in Staffordshire;
- implement the Winterborne recommendations for people with learning disabilities;
- support the development and implementation of the LD strategy to get to get people to work and lead independent lives; and

- support the implementation of the recently approved Carers Strategy and Carers Breaks Plan.

6.5 Staffordshire Commissioning Support Unit (SCSU)

The Service Level Agreement for Commissioning Support for 2012/13 has now been agreed and work is continuing to agree a service specification for 2013/14.

However, the CCG will be reviewing delivery of these services over the remaining months of 2012/13 and we will be deciding which services to tender for during 2013/14. SCSU will be notified of our decisions to tender for support services as early as possible.

Chapter 7 - Communications and Engagement

7.1 Our Approach to Communications and Engagement

Communications and engagement is at the heart of the ESCCG commissioning Cycle and we are committed to improving levels of engagement throughout East Staffordshire. Our Communications and Engagement Plan sets out how we will communicate and engage with all our stakeholders including patients, carers and the public; commissioning and strategic partners; provider organisations; the voluntary sector; member GP practices and CCG staff.

The Plan is underpinned by our model of engagement, which has been designed to ensure that our our patients will not only be able to influence decision-making in an informed way, but allows for continuous feedback on how views, aspirations and experiences will make a difference. We believe that by demonstrating tangible change - '*you said, we did'*- we will secure wide, representative and continued patient interest.

7.2 Our Legal Duties

Section 242 of the NHS Act 2006 requires NHS organisations to have arrangements in place to involve users, carers and families in the planning, development, delivery and operation of services. Section 24A of the Act extends this requirement to include evidence of how this involvement and feedback has made a difference in the commissioning decisions made. The commissioning cycle adopted in East Staffordshire CCG, and described earlier in this Plan, has been designed to ensure that it engages with its community at every stage and that outcomes evidence tangible change and improvements.

In addition, the Equality Delivery System operational tool is helping us to deliver our legal duty under the Equality Act 2010. Working through the goals identified with staff, patients and partners, we will ensure that we not only deliver and act on the outcomes required, but that we fully appreciate the impact our actions have on people's lives. Our Equality and Diversity Strategy sets out how we will meet and exceed our legal duties and can be found at www.eaststaffsccg.nhs.uk

7.3 Our Aims and Objectives

The full Communications and Engagement Plan, available at www.eaststaffsccg.nhs.uk sets out our aims and objectives for each identified stakeholder group, the actions taken to date and the proposed actions going forward. We have used a locally developed Participation Pyramid as a model to define the different levels of communication and engagement that can be applied.

The Plan sets out to how we will achieve the following:

- We will demonstrate that the CCG has a good understanding of the profile of the local population including communities of interest and geography, minority and vulnerable groups;
- We will ensure that the result of engagement and insight will be reflected in the CCG decision-making process;
- We will ensure the development and implementation of organisational and service change through planned and proactive communications;
- We will foster a culture of good, two-way communications with all stakeholders;
- We will develop true partnership working with the Health &Wellbeing Board, Local Authority Public Health, and the NHS Commissioning Board;
- We will make the best use of available expertise, best-practice and commissioning support from clinical service-based networks and pharmaceutical industry partners;
- We will foster strong working relationships with the voluntary sector, making best use of expertise and existing networks, especially in the engagement of hard to reach communities;
- We will make the best use of innovative and technological developments to engage and communicate, particularly with youth communities, including the development of online engagement via social media;
- We will ensure we target communications and engagement using social marketing expertise and knowledge of the varying health needs across CCG wards;
- We will manage public expectation in relation to finite resources;
- We will ensure that CCG Member GP Practices, staff and other internal stakeholders are well informed and engaged.

We acknowledge our legal duties relating to communications and engagement according to all relevant legislation and we have outlined our approach to equality. Based on the high-level priorities contained in the East Staffordshire Delivery of Change Plan, we have described how we will work with all of our stakeholders to improve the overall health of the population we serve.

7.4 Patients, Carers and the Public

To date, we have made significant progress to ensure we engage patients and carers in all aspects of the commissioning cycle; there are a number of examples contained in the full Communications and Engagement Plan. We have also developed a local model of engagement (see Figure 10 below) which includes the creation of a Patient Board to work in partnership with the Governing Body. This Board will include representation from our existing District Group, HealthWatch, voluntary organisations and ESCCG Executives. It will be chaired by our Lay Member for Patient and Public Involvement and will have clear lines of accountability and responsibility in order to demonstrate that patients are at the heart of everything we do.

We have recently launched a membership scheme, which is open to individual residents of East Staffordshire as well as voluntary organisations and patient groups. We currently have 150 members and have set ourselves a target to recruit 1,000 members by 1st April 2013. Building on our initial target audience, we hope to extend our offer of membership to include local businesses towards the end of 2013/14.

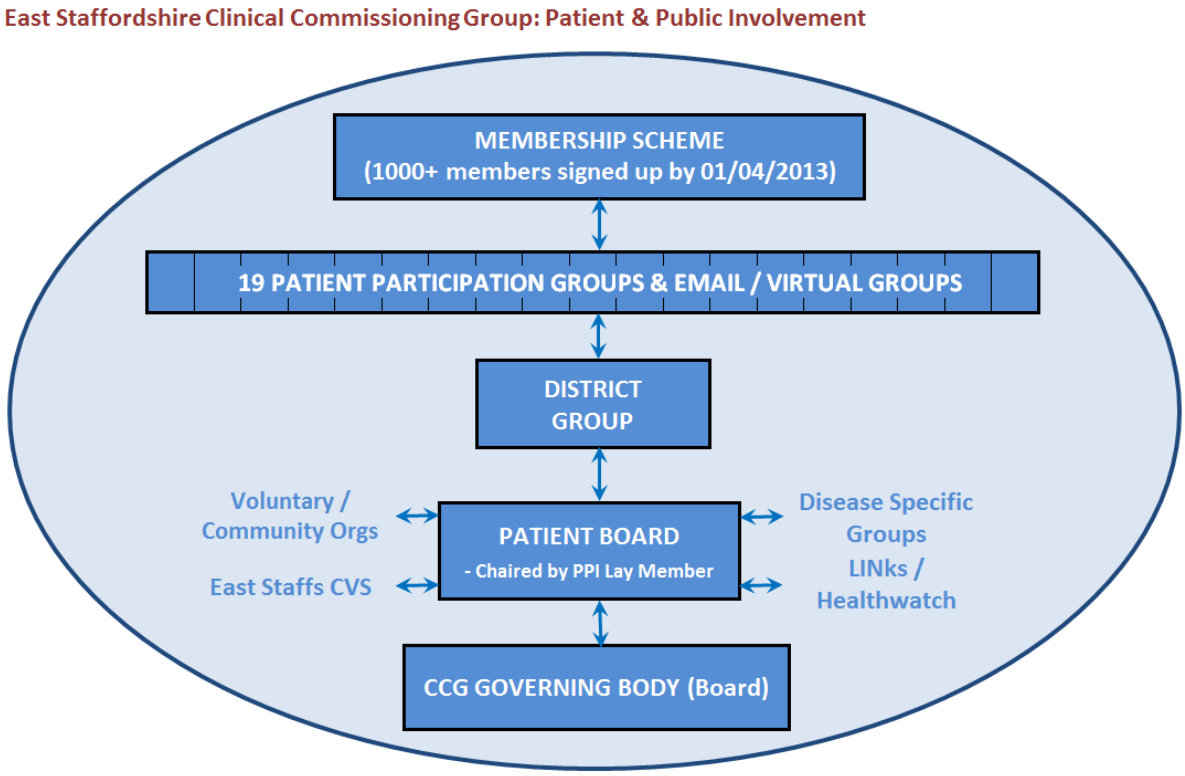


Figure 10: ESCCG Model of Patient Engagement

Working with Staffordshire Commissioning Support Unit (SCSU), we have adopted a model of involvement and insight, which provides a single repository for patient information. It will collate information from patient complaints, patient involvement work and directly from our Member GP Practices. Using monitoring dashboards, our Patient Board and Quality Committee will review patient experience information on a monthly basis and make recommendations, where necessary, to the Governing Body.

We will develop a systematic approach to promoting Shared Decision Making whereby our patients are encouraged to participate in selecting treatment and management options for their healthcare. We have agreed to use a learning event in February to debate the subject with local GPs and hospital consultants. We will then build on feedback from the event to develop a three-year strategy.

Consideration needs to be given to how we communicate with the wider public. We have developed our website and secured media relations support from SCSU. We now need to further develop tools and processes including digital and social media to ensure we have a range of quick and easy ways for members of the public to provide direct feedback. We must pay particular attention to the needs of people with the nine protected characteristics and those from hard to reach communities.

7.5 Commissioning Partners

ESCCG works alongside a number of strategic and commissioning partners including the Health & Wellbeing Board, neighbouring CCGs, the Joint Commissioning Unit, Public Health and the National Commissioning Board.

We must act as a system enabler, ensuring we work with all available partners to shape pathways of care that meet the needs of our patients rather than the individual organisations. We are participating in multiple discussions to ensure integrated commissioning becomes embedded within our local health economy.

7.6 NHS and Private Providers

We have a range of formal and informal communications and engagement activities in place with our key NHS and private providers. Going forward, we have highlighted the importance of improved communication between providers as an essential requisite to achieving integration. We have also acknowledged the potential of the private sector to contribute ideas for service improvement and will include them in our Stakeholder Event Programme in future.

We have clearly articulated our relationship with SCSU and put measures in place to manage engagement with this provider.

7.7 Independent Contractors

Our relationship with Primary Care Contractors (Dental, Pharmacy and Optometric) is explained in our C&E Plan. We already work closely with the Local Optometric and Pharmaceutical Committees but more effort could be made to understand the skills and capabilities within our local dental providers.

7.8 Third Sector Organisations

ESCCG values the strength of its relationship with East Staffordshire Communities & Voluntary Services (CVS) and the wider voluntary sector. Voluntary organisations have particular expertise and existing networks with diverse and hard to reach communities. We would like such organisations to sit on our Patient Board and many have already been invited to join our membership scheme.

We would like to ensure a level playing field for voluntary organisations who can offer services to our patients. We have committed to ensuring that procurement and tendering processes are adjusted on a scalable basis to the size of the provider and the size of the contract available whilst ensuring that we are not compromising on quality.

7.9 Our Member Practices

Our member GP Practices are the heart of our organisation. Through the Steering Group, they retain shared accountability for decision-making throughout the commissioning cycle and we ensure that all priority areas are assigned a lead GP. We ensure that our members can communicate soft intelligence into the CCG; we have a dedicated contact for all ad hoc queries and information to ensure it is directed appropriately. Building on the website, we want to further develop our electronic methods of communication and engagement to minimise the need for GPs to attend meetings in order to contribute.

We are currently engaging our Member GP Practices to create a Primary Care Development Plan. This will build on the existing agreement to share benchmarking information for the purpose of sharing best practice.

7.10 Our Staff

We know that our staff value being part of a small team and being able to engage with senior managers. Building on this, we want to ensure that using technology does not compromise or diminish opportunities for face-to-face contact, and we wish to ensure that regular dialogue between the whole CCG management team, including Executive GPs, occurs on a regular basis.

We will ensure that our staff are consulted on major decisions such as federation with other CCGs, changes to staffing structures and the overall financial position of ESCCG including delivery of QIPP.

Our duty to engage and responsibilities to equality are understood and valued by our staff. We want to build on this to ensure the Equality Delivery System is embedded in our organisational culture.

To capture all of our intentions relating to communications and engagement, we have created an Action Plan as a standalone chapter in the Communications and Engagement Plan. The Governing Body will monitor progress against this action plan and may delegate authority to the Patient Board for monitoring of key actions relating to patients, carers and the public.

Chapter 8 - Working in Partnership

The CCG works closely with its key partners and local healthcare providers to plan and commission healthcare on behalf of the population.

8.1 Commissioning Partners

In order to fulfil all of its statutory duties and improve the health outcomes for the people of east Staffordshire, ESCCG has embraced a culture of working in partnership with a range of other commissioning partners such as other CCGs, local authorities and the NHS Commissioning Board. This collaboration allows for robust commissioning arrangements which provide assurance and deliver improved value for money through economies of scale. These arrangements also ensure that the CCG is focussing on the health needs of our population and on improving health outcomes, together with ensuring integrated commissioning approaches across health and social care.

In readiness for authorisation, the CCG has been actively engaged in the Transition Steering Group which was set up to manage the transition of statutory functions and responsibilities from the local PCTs to the CCGs. We will continue to work proactively with our PCT cluster in order to ensure that there is a seamless transition of functions into the new NHS architecture.

Our key commissioning partners are East Staffordshire Borough Council, Staffordshire County Council, the other Staffordshire CCGs and the Local Area Office of the National Commissioning Board. We recognise the complexity of working in a two tier local government area and we are working closely with both of our Local Authority partners to develop our local enhanced JSNA; this will take account of local community needs and resources in a more sensitive and accurate way than previously.

We are committed to improving the excellent relationships we already have with East Staffordshire Borough Council (ESBC) and have invited two members of the local Borough Council to sit on our CCG Executive Board to enhance joint working and communications.

We have embraced the offer of becoming more involved with local health scrutiny alongside our local strategic partners. Our Public Health lead attends both the LSP (Local Strategic Partnership) Board and the CCG Board meetings as does a dedicated lead GP Executive Board member who is the board lead for partnerships with the Local Authorities.

8.1.1 Health & Wellbeing Board

The Staffordshire Health and Wellbeing Board (H&WBB) provides the countywide focus for Health and Wellbeing and brings together the County Council, CCGs, the NHS Commissioning Board Local Area Team, Police and Fire Service. There is also nominated representation from 2 of the 8 District Councils in Staffordshire.

The Health and Social Care Act (2012) places various statutory responsibilities on Health and Wellbeing Boards. Of these, the development of the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS) are the most important of the duties. Health and Wellbeing Boards should ensure these are produced jointly by all partner organisations including local authorities, clinical commissioning groups, HealthWatch and the NHS Commissioning Board.

Considerable progress has been made so far on the co-production of a Staffordshire JSNA, which has informed this Plan and the JHWS will be completed very shortly following the agreement of the emerging priorities.

During its current shadow period the Staffordshire Health and Wellbeing Board has:

- Agreed a shared vision and common strategic purpose, principles and approach
- Endorsed an updated Staffordshire Joint Strategic Needs Assessment.
- Established a set of overarching strategic themes:
  (i) Prevention and Early intervention
  (ii) Care and Support
  (iii) Safety and Protection.
- Has a set of 3 priority outcomes established by the Staffordshire Strategic Partnership:
  (i) Reduce the impact to the individual, community and society caused by alcohol misuse
  (ii) Positively support the ageing population
  (iii) Reduce crime and the fear of crime.
- Commissioned developmental support from the Kings Fund to inform the development of options for integrated commissioning and to support the development of the Board.
- Has drafted 10 priorities for health and wellbeing which are currently being consulted upon.

The existing pattern of health and social care spend is characterised by high cost institutional, hospital and residential based care services, with far less investment made in prevention, early intervention and community based services. The intention of the JHWS is to invert this pattern of spending, shifting investment from traditional high cost placements to community based services which focus on the wider determinants of health and healthy communities.

The Health and Wellbeing Board has recently sought support from District and Borough councils to produce an Enhanced Joint Strategic Needs Assessment (eJSNA). An eJSNA will give a greater local context and flavour than the current JSNA and enable a fuller understanding of “community assets” and needs. The local Health and Wellbeing Strategy will be based on the needs identified via the eJSNA process.

The key elements of local eJSNA as applies to East Staffordshire are to reflect wider determinants of health, identify community assets and to understand community perspectives. A local eJSNA could cover specific issues, like housing, leisure or focus on particular issues of concern, like poor educational attainment, stillbirth rates or alcohol.

The work completed to date suggests that the emerging priorities for the JHWS are consistent with and complementary to the priorities contained in this Plan.

They are:

Priorities for Children and Young People

Priority 1: Giving children the best start by improving health at the beginning of life
Priority 2: Vulnerable children and safeguarding
Priority 3: Improving educational attainment

Priorities for Adults and Families across the Life Course

Priority 4: Living a long and healthy life
Priority 5: Long term conditions
Priority 6: Independent living – include independence in older age

Priorities for Older People

Priority 7: Dementia
Priority 8: Preventing early death and improving quality of life

Underpinning Priorities:

Priority 9: Wider Determinants and Wellbeing
Priority 10: Narrowing the gap

ESCCG will continue to work proactively with the H&WBB to refine the priorities for the JHWS and will ensure that joint working initiatives support both Plans.

8.1.2 Local Strategic Partnership (LSP)

In the future, the LSP agenda will be managed by a single high level Public Services Board (PSB). The PSB brings together the most senior decision makers across the public service organisations in East Staffordshire with a view to improving public service delivery in a meaningful and transparent way. The PSB will identify areas for joint commissioning and efficiencies across the public sector; identify opportunities for pooling of funding and establish a platform for future working with health bodies including the Health & Well-Being Board and our CCG. The PSB acts as the responsible authorities group for Community Safety and will act as the local focus for Health and Wellbeing.

8.1.3 Community Safety Partnership

The Community Safety Partnership (CSP) in East Staffordshire sits within the Local Strategic Partnership architecture following a comprehensive restructuring of partnership working in 2011/12. Alignment with the LSP ensures that community safety issues are not managed in isolation to wider issues such as health and well-being.

8.1.4 Working with other CCGs

East Staffordshire CCG has collectively agreed with other Staffordshire CCGs who will be the lead commissioner for each contract from April 2013; this includes all acute, mental health, hospice, third sector, community and ambulance service contracts for the area.

The CCGs have also identified leads for some core CCG functions including some aspects of medicines management (including the accountable officer for controlled drugs function), individual funding requests, continuing healthcare, safeguarding for children and adults, children’s services, out of hours, patient transport services, urgent care system management and independent sector providers.

East Staffordshire CCG and South East Staffordshire and Seisdon CCG also have a shared post in the Chief Nurse; this enables us to manage our quality and quality governance arrangements in a consistent way internally and with our key providers and enables us both to have access to these specialist key leadership skills.

All of these arrangements have been formally documented in a signed 'collaboration agreement' for the CCGs in Staffordshire. In addition to this agreement, which has detailed service specifications for each lead area, there is also an agreed comprehensive schedule setting out which CCG is taking the lead for each contract when they transfer from the relevant PCTs on 1 April 2013. A headline summary of

these agreements is provided in Appendix 2.

We also have key commissioning relationships with South Derbyshire CCG and West Leicestershire CCG and have set up regular meetings with Derbyshire CCG senior managers and lead clinicians. We will further improve and develop this relationship and anticipate that we will continue to share best practice and pathway/service redesign intentions and policies.

The Derby CCGs are invited to all the contract monitoring and quality monitoring meetings that we have set up with BHFT.

We also have a close working relationship with individual GP practices that sit within the Derbyshire boundaries but who predominately use BHFT as their main acute provider.

8.1.5 NHS Commissioning Board

The NHS Commissioning Board Local Area Team (NCB LAT) is responsible for commissioning specialised services, primary care services and other more niche services such as prison healthcare.

It will be imperative for the CCG to establish good working relationships with the NCB LAT due to the connections between commissioning pathways for which we are responsible.

The arrangements for LAT commissioning are still being worked through as the teams establish themselves, however, we are confident that we will be able to develop proactive and supportive commissioning arrangements with our local team.

8.1.6 Commissioning Support Services

From 1 April 2013, East Staffordshire CCG will have a contract with Staffordshire Commissioning Support Unit (SCSU). SCSU provides a range of services to a number of CCGs. These services are best provided ‘at scale’ and it would be costly and inefficient for the CCGs to provide them for themselves. The services currently available from the SCSU include financial accounting, payroll, human resources, information technology, business intelligence, communications, contracting support and procurement services.

The SCSU, like ESCCG, is a new organisation and is going through its own authorisation process. At ‘Checkpoint 2’ in March 2012, SCSU was categorised as ‘Scenario A: proceeds with medium to low issues’.

For 2012/13, ESCCG has recently agreed a service level agreement with SCSU for a menu of services. Before the end of March 2013, we will be reviewing which services we wish to continue to buy, which we may provide for ourselves in future and which services we may look to purchase from elsewhere.

8.1.7 Public Health

The Health and Social Care bill gave Local Authorities a mandate to promote health for their population. As part of this the PCT Public Health team will move from the NHS to Staffordshire County Council by April 2013, and there is a commitment to maintain the strong local links between Public Health, the CCG and East Staffordshire Borough Council.

The CCG has negotiated a Memorandum of Understanding with the Public Health service which was agreed at the CCG's October Board meeting.

The services provided by the Public Health team will be critical to the CCG and these will include:

- population health needs analysis;
- advice on clinical effectiveness;
- health intelligence;
- support for prioritisation processes at a strategic and individual level,;
- commissioning of health promoting and screening services;
- strategic advice in health planning; and
- developing opportunities to jointly commission services between CCG and PH and other partners to improve the health of our population.

8.1.8 Joint Commissioning Unit (JCU)

The legacy PCTs in South Staffordshire currently have a section 75 arrangement in place to fund a local authority based Joint Commissioning Unit (Staffordshire County Council), which commissions across health and social care in the areas of dementia, older people and long term conditions, prevention, mental health, and learning disabilities.

These arrangements are currently being reviewed by the King's Fund; future commissioning arrangements will be determined following the review and captured in a revised service level agreement from April 2013.

Joint Commissioning Strategies have been agreed supported by implementation plans. The JCU is also responsible for procurement and quality of services and links with strategic housing.

Recent outcomes from the JCU include progressing the personalisation agenda, securing Personal Health Budgets, the learning disability NHS campus re-provision programme, the development of a third sector mentoring pilot, improvements in support for carers, and progressing the integration of health and social care.

In order to further improve collaborative working relationships we have an identified lead commissioner from the Joint Commissioning Unit who is linked to us in ESCCG and who also leads the joint commissioning of mental health services.

Our intention is to co-locate with district commissioners and we are awaiting the outcome of proposals to physically share the same building in East Staffordshire.

With all of these collaborative arrangements, East Staffordshire CCG recognises that it is important to work with other CCGs in re-negotiating service level agreements, memorandums of understanding and formal contracts, both to ensure each CCG is getting best value from these arrangements, and also to ensure that the local health system is not destabilised unnecessarily.

8.1.9 Other Commissioning Partners

We recognise that there will be other commissioning partners we need to work with and we will ensure that maintain all of the necessary links through our communications and engagement activities.

For example, clinical networks are critical partners that we will continue to work with. ESCCG is very actively involved in working with the local cardiac and stroke network but we recognise that we need to strengthen communications with other local networks such as the cancer networks.

8.2 Our Provider Partners

ESCCG has led the establishment of the East Staffordshire Health Economy Forum to oversee the strategic direction and implementation of an East Locality strategy; this will consider the future of BHFT, SSSHFT and SSOTPT and the commissioning of their services.

We have agreed to work in true partnership in an open and honest way to ensure the best outcomes for the health of the people in East Staffordshire. This Forum will also seek to ensure the safe delivery of transformational change programmes and the sustainability of the local health economy.

A brief summary about our main providers is given below.

8.2.1 Burton Hospital FT (BHFT)

BHFT is the principal provider of specialist, acute and community clinical services to the population of Burton on Trent, South Staffordshire, South Derbyshire and North West Leicestershire and have over 2,500 staff and a turnover of £170m. The Trust recently acquired the two community hospitals, Samuel Johnson in Lichfield and Sir Robert Peel in Tamworth, in addition to the acquisition of the Independent Sector Treatment Centre (ISTC) in the summer of 2011.

In 2012/13 ESCCG has a contract with BHFT for £59 million; 67% of hospital admissions from ESCCG go to Burton. ESCCG is BHFT's largest commissioner with 47% of the Trust's work coming from this CCG.

BHFT has a successful track record of delivering significant savings targets. Its efficiency requirement for the next three years is at least £17m. Delivering such significant savings without impacting upon the quality of services, or losing income, is a considerable challenge for the Trust and we recognise that we need to support the Trust with their own QIPP programme.

BHFT has recently engaged Deloitte to support a sustainability review; this will involve looking at all the services that are currently provided by the Trust and options for the future.

We have recently been working in partnership with South East Staffs & Seisdon CCG, BHFT, the Cluster and the Strategic Health Authority to undertake a comprehensive bed modelling review with the Trust to agree a vision and strategic plan for the future of in-patient services in the local health economy for 2016/17.

The work undertaken as part of the bed modelling demonstrates that whilst savings can continue to be made, the overall contract value for Burton Trust is unlikely to reduce due to increasing demographic growth combined with an ageing population. In addition to the normal QIPP savings schemes, significant transitional changes in the way services are delivered across the local health economy need to be considered.

Other areas of service and policy development that will have an impact on BHFT are reconfigurations of services for hyper acute stroke and major trauma and the closure of the A&E department at Mid Staffordshire Hospital.

8.2.2 Royal Derby Hospitals FT

The Royal Derby Hospitals Trust is also a significant provider of acute and specialist services for the CCG. ESCCG currently has a contract with the Trust for £11 million in 2012/13.

This Trust is also financially challenged and is also going through a sustainability review.

8.2.3 Staffordshire and Stoke on Trent Partnership Trust (SSOTPT)

The Transforming Community Services programme has resulted in the separation of provider services from all commissioning PCTs.

In Staffordshire and Stoke on Trent, the provider services of three PCTs came together to form a new NHS community Trust (SSOTPT), on 1 September 2011. In August 2012, the Trust acquired adult Social Care services from Staffordshire County Council.

The ESCCG contract with SSOTPT is worth £9.5 million in 2012/13.

The Trust provides a range of health and social care services and is one of the largest healthcare organisations in England with a turnover of £350 million and over 6000 employees. SSOTPT will be expected to meet the 4% CIP savings target.

The Trust runs five community hospitals in the northern part of the county. They are pursuing an integrated model of care across community health and adult social care in Staffordshire and they have recently applied for FT status.

This new configuration of services is providing both benefits and challenges to the CCG and the local population. The main benefit should be a truly integrated workforce following the implementation of the Trust's transformation agenda. The integration of social care with health will also provide further opportunities for rationalisation not only in the delivery of clinical services but also streamlining of back office functions.

The main challenges for ESCCG in relation to this provider are related to having access to accurate information about service delivery and outcomes to inform commissioning decisions. As noted in chapter 6 above, there are a range of service

reviews planned in this year and the coming year to start to look at those service areas requiring some scrutiny.

8.2.4 South Staffordshire and Shropshire Healthcare FT (SSSHFT)

SSSHFT is the main provider of mental health and learning disability services to the CCG. The ESCCG contract with the Trust for 2012/13 is worth £11.6 million.

The Trust has recently completed a Long Term Financial Model (LTFM) as part of the Full Business Case (FBC) in relation to the 'Modernisation of Mental Health services within Shropshire', which shows a forecast reduction in its current financial risk rating from a 4 to a 3. The Trust is forecast to experience reductions in income levels (9% by 2015/16), surplus margins, and return on assets and a weakening of current liquidity ratios in future years; despite this the overall planned financial position remains sustainable.

The Trust's LTFM shows that in order to deliver its financial targets in the future it is required to deliver both an annual cost improvement target of around 5% of its income base (approximately £8 million per year), along with shedding the costs associated with existing PCT commissioner disinvestment plans (approximately £5 million).

This is at the same time as the delivery of a £45 million capital development programme over a three year period, where the increase in revenue investment is to be partly offset by the redesign of existing services (approximately £6.3 million).

ESCCG continues to lead on this contract on behalf of all South Staffordshire CCGs and will continue to work in partnership with the JCU and SCSU to minimise risks associated with the movement to "care cluster pathways" and PbR.

We will also provide maximum clinical input to the commissioning of care cluster pathways to ensure that patient pathways are improved.

8.2.5 Other Provider Partners

We recognise that there are a range of other provider partners that we need to work with including third sector partners such as Housing Associations and Citizens' Advice services, and private sector partners such as private direct care providers and the pharmaceutical industry.

We also need to make the appropriate linkages with the other new organisations that are developing in the NHS family such as Clinical Senates, Health Science Networks and Local Education and Training Boards.

As described earlier, further details about how we intend to work with these organisations is provided in our Communications and Engagement Plan.

Chapter 9 - Resources

In order to deliver the priorities in this Plan, the CCG needs to have the appropriate resources in terms of budget, workforce and infrastructure.

9.1 Finance – Medium Term Financial Plan 2012/13 – 2015/2016

ESCCG is actively managing around 74% of the commissioning budget under delegated authority from the PCT Cluster and led the 2012/13 commissioning and contracting round with our local providers.

There are significant QIPP and financial challenges across South Staffordshire and our CCG has a share of this as described earlier. Using the national allocations funding formula, ESCCG is also lower funded per head of population than other CCGs in the Staffordshire area; this equates to a potential shortfall of £2.1 million per year based on the fair shares toolkit formula.

The PCT has planned to make a small surplus of surplus of £0.75M in 12/13 and made a surplus of £0.35M in 11/12. ESCCG was only required to break even in 2011/12 however, we did make a small surplus of £21,000; for 2012/13 we are forecasting a year end surplus of £0.9 million.

The CCG has had access to a Strategic Change Reserve (SCR) of £2 million. This funding is for pump priming investment in new projects and services that will realise recurrent efficiencies within 12 months. This year the SCR has been used to offset the costs of the BHFT contract over performing but this cannot be allowed to continue if the CCG is to make progress with its long term QIPP programme.

9.1.1 Budget for 2012/13

The 2012/13 Financial Plan for the CCG ensures delivery of the requirements laid out in the 2012/13 Operating Framework and the continued delivery of the QIPP agenda.

The CCG has a balanced financial plan for 2012/13, which was formally approved at the start of the year. The CCG’s devolved budget for 2012/13 is £149 million, which is the CCG’s share of the £723 million devolved from the Staffordshire PCT Cluster; this is equivalent to 72% of the total PCT Resource Limit.

The budget for 2012/13 has been reduced from that in 2011/12; this is due to the 2012/13 CCG budgets reflecting the anticipated transfer of responsibility for a number of commissioning areas to Public Health (£38m, equating to 4% of the overall PCT budget) in 2013/14, and therefore have been excluded.

Table 7: ESCCG Financial Plan for 2012/13

Table 7: ESCCG Financial Plan 2012/13	Annual Budget £,000
Based on Month 6 Position	
Total Income Available	**145,196**
Expenditure/Reserves	
Acute Contracts	84,387
Mental Health	12,174
Community Services	9,733
Other Commissioned Services	16,505
Total Healthcare	**122,799**
Prescribing	20,708
HQ Recharges	1,504
Contingency Reserve	916
QIPP/Other	- 731
Total Expenditure	**145,196**
Total Surplus/(Deficit)	-

During this year of transition, management of financial risk is crucial to ensure the successful delivery into the reformed landscape. The CCG has carried out a risk assessment of its 2012/13 budgets and there are a number of risks which will need to be actively managed and addressed during the year (see table 8 below). The majority of these risks are likely to remain a risk in 2013/14.

Table 8: Current Financial Risks

2012/13 Risk Assessment	East Staffordshire Clinical Commissioning Group	
Risk	**Mitigating Actions**	**Level of Risk**
Delivery of QIPP financial savings	➢ Monthly monitoring of QIPP plans and returns to Cluster ➢ Confirm and Challenge process with Cluster ➢ Agenda item on CCG QIPP, Finance and Performance Committee ➢ Identification of additional QIPP schemes to create headroom	Medium
Managing acute trust activity within agreed contract values	➢ Contract modelled on month 10 forecast outturn for 2011/12 with agreed adjustments for QIPP, 18 Weeks etc. ➢ BHFT SCR first call on over performance risk. ➢ CCG regular monitoring of contract performance. ➢ Apply contract terms in full (18 wks, fines,penalties, CQUINS) ➢ Sharing with CCG practices information /benchmarking. Follow up where appropriate using Practice Integration role. ➢ Click view being rolled out for practices to deep dive into data where required ➢ Contigency reserve in place	Medium
In year costs increasing costs and volumes of activity relating to Continuing Care	➢ Reporting to CCG QIPP, Finance and Performance Committee. ➢ SLA in place with Host organsiation to support active management/review/escalation. ➢ Additional funding reflected within 2012/3 budget ➢ Risk sharing with Local Health economy CCGs.	High
Prescribing Budgets Overspend	➢ Medicines Management Team supporting practices in achievement of QIPP and management of practice budgets. ➢ Benchmarking data/reports shared ➢ Budgets monitoring at practice level and information reviewed at CCG QIPP, Finance and Performance Committee, including the delivery of QIPP schemes at practice level. ➢ Budgets uplifted and Nice Reserve ➢ Review/Monitoring of any Acute impact on Primary prescribing.	Medium

We have mapped our financial projections for the next 4 years and these are set out in Table 9 below. These projections will be refined over the coming months as CCGs allocations are notified later in 2012.

Table 9: 4 Year Financial Forecast

Appendix

East Staffordshire Clinical Commissioning Group

	Base case				Upside				Downside			
	2013/14 £'000	2014/15 £'000	2015/16 £'000	2016/17 £'000	2013/14 £'000	2014/15 £'000	2015/16 £'000	2016/17 £'000	2013/14 £'000	2014/15 £'000	2015/16 £'000	2016/17 £'000
Opening Recurrent Resource	146,808	150,478	154,240	158,096	146,808	150,845	154,993	159,255	146,808	149,744	152,739	155,794
Resource Growth	3,670	3,762	3,856	3,952	4,037	4,148	4,262	4,380	2,936	2,995	3,055	3,116
Repayment of Prior Year Surplus	157	500	500	500	157	500	500	500	157	500	500	500
Other Resources	1,363	1,363	1,363	1,363	1,363	1,363	1,363	1,363	1,363	1,363	1,363	1,363
Resources available	**151,998**	**156,103**	**159,959**	**163,911**	**152,365**	**156,855**	**161,118**	**165,497**	**151,264**	**154,601**	**157,656**	**160,772**
Recurrent Baseline	146,044	149,239	152,518	156,297	146,044	148,824	153,255	157,433	146,044	148,505	151,047	154,041
Resource Protected for non recurrent spend	2,259	3,085	3,162	3,241	3,041	3,100	3,185	3,273	2,259	3,055	3,116	3,178
Inflation/Efficiency	- 33	- 33	- 34	- 35	- 968	- 980	- 1,015	- 1,043	902	906	932	951
QIPP	- 1,971	- 819	- 149	- 22	- 1,451				- 3,640	- 2,465	- 1,863	- 1,782
Investments	1,295	1,229	1,011	941	1,295	1,229	1,011	941	1,295	1,229	1,011	941
Demand Growth	1,361	1,374	1,420	1,455	1,361	1,377	1,427	1,466	1,361	1,367	1,406	1,434
Pass through payments	1,415	1,415	1,415	1,415	1,415	1,415	1,415	1,415	1,415	1,415	1,415	1,415
Increase in Contingency, Surplus etc.	1,128	113	116	119	1,128	124	128	131	1,128	90	92	93
Strategic Support	-	-	-	-	-	-	-	-	-	-	-	-
Additional Resources Available for Investment	-	-	-	-		1,265	1,212	1,381				
Total spend	**151,498**	**155,603**	**159,459**	**163,411**	**151,865**	**156,355**	**160,618**	**164,997**	**150,764**	**154,102**	**157,157**	**160,272**
Surplus/(Deficit)	**500**	**500**	**500**	**500**	**500**	**500**	**500**	**500**	**500**	**500**	**500**	**500**

9.1.2 QIPP for 2013/14

We intend to make QIPP savings of £1.9 million in 2013/14. The content of the QIPP programme for 2013/14 is reflective of the CCG's 2010/11 spend and outcome factsheet, which demonstrates in the main the CCG has no areas where it is a major outlier on spend or outcome. Those areas identified as being marginal high spend and / or worse outcome, are areas that have been reflected within the CCGs commissioning priorities and associated QIPP schemes.

Prescribing trends also show the CCG as being below both the West Midlands Average and England. The CCG continues to identify QIPP programmes to support funding for demographic growth and investment in community services to support admission avoidance where appropriate. The QIPP values we have identified reflect the level of challenge which will need to be delivered through ESCCG commissioning programmes.

The financial impact of the QIPP challenge will be saved through a range of actions which will fall into two types; those that are activity based and therefore will affect the business of NHS Providers and those others such as reducing prescribing costs, and maximising efficiencies within corporate expenditure.

Table 10 below sets out our high level QIPP programme from 2012 to 2016.

Table 10: QIPP Programme 2012 - 2016

Commissioning Priority Area/ QIPP Schemes	QIPP/Transactional	2012/13 £,000	2013/14 £,000	2014/15 £,000	2015/16 £,000	2016/17 £,000	ESCCG Potential Savings 2013/14-2015/16 £,000	% value incorporated in plan
System Efficiencies								
Mental Health (FYE 13/14)	QIPP /Transactional	176	77	-	-	-	-	-
HUB	Transactional	50	50	-	-	-	-	-
Bed Closures FYE	Transactional	835	-	-	-	-	-	-
Bed Closures	QIPP	660	-	-	-	-	-	-
Procedures of limited value	QIPP	-	142	142	-	-	475	60%
Cancelled procedures	QIPP	-	10	10	10	-	52	60%
Zero Length of Stay - Children	QIPP	-	34	23	11	-	114	60%
Day Surgery	QIPP	-	19	13	6	-	65	60%
Nursing Home Project	Transactional	-	126	-	-	-	-	-
Wolverhampton Trsf*	Transactional		420			-	-	-
Loan Equipment Tender	Transactional		40					
Fines & Penalties	Transactional		50					
Unbundling Cardiology Trsf	Transactional	-	TBC	-	-	-	-	-
System Efficiencies Sub Total		1,721	968	188	27	-	706	60%
Staying Well in Later Life/LTC								
Home Oxygen Review	QIPP	46	-	-	-	-		
End of Life - No procedure/Trauma	QIPP	-	30	30	30	-	119	75%
Frail Elderly	QIPP	-	73	49	12	-	244	55%
Falls Service	QIPP	-	123	123	123	-	493	75%
Staying Well in Later Life/LTC Sub Total		46	226	202	165	-	856	69%
Promoting Healthy Life Styles								
GUM/Lifestyle/Chlamydia	Transactional	167	-	-	-	-		
Alcohol	QIPP	-	-	43	87	-	434	30%
Obesity	QIPP	-	-	29	58	-	290	30%
Smoking	QIPP	-	-	7	13	-	67	30%
Promoting Healthy Life Styles Sub Total		167	-	79	158	-	791	30%
Urgent Care								
Integrated urgent Care (IUCC)	QIPP	21	-	-	-	-		
Urgent Care Sub Total		21	-	-	-	-		
Outpatient Redesign								
Outpatient Redesign-Urology/Opthalmology/Cardiology	QIPP	445	-	-	-	-		
Rhuematology Redesign FYE	Transactional	194	-	-	-	-		
Outpatient Redesign- Gynae/Ortho - Shoulder/ENT/Cardiology	QIPP	-	50	-	-	-		
Outpatient Redesign Sub Total		639	50	-	-			
Primary Care/Medicines Management								
Waste Reduction 5% p.a	QIPP	-	50	50	50	-		
Scriptswitch/ Pharmacy interventions	QIPP	235	100	75	50	-		
Diabetes - Tender	QIPP	-	85	-	-	-		
Primary Care/Medicines Sub Total		235	235	125	100	-		
Balance to be Identified - Excluding Headroom		-	492	225	- 301	22		
Total QIPP		2,829	1,971	819	149	22		
Value of CCG Contingency Held		1,520	1,561	1,599	1,639			

* subject to IATA if no change to list size period used as basis of allocation for 2013/14 allocations in agreement with Wolverhampton PCT.
If change to period used for basis of list size regarding allocation first call on growth funding.

We also recognise that in order to achieve the commissioning objectives and outcomes we have set ourselves in Chapter 5, we will need to make some investments.

Our investment plan is set out in Table 11 below.

Table 11: Investments 2012- 2016

Commissioning Priority Area/ Investments	2013/14	2014/15	2015/16	2016/17
	£,000	£,000	£,000	£,000
Staying Well in Later Life/LTC				
Home Oxygen Review	5	-	-	-
Community Dietician	46	-	-	-
Falls Service Admin/Physio	26	-	-	-
Stoke/TIA	76	183	-	-
Risk Stratification	14			
Staying Well in Later Life /LTC Sub Total	167	183	-	-
Mental Health				
Dementia Strategy	35	105	70	
Mental health	35	105	70	-
Primary Care/Medicines Management				
Scriptswitch	50	-	-	-
Priamry Care/Medicines Management Sub Total	50	-	-	-
Other Pressure Areas- Excl Demand Growth				
Continuing care/NHS111/FET/NICE	1,043	941	941	941
Total Investments	**1,295**	**1,229**	**1,011**	**941**

9.2 Workforce

The CCG has a small management team to support the core work in this plan. In addition, the CCG team has a range of other staff and expertise it can draw from such as the Local Authority Public Health team and Joint Commissioning Unit, the Staffordshire Commissioning Support Unit, the National Commissioning Board Local Area Team and many others.

A staff structure for the directly employed team is shown in Appendix 5.

In addition, ESCCG shares a contract management team with South East Staffordshire and Seisdon CCG as we have the same core providers; this adds real value to the commissioning team and allows us to build shared contracting expertise.

The CCG has developed a comprehensive organisational development (OD) plan to support the growth and development of the CCG and the staff who work with us. This plan can be found at www.eaststaffsccg.nhs.uk

9.3 Commissioning & Business Intelligence

The delivery of commissioning intelligence to the CCG is under pinned by a number of relationships with the CCG, in particular Staffordshire Commissioning Support Unit (SCSU), Public Health and our commissioning collaborative partners. These relationships are formalised via Service Level agreements which highlights the expectations on each party to support this process. Responsibility for the overview of the various SLA's is undertaken by the Chief Finance Officer and performance and governance arrangements are included within the Terms of Reference of the QIPP, Finance and Performance Committee. In addition to the Service Level Agreement, the CCG is also continuing with subscription membership to a number of recognised bodies that support delivery of commissioning intelligence either via SCSU or directly to the CCG i.e. Keele University with regard to prescribing data.

The CCG is currently working with the SCSU with regard to production of action plans for full implementation of a suite of business intelligence reports both from an activity and financial perspective. This will be accessible to the CCG management team and all CCG member practices and will offer full "drill down" capability to provide detailed information at the right level. The plan is to ensure these processes are fully embedded by March 2013, earlier where possible.

An element of the SCSU charge of £10.88 per head of population includes increased investment for the IM&T requirements of business intelligence systems data. Within the CCG structure there is a Practice Integration Manager role identified to support practice understanding and engagement in interpreting the data provided and to facilitate changes in behaviour where appropriate.

Where change is required on a large scale, implementation of projects is undertaken using Prince 2 methodology, under pinned by robust data supporting the project initiation documentation, and including triangulation of data.

Information governance arrangements are aligned to the CCG's IG Toolkit compliance and covered by Data Protection agreements within the body of the SLA's agreed. Quality assurance on the data requirements are performed by the SCSU both through the employment of Data Quality roles and HCCS for secondary care data, in addition validation by National Audit Commission regarding PbR audit reviews, and providers own IG toolkit submissions.

9.4 Information Technology (IT) and Information Systems

The CCG needs an appropriate level of information technology infrastructure in order to operate effectively. We will be buying IT support for both the CCG and ES practices via the SCSU service level agreement.

One of the key ICT challenges for the CCG is the number of primary care IT systems currently in use in the patch which creates a level of complexity in data analysis and information sharing.

The CCG will be working with the CSU to agree a range of improvements to GP IM&T systems in the near future and these will be reflected in the primary care development plan.

9.5 Estate

At this stage, the CCG Headquarters are likely to remain at Edwin House in Burton-upon-Trent.

The CCG has negotiated a cost effective lease on the building and the landlord has committed to a range of improvements. The lease will be kept under review as part of the budget planning process to ensure that these arrangements remain value for money.

Chapter 10 - Future Risks and Challenges

All of the key risks and challenges set out in this Plan are not dissimilar from those faced by other CCGs in the country.

These largely centre around the changing demographic profile of the population which will increase demand for services and the pressure on NHS finances. It is therefore imperative that the CCG has robust QIPP plans in place in order to drive efficiency and reduce the burden of long term disease; only by doing this will the CCG release sufficient funding to deliver new and improved services.

The CCG has recognised its key role in galvanising the health economy to deliver sustainable QIPP plans for the whole health system; this is why we have established the Health Economy Forum with the most senior leaders.

At an organisational level the main risks and challenges to the organisation are provided in detail in the Board Assurance Framework which sets out the key corporate risks and the actions the CCG is taking to manage those risks.

The CCGs risk management process is detailed in the Integrated Governance Framework which can be found at www.eaststaffsccg.nhs.uk

Thank you for reading our Plan - please give us your feedback….

This is our first strategic plan as a new CCG.

We would welcome any comments or suggestions you have for us to improve it.

We want to make sure it is relevant, accessible and understandable for all our stakeholders.

Further information and useful links are detailed in Appendix 1.

To contact us please go to our website and use the contact form at

www.eaststaffsccg.nhs.uk

Or call us on 01283 507100.

If you would like to get involved in the work of the CCG or you think you have something to contribute in a particular health area, please join our membership scheme.

Details are provided on our website.

Most of our practices have patient participation groups; contact your own practice for further information or contact vanessa.day@northstaffs.nhs.uk for further details.

Appendices

Appendix 1	Further information and useful links
Appendix 2	Summary of South Staffordshire CCG's Collaborative Commissioning Arrangements
Appendix 3	ESCCG Clinical Leadership
Appendix 4	Proposed Commissioning Outcomes Framework Indicators 2013/14
Appendix 5	ESCCG Staff Structure Chart

Appendix 1 Further Information and Useful Links

You can find lots more information about ESCCG and all the work we are doing on our website www.eststaffsccg.nhs.uk including many of the documents referred to in this Plan, such as:

The ESCCG Constitution – this sets out the governance arrangements between ESCCG and the 19 member practices.

Integrated Governance Framework – this sets out how the CCG manages all aspects of governance and the rules and framework that we operate within

Collaborative Commissioning Agreements – these agreements set out the relative roles and responsibilities of ESCCG and the other CCGs that commission on our behalf.

Case studies – these are the case studies that we submitted as our evidence for authorisation. They provide further detail about specific projects in commissioning in urgent care, mental health and alcohol services over the last 12-18 months.

Communications and Engagement Plan – this plan sets out how ESCCG will communicate and engage with the public, patients, practices and all our other stakeholders.

Health and Wellbeing Strategy (HWBS) – this is the strategy that is being developed by health, the Local Authority, and other key partners that sets out the shared public sector priorities for addressing the needs identified in the JSNA.

Organisational Development Plan – this is the Plan that the CCG has for its own development so that it can become a really effective organisation.

Joint Strategic Needs Assessment (JSNA) – this is a document complied by the local NHS and Local Authorities that sets out the needs of the local population. This plan is wider than health and covers other areas such as housing, employment and other social needs.
http://www.staffordshireobservatory.org.uk/IAS/jsna/2012

Other Useful Websites:

Burton Hospitals Foundation Trust (our main acute care provider)
www.burtonhospitals.nhs.uk

Staffordshire & Stoke on Trent Partnership Trust (our main community services provider)
www.stafforshireandstokeontrent.nhs.uk

South Staffordshire and Shropshire Healthcare Foundation Trust (our main mental health services provider)
www.southstaffsandshropshealthcareft.nhs.uk

Derby Hospitals Foundation Trust
www.derbyhospitals.nhs.uk

Staffordshire County Council
www.staffordshire.gov.uk

East Staffordshire Borough Council
www.eaststaffsbc.gov.uk

Appendix 2 Summary of South Staffordshire CCG Collaborative Commissioning Arrangements

Main provider contracts	**CCG lead**
South Staffordshire and Shropshire Healthcare	East Staffordshire CCG
Burton Hospital Foundation Trust	East Staffordshire CCG
Mid Staffordshire Foundation Trust	Stafford and Surrounds CCG
Staffordshire and Stoke on Trent Partnership Trust	Cannock Chase CCG
Independent sector	CCG with most activity per private provider to hold the contract.
West Midlands Ambulance Service	Options currently being discussed with ambulance service. Will be CCG link person for East, West and Stoke on Trent and North Staffordshire.
Commissioning Support Service	Each CCG will hold their own SLA.
Public Health SLA	Each CCG will hold their own SLA.
Voluntary sector	Each CCG will hold their own contracts.
Internal CCG collaboration	
Hospices	Cannock Chase CCG
Individual Funding Requests	South East Staffordshire and Seisdon CCG
Continuing healthcare	Stafford and Surrounds CCG
Medicines management	South East Staffordshire and Seisdon CCG

Safeguarding	South East Staffordshire and Seisdon CCG
Children and Young people	South East Staffordshire and Seisdon CCG
Urgent care	Stafford and Surrounds CCG
Out of Hours	Stafford and Surrounds CCG
Patient Transport Services	South East Staffordshire and Seisdon CCG
JCU CCG links	
Older people	To be agreed
Children and Young people	South East Staffordshire and Seisdon CCG
Dementia	Stafford and Surrounds CCG
Learning Disabilities	Cannock Chase CCG
Mental Health	East Staffordshire CCG
Others	
Networks	Stoke on Trent CCG
Estates	Propco
Research Networks	To be agreed.

Appendix 3 ESCCG Clinical Leadership

Service/Priority area	Clinical / GP Leader
Cardiology	John Tansey
CAMHS	John Cleary
Community Services	Michele Fildes
Dementia	Howard Skinner / John Cleary
Dermatology	Liz Gunn
Diabetes	Judith Crosse
Drugs / Alcohol / Healthy Lifestyles	John Tansey
End of Life	Liz Waddy
Falls	Wai Lim
GP Education	Cathy Faarup
Home Oxygen	Liz Gunn
IFR & Prioritisation	Rachel Gallyot
Life Expectancy / Health Inequalities	Charles Pidsley
Long-term Conditions	Chris Gunstone / Lesley Needham (PM)
Medicines Management	Judith Crosse
Mental Health	John Cleary / John Tansey
Neurology	Dr J Devikanand (Anand)
Ophthalmology	Liz Gunn
Orthopaedics	Liz Gunn / Wai Lim
Outpatient redesign	Liz Gunn
Paediatrics / Children's services	Katie Mitchell
Parkinson's	Wai Lim
Physiotherapy	Liz Gunn
Primary Care Development	Cathy Faarup / Charles Pidsley
Sleep Apnoea	Liz Gunn
Urgent Care	Chris Gunstone / Wai Lim
Urology	Jeremy Lockwood

Appendix 4 Proposed Commissioning Outcomes Framework Indicators 2013/14

The NHS Commissioning Board, supported by NICE and working with professional and patient groups, will develop a Commissioning Outcomes Framework (COF) that measures the health outcomes and quality of care (including patient reported outcome measures and patient experience) achieved by clinical commissioning groups.

The COF will allow the NHS Commissioning Board to identify the contribution of clinical commissioning groups to achieving the priorities for health improvement in the NHS Outcomes Framework, while also being accountable to patients and local communities. It will also enable the commissioning groups to benchmark their performance and identify priorities for improvement.

More information is available at http://www.nice.org.uk/aboutnice/cof/cof.jsp

All of the commissioning outcomes in the framework will be covered by ESCCG's commissioning intentions.

The outcomes in the Framework are as follows:

Cardiovascular

- Under 75 mortality rate from cardiovascular disease
- Mortality within 30 days of hospital admission for stroke
- People with stroke who are discharged from hospital with a joint health and social care plan
- People who have received psychological support for mood behaviour and cognitive disturbance by 6 months after stroke
- People with stroke who are reviewed 6 months after leaving hospital
- People with stroke who are supported to leave hospital by a skilled stroke early supported discharge team
- People who have had an acute stroke who receive thrombolysis
- People who have had a stroke who are admitted to an acute stroke unit within 4 hours of arrival at hospital
- People who have had an acute stroke whose swallowing is screened by a specially trained healthcare professional within 4 hours of admission to hospital

Gastrointestinal

- Emergency admissions for alcohol related liver disease

Respiratory

- Under 75 mortality rate from respiratory disease

- People with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 referred to a pulmonary rehabilitation programme
- Emergency admissions for children with lower respiratory tract infections
- Emergency re-admissions: COPD

Mental Health

- People with dementia prescribed anti-psychotic medication
- People with severe mental illness who have received a list of physical checks
- People on Care Programme Approach (CPA) followed-up within 7 days of discharge from psychiatric inpatient stay
- Recovery following talking therapies for people of all ages
- Recovery following talking therapies for people older than 65
- Access to community mental health services by people from black and minority ethnic groups
- Access to psychological therapies services by people from black and minority ethnic groups

Endocrine, Nutritional and Metabolic

- Myocardial infarction, stroke and stage 5 chronic kidney disease in people with diabetes
- People with diabetes who have received nine care processes
- People with diabetes diagnosed less than a year who are referred to structured education
- People with diabetes who have an emergency admission for diabetic ketoacidosis
- Complications associated with diabetes
- Lower limb amputation in people with diabetes

Maternity and Reproductive Health

- Antenatal assessments <13 weeks
- Maternal smoking in pregnancy
- Maternal smoking at delivery
- Breast feeding initiation
- Breast feeding prevalence at 6-8 weeks

Cancers and Tumours

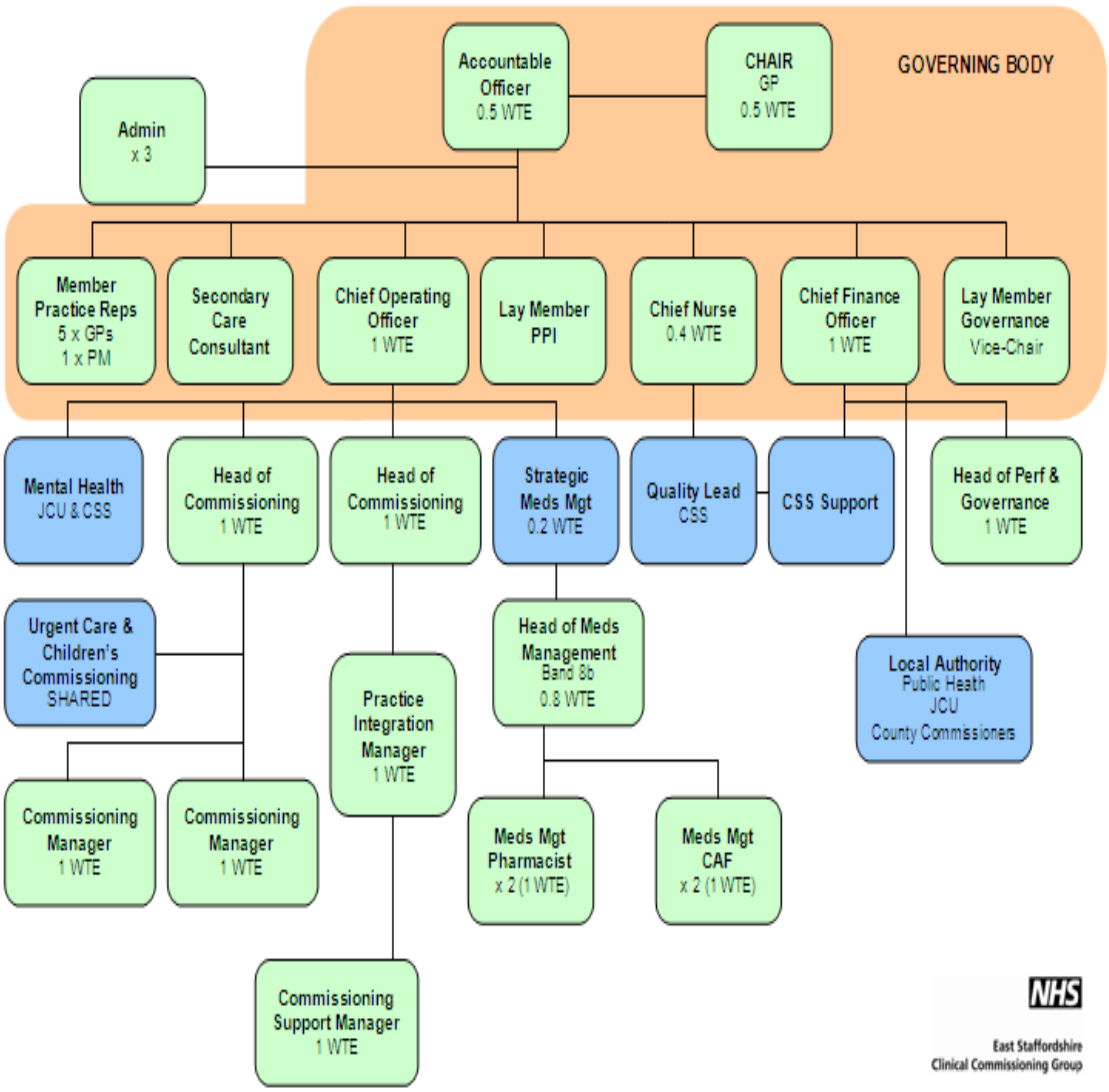
- Under 75 mortality rate from cancer

Other/Cross-cutting

- Health-related quality of life for people with long-term conditions
- Proportion of people feeling supported to manage their condition

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
- Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
- Emergency admissions for acute conditions that should not usually need hospital admission
- Emergency re-admissions within 30 days of discharge from hospital
- Patient reported outcome measures for elective procedures: hip replacement
- Patient reported outcome measures for elective procedures: knee replacement
- Patient reported outcome measures for elective procedures: groin hernia
- Patient reported outcome measures for elective procedures: varicose veins
- Patient experience of GP out-of-hours services

Appendix 5 ESCCG Staff Structure Chart



Glossary of Abbreviations

A	A&E	Accident and Emergency
	AAACM	All-Age All-Cause Mortality
	AO	Accountable Officer
	AQP	Any Qualified Provider
	ASD	Autistic Spectrum Disorder
	ASI	Accelerating Stroke Improvement
	AWM	Adult Weight Management
B	BAC	Burton Addiction Centre
	BHFT	Burton Hospitals NHS Foundation Trust
	BME	Black and Minority Ethnic
	BURDOC	Former GP Co-operative for out of hours provision
C	C.Difficile	Clostridium Difficile – a naturally occurring bacteria that can cause diarrhoea
	CAB	Citizen's Advice Bureau
	CAMHS	Child and Adolescent Mental Health Services
	CBT	Cognitive Behavioural Therapy – a psychology treatment
	CCG	Clinical Commissioning Group
	CFO	Chief Finance Officer
	CHC	Continuing Healthcare
	CHD	Coronary Heart Disease
	CIP	Cost Improvement Programme
	CIT	Community Intervention Team
	COPD	Chronic Obstructive Pulmonary Disease
	CPN	Community Psychiatric Nurse
	CQI	Continuous Quality Improvement
	CQC	Care Quality Commission
	CQRM	Clinical Quality Review Meeting
	CQUINs	Commissioning for Quality and Innovation – a contract payment mechanism
	CSP	Community Safety Partnership
	CSS	Commissioning Support Services
	CSU	Commissioning Support Unit
	CVD	Cardio Vascular Disease
	CVS	Community and Voluntary Service
	CWMS	Child Weight Management Service
D	DH/DoH	Department of Health
	DN	District Nurse
	DOG	District Operational Group
E	EDS	Equality Delivery System
	eJSNA	Enhanced Joint Strategic Needs Assessment
	EMAS	East Midlands Ambulance Service
	ENT	Ears, Nose and Throat
	EOL	End of Life
	EPaCCS	Electronic Palliative Care Coordination System

	EPAU	Emergency Pregnancy Assessment Unit
	ES	East Staffordshire
	ESBC	East Staffordshire Borough Council
	ESCCG	East Staffordshire Clinical Commissioning Group
	ESD	Early Supported Discharge
	ESDoC	East Staffordshire Delivery of Change – ESCCG's strategic plan
	EUCNB	Emergency and Urgent Care Network Board
F	FBC	Full Business Case
	FeV1	A measurement of lung function
	FT	Foundation Trust
G	GI	Gastro-Intestinal
	GMS	General Medical Services
	GP	General Practitioner
	GPwSI	GP with a Specialist Interest
	GTT	Glucose Tolerance Testing
H	H&S	Health and social (care)
	H&WB	Health and Wellbeing
	H&WBB	Health and Wellbeing Board
	HASU	Hyper Acute Stroke Unit
	Hba1c	A measure of blood glucose (usually in relation to diabetes)
	HEFT	Heart of England Foundation Trust
	HMSO	Her Majesty's Stationery Office
	HSJ	Health Service Journal
	HWBS	Health and Wellbeing Strategy
I	IAPT	Improving Access to Psychological Therapies
	ICD-10	A coding system for health care conditions
	ICT	Information Communications and Technology
	IFR	Individual funding requests
	IMD	Indices of Multiple Deprivation
	IM&T	Information Management & Technology
	ISTC	Independent Sector Treatment Centre
	IT	Information Technology
	IUCC	Integrated Urgent Care Centre
J	JCU	Joint Commissioning Unit
	JHWS	Joint Health and Wellbeing Strategy
	JSNA	Joint Strategic Needs Assessment
K	KPI	Key Performance Indicator(s)
	KPMG	Global network of professional firms providing audit, tax and advisory services
L	LA	Local Authority
	LAT	Local Area Team
	LD	Learning Disability (or disabilities)

	LDC	Local Dental Committee
	LES	Local Enhanced Service
	LINk	Local Involvement Network
	LMC	Local Medical Committee
	LOC	Local Optical Committee
	LOS	Length of Stay
	LPC	Local Pharmaceutical Committee
	LPN	Local Professional Network
	LSOA	Lower Super Output Area
	LSP	Local Strategic Partnership
	LTC	Long Term Condition(s)
	LTFM	Long Term Financial Model
M	MH	Mental Health
	MHRA	Medicines and Healthcare Products Regulatory Agency
	MOU	Memorandum of Understanding
	MRSA	Methicillin-Resistant Staphylococcus Aureus – a bacterial infection
	MSFT	Mid Staffordshire Foundation Trust
	MSK	Musculo-skeletal
N	NAPC	National Association of Primary Care
	NAPP	National Association of Patient Participation
	NCB	NHS Commissioning Board
	NCB LAT	NHS Commissioning Board Local Area Team
	NEL	Non-elective (unplanned care)
	NHS	National Health Service
	NHSCB	National Health Service Commissioning Board
	NICE	National Institute for Health and Clinical Excellence
	NPSA	National Patient Safety Agency
	NSAID	Non-Steroidal Anti-Inflammatory Drugs
O	OD	Organisational Development
	ONS	Office for National Statistics
	OOH	Out of Hours
	OPs	Out Patients
	OSC	Overview and Scrutiny Committee
P	PAT	Physical Activity Team
	PAU	Paediatric assessment unit
	PbR	Payment by Results
	PCDP	Primary Care Development Plan
	PCT	Primary Care Trust
	PEARS	Primary Eye-care Acute Referral Service
	PH	Public Health
	PM	Practice Manager
	PMS	Personal Medical Services
	POLCV	Procedures of Limited Clinical Value
	PPG	Patient Participation Group
	PPI	Patient and Public Involvement

	PSA	A measure of prostate gland health
	PSB	Public Services Board
Q	QIPP	Quality, Innovation, Productivity and Prevention
	QMAS	Quality Management and Analysis System
	QOF	Quality and Outcomes Framework
	QP	Quality and Productivity
R	R&D	Research and Development
	RCGP	Royal College of GPs
	RCN	Royal College of Nursing
S	SCR	Strategic Change Reserve
	SCSU	Staffordshire Commissioning Support Unit
	SES	South East Staffordshire
	SHA	Strategic Health Authority
	SLA	Service Level Agreement
	SMI	Severe Mental Illness
	SPA	Single Point of Access
	SPOT	Spend and Outcome (a profile comparing CCGs)
	SSOTPT	Staffordshire and Stoke on Trent Partnership NHS Trust
	SSSHFT	South Staffordshire and Shropshire Healthcare NHS Foundation Trust
T	T&O	Trauma and Orthopaedics
	TIA	Transient Ischaemic Attack (a mini stroke)
	TQM	Total Quality Management
U	UTI	Urinary Tract Infection
V	VFM	Value for Money
	VTE	Venous Thromboembolism (a blood clot)
W	WMAS	West Midland Ambulance Service
	WTE	Whole Time Equivalent (full time working hours)

Equality Analysis

Piece of work being assessed: **East Staffordshire CCG Delivery of Change Plan**

Aims of this piece of work: To set out the 3 year strategic plan for commissioning - from 2012 - 2016

Name of lead person: Clare Powell

Other partners / stakeholders involved: GP Members / Stakeholders

Date of assessment: 30.10.12

Who is intended to benefit from this piece of work? Patients, the public, GP member practices, staff and stakeholders

Equality Scheme strand	Baseline data and research on the population that this piece of work will affect: what is available; what does it show; are there any gaps? Use both quantitative / qualitative research and user data / consultation with users if available	Is there likely to be a differential impact? Yes or No
Gender Reassignment Race / Religion or Belief Disability Sex and Sexual Orientation Age Marriage & Civil Partnership Pregnancy & Maternity	The commissioning strategy set out in the East Staffordshire Delivery of Change Plan 2012-2016 meets the CCG's Public Sector Equality Duty, as guided by the core requirements of the Equality Act 2010, the NHS Constitution and the CCG's own Constitution. All of the Priority Programmes will be individually equality assessed so that any unintended equality consequences are dealt with via the programme governance arrangements. Some priorities are specifically targeted towards a protected group e.g. Teenage mums and people with learning disabilities. We also quite intentionally intend to disproportionately target resources towards our most health deprived populations. Implementation of Quality, Innovation, Productivity and Prevention (QIPP), determines the need to recognise that any service-based changes may result in some groups being disproportionately affected. However this is dependent on whether potential users of the service in question fall within specified protected characteristics.	NO – except where this is intended
Human Rights	Will this piece of work impact on anyone's human rights?	NO

Equality Analysis Action Plan

Strand	Issue	Action required	How will you measure the impact/outcome?	Timescale	Lead
