Brighton and Hove
Clinical Commissioning Group

Brighton and Hove Clinical Commissioning Group 2 Year Operating Plan

Getting Brighter and Healthier

2014-2016

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Brighton and Hove CCG 2 year Operating Plan

1. Foreword

The Operating Plan for Brighton and Hove Clinical Commissioning Group (CCG) describes how we intend to deliver the vision outlined in our 5 Year Strategy 2014-2019. Our plans address the priorities identified by needs assessment of our local population, views of our member practices, patients, the public and the wider clinical community.

The period covered by this plan will see a more radical shift in how we respond to health needs. We will move from a model of care that is predominantly acute based and delivered in response to crisis to one that is more proactive, integrated and community based. Under the auspices of Better Care, the CCG will invest significantly in developing these new models of care and in enabling integration within and across sectors to improve quality of care, patient experience and deliver better more patient centred outcomes.

Our intention is to maintain people at home and in the community wherever possible, ensuring any stay in hospital is kept to a minimum and facilitated by effective and consistent early discharge. We will do this in collaboration with providers of services and our commissioning colleagues to ensure alignment of our commissioning plans and delivery of essential improvements such as the 3Ts (Trauma, Tertiary and Teaching) capital development of the Royal Sussex County Hospital.

In order to effect this change we recognise the importance of high quality primary care. General Practice is the bedrock of health provision and caters for 90% of patients contact with the NHS. However, the model we have currently is not sustainable. In 2015 we will publish our Primary Care Strategy which will describe how we will support General Practice around key enablers such as information systems, workforce and premises and how we will facilitate more formal collaboration between practices in order to provide more joined up and equitable services across the City.

Whilst we are in a relatively good position financially we recognise the need to continually improve our level of efficiency and to transform services so they are fit for purpose in future years. 2014-16 will be a period in which we expect to see the full effect of Quality, Innovation, Prevention and Productivity (QIPP) savings released from our urgent care programmes as people are supported to be maintained in the community through improved pathways of care and increased community capacity. In re-commissioning a number of integrated pathways for elective care we expect to deliver a better quality of service but also provide greater value for money.

We will continue to work with providers to rectify areas where local performance against national targets or outcomes have fallen short so that all patients are seen and treated quickly, and the pledges and rights within the NHS Constitution are upheld. We know that in some areas, cancer, diabetes and stroke for example we are not achieving the outcomes we should and recognise that solution to these issues often lie with provider organisations working in a more joined up way as part of a more formal network. We will strengthen our mechanisms for joining up commissioning and performance management with partner CCGs and NHS England in these areas.

We are proud to serve the diverse population of Brighton and Hove and recognise the growing BME population. We are working with a number of BME groups and communities in the city to develop a partnership of BME organisations that will work together to map and reach communities

appropriately and seek the views of the community and the individual. We have a specific programme of work to raise awareness within the CCG and wider membership on Transgender issues. We recognise the enduring health inequalities that exist in our City. In 2014/16 we have earmarked £0.5mm to address this and following the outcome of a preventing premature mortality audit in general practice we will fund a range of evidence based interventions which will address those areas where we know we could and should have prevented years of life lost.

Other significant challenges this year include minimising hospital acquired infections particularly Clostridium Difficile (C-Diff), consistently maintaining waits in A&E below 4 hours, promoting health and wellbeing and ensuring physical and mental health services are delivered in a joined up way. We will strengthen mechanisms for feedback (including our Patient Participation Groups and uptake of the Friends and Family Test), continue to learn from the information we get from patients and public and implement local actions plans in response to the Francis Report, Berwick and Winterbourne.

2. Introduction and context

This plan sets out how Brighton and Hove CCG will commission services that improve health, reduce inequalities, promote wellbeing and independence, and contribute to delivering a sustainable local health economy.

It summarises detailed Quality, Innovation, Productivity and Prevention (QIPP) plans which will help us deliver the system vision outlined in our 5 Year Strategy 2014-2019 and ensure our legal and statutory duties are met including delivery of an agreed financial surplus.

It describes the required steps to deliver the six characteristics of a high quality, sustainable health economy namely:

1. Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care
2. Wider primary care, provided at scale
3. A modern model of integrated care
4. Access to the highest quality urgent and emergency care
5. A step-change in the productivity of elective care
6. Specialised services concentrated in centres of excellence

3. Demographics of the City

Brighton and Hove CCG covers a geographical area of approximately thirty four square miles and shares the same boundaries as Brighton and Hove City Council.

Brighton and Hove has an unusual population distribution with relatively large numbers of people aged 20 to 44 years, relatively fewer children and older people, and relatively more people (particularly women) aged 85 years or over who are likely to need more services. The diagram on the following page illustrates the significant difference between the local population and that of England as a whole:

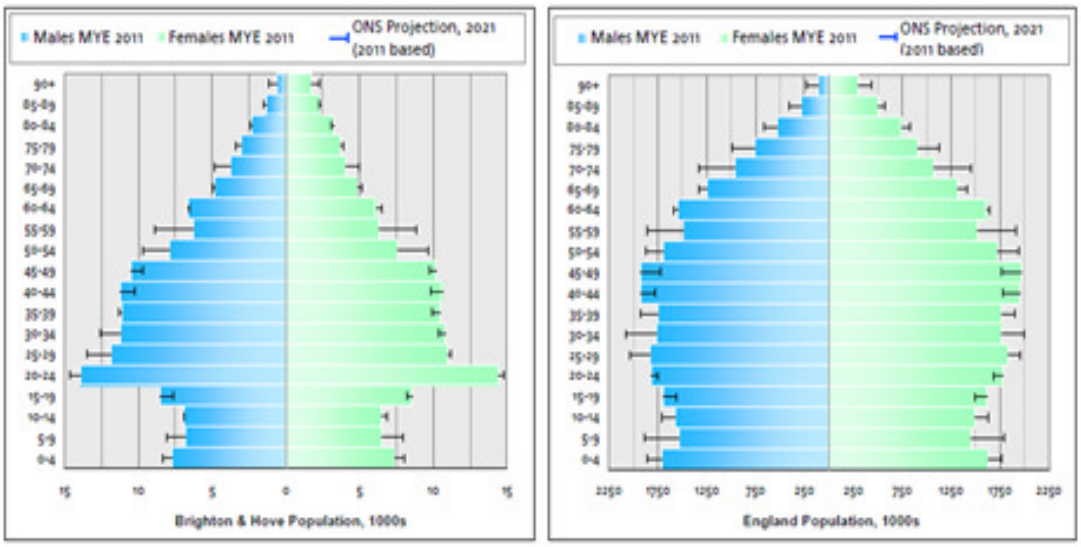


Figure 1: Population Pyramid – Mid Year Estimates 2011 and Projected Population for 20121

The 2011 census highlights the considerable change in the population of Brighton and Hove over the last ten years particularly in respect to our BME population, older people and working age adults. The diagram on the next page shows the increases and decreased reflected in the census:

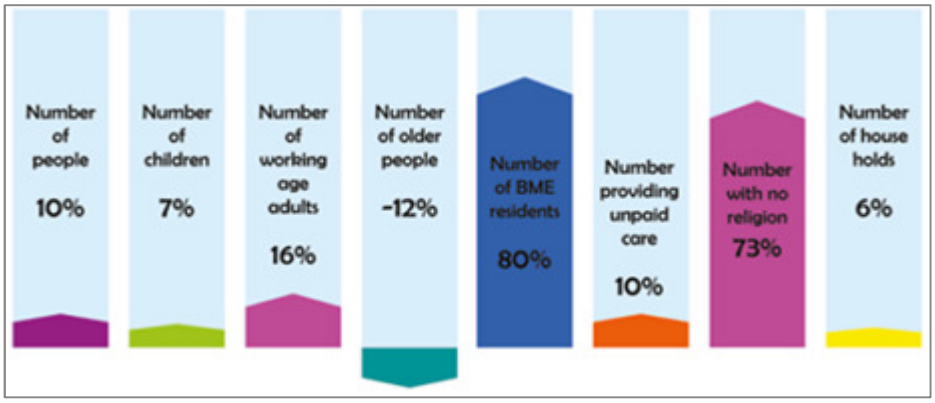


Figure 2: Change between 2001 and 2011 Census in Brighton and Hove

3.1 Predicted future need

Changes in the population age structure affect the need for health and social care services. Population projections therefore have an essential role in assessing the future need for services. Current trends in births, deaths and migration are projected forwards and used to produce population projections.

Over the next ten years we forecast on-going changes to our local population. The resident population is predicted to rise to 289,900 by 2021 (6% increase from 2011) –16,900 more people. The greatest projected rise will be seen in the 25-34 & 50-59 year age groups. There are also projected to be higher numbers of children under 15 years. The number of people aged 75 years or over is expected to rise by 10% from 18,272 in 2011 to 20,085 in 2021. We also forecast a rise in the number students associated with the expansion of the existing Universities in the City.

3.2 Key population groups within the city

Brighton and Hove City has a unique and diverse population. The following are some of the key population groups within the city and considered in our plans:

- *BME groups* – The 2011 Census shows that 19.5% of the city's population are from a BME group.
- *LGB* - Estimates suggest that there may be 40,000 people from Lesbian, Gay, Bisexual (LGB) communities living in Brighton & Hove, around 15% of the city's population.
- *Carers* - 9% of the population (approximately 24,000 people)
- *Migrants* - 2010 figures show that 15% of the city's population was born abroad.
- *Students* - there has been an increase in the numbers of students in the city to more than 35,200 in 2011/12. This is approximately 13% of the total population.
- *Military veterans* – an estimated 17,400 military veterans live in the city.
- *Gypsies and travellers* – an estimated 198 gypsies and travellers
- *Homeless* – there are approx. 3000 homeless people in Brighton and Hove

In terms of the highest levels of need for excluded communities, local research (Public Health needs assessments and others) has shown that the most acute and worrying needs exist for Traveller, Transgender and Homeless people.

Our plans respond to the changing and diverse nature of the local population and our work programme is prioritised on the basis of need.

4. Needs Assessment and Benchmarking

In addition to the demographic information described in the above section the CCG has triangulated information from a number of other sources to identify where we are an outlier in terms of quality and/or finances. The section below summarises our findings, more detail can be found in out 5 Year Strategy 2014-2019

4.1 Joint Strategic Needs Assessment (JSNA)

We identify need by working with public health staff to develop the overview of local health and wellbeing needs, and inequalities, known as the Joint Strategic Needs Assessment (JSNA). This comprehensive document also takes account of the patient voice, benchmarking and activity data, and quality indicators.

The JSNA enables us to understand the different needs of people in different areas based on factors such as the age structure of the population, socio-economic status, ethnicity, and access to health services which are all associated with particular health risks. It also allows us to identify areas where we are doing well and those which need improvement.

The JSNA identified five key health needs in the city:

Cancer and screening access: Mortality from all cancers in under 75 year olds is significantly higher in Brighton and Hove than England and the South East. There are three NHS cancer screening programmes in England: breast, cervical and bowel and in Brighton & Hove, screening uptake rates are generally lower than both regional and national figures. Cancer and cancer screening is identified as one of the five priorities in the Joint Health and Wellbeing Strategy (JHWS). Section 6.8 of this document describes how we will deliver the CCGs cancer plan and the aspirations set out in the JHWS.

Diabetes: The prevalence of diabetes is increasing nationally due to increased obesity, an aging population and increasing numbers of South Asian people, who are at greater risk of developing diabetes. In Brighton & Hove numbers have also increased with 3.3% of people registered with GPs having diabetes in 2012 compared with 2.9% in 2008. The CCG plans to commission an integrated diabetes service in 2015 to improve the quality services and drive up health outcomes. See section 6.3 for more details.

Coronary Heart Disease: Despite reductions over recent decades, coronary heart disease remains the most common cause of death nationally. It was the main cause of death for 218 people in Brighton & Hove in 2011 which was approximately 10% of all deaths. In 2011/12 2.3% of all patients registered local GPs had coronary heart disease. The Better Care Plan includes in its definition of frailty a cohort of patients with CHD and outlines how we will improve services for these patients. See section 6.5. The CCG is currently undertaking a Preventing Premature Mortality Audit which includes CHD. The results of the audit will be used to inform changes in Primary Care to improve care for patients with CHD. See section 6.12.

Dementia: It is estimated that there are currently almost three thousand people aged 65 years or over with dementia in Brighton & Hove. However this is lower than expected prevalence and therefore more needs to be done to identify this cohort. The CCG have jointly developed with Brighton and Hove City Council a Dementia Plan which describes how we will deliver local improvements in line with the National Dementia Strategy and raise dementia diagnosis rates to 67% by March 2015. See section 6.5.

Musculoskeletal conditions: Musculoskeletal conditions are a range of conditions including back pain, shoulder pain, hip and knee pain which can limit mobility in older people and make them vulnerable to falls. In each year it is estimated that about 40% of the adult population have low back pain, 5% have hip pain and 60% of over 65s severe knee pain. Brighton and Hove has a high programme budget spend in this area yet has poor patient reported outcomes. To address the CCG will recommission and implement a new MSK service in 2014/15. See section 6.7.

The JSNA also identified the following two priority areas where the CCG needs to work with commissioning partners in Public Health and Area Team to improve services:

HIV/AIDS: In 2011 Brighton & Hove had the ninth highest HIV prevalence in England at 7.6 per 1,000 15-59 year olds compared with 1.7 in England as a whole and the highest prevalence anywhere outside of London. Brighton and Hove also has the highest rates of common sexually transmitted infections outside London. The CCG will continue to work with our public health colleagues to improve the sexual health of the residents of Brighton and Hove.

Influenza immunisation: Influenza is a highly contagious viral infection that can cause serious illness and death, especially in vulnerable groups including very young and elderly people. Immunisation is available for people in these groups including everyone over the age of 65. In 2012/13, uptake in Brighton & Hove among those eligible was just under 70%, which is a slight decrease from the previous year, lower than England as a whole and below the national target of 75%. This year we used an incentive scheme for GPs to increase the numbers of flu vaccines they gave out and worked closely with the hospital to support them in vaccinating at risk groups. However we know our numbers could always be improved so together with public health colleagues we commissioned a large piece of social marketing research (funded by public health) to find out what the barriers are to peo-

ple having their flu vaccine, for example why don't older people come in. We will be using these findings to inform this year's plan and have set up a working group to look at how we can get the message about the flu vaccine out to over 65s.

5. Developing our plans

Our plans have been pulled together following an extensive year-round engagement process with:

i. our member practices:

- we have identified primary care based clinical leads for each of our key commissioning areas whose role it is to link back to member practices;
- bi-monthly discussions and workshops with each of our three Localities (West, Central and East) on commissioning plans;
- on-line surveys on specific re-commissioning issues;

ii. patients and the public:

- quarterly public events discussing key themes;
- regular meetings with third sector organisations contracted to provide feedback from traditionally excluded groups;
- quarterly meetings with Healthwatch to triangulate feedback on services;
- Feedback from Patient Participation Group (PPG) members via elected Patient Reps on Locality Management Groups, established PPG network;
- Specific consultations with patients, public and other stakeholders for each of our major programmes of work

iii. The City Council,

- We have a regular Joint Officers Group where our draft plans have been discussed at the earliest stage and co-designed. The Council are represented on our CCG Governing Body where commissioning plans are regularly discussed;
- Our Plans align with the Health and Wellbeing Strategy for the City and are signed off in draft and final form by the Health and Wellbeing Board;
- Plans for the Better Care Fund have been agreed with the Health and Wellbeing Board and our governance structures around strategic planning and operational delivery of integrated plans are being strengthened.

iv. neighbouring CCGs and co-commissioners from NHS England:

- We have a memorandum of understanding with neighbouring CCGs to act as a co-ordinating commissioner for Brighton and Sussex University Hospitals. As such we have led the process on developing commissioning intentions for the Trust on behalf of our neighbouring CCGs and ensuring these align with NHS England and longer term strategic aims around the 3Ts Development. There are robust governance mechanisms in place to ensure collaboration between commissioners and with the Trust.
- Wherever possible and appropriate the CCG will work with the wider health economy to commission services. There is a Sussex-wide programme of work agreed by CCGs and undertaken by Sussex Collaborative Delivery Team (SCDT) hosted by Eastbourne, Hailsham and Seaford CCG.
- Through the Sussex Collaborative 3 monthly meetings occur with Area Team including the SCN, Specialised Commissioning and Director of commissioning. To gain an understanding and work out how the different priorities impact on co commissioners and how the different organisations can work together.

- The CCGs in Sussex are represented at the National NHS England Specialised Commissioning Led work on Pathways. There are members on the overall Steering Group and Co-leads on Trauma and Paediatric Pathways.

v. Providers

- We have held engagement events with all of our major providers and stakeholders to shape and develop our plans.
- On-going regular engagement with providers to co-design, align plans and negotiate contracts.

6. Quality Innovation Prevention and Productivity Plans (QIPP)

The following section describes in more detail our QIPP plans designed to meet the priorities described in the previous sections. Each of the QIPP plans sets out why we have prioritised the programme, what we plan to do and provides high level information regarding finance, activity and outcomes. Detailed schedules regarding milestones, finance, activity, outcomes etc. are contained in the Appendices.

6.1 Community and Integrated Services QIPP Summary

Introduction and Strategic Context

Providing responsive pro-active care in the community is a key priority for Brighton and Hove CCG. We know from feedback from patients and their carers that they want services to be more holistic and personalised. They want services to be supportive of them to achieve self-care and to be able to plan their future care (care planning); services which involve them in decisions about their care (shared decision making) and services which support them in their own homes without having to go to hospital if there are alternatives (care closer to home). These initiatives will be supported by our "Information about me and my care" portfolio including online patient GP record access, remote monitoring and telecare, potentially including smart phone apps.

In 2014-15 the CCG will focus on monitoring the redesigned care pathways; embedding changes and developing the models of care to ensure they deliver the anticipated outcomes and they are responsive, for example to patient and carer feedback and changing patterns of demand.

Local needs assessment identified diabetes and CHD as areas requiring improvement and that our homeless population have extremely poor health outcomes and access to healthcare services. The following section describes how we will address these needs.

Key Transformational Programmes

There are two large scale transformational community and integration programmes. 'Better Care' (incorporating a more integrated model of care for frailty and an integrated service for homeless people in the city) and a remodelled integrated diabetes service.

6.2 Better Care Fund

The Better Care Fund provides an opportunity to improve services to some of the most vulnerable residents in the city, placing them and their carers at the centre of their own care. It will also transform how local health & social care services are delivered so that people are provided with better integrated care and support.

The funding received is predicated on the fact that there will be a reduction in the amount spent on care for people in acute settings and releases from efficiencies elsewhere in the system. The aim is to have a more coordinated and integrated approach to supporting people in community settings where possible and to reduce unnecessary admissions to hospital and care homes. There will be an emphasis on proactive care, 24/7 working, minimising the time spent in hospital and improving

hospital discharge.

The Better Care Plan in Brighton and Hove will concentrate on delivering an integrated model of care for people who are 'frail.' In Brighton and Hove we have taken a broader definition of 'frailty'. Rather than just focus on older people who are frail we will include people who have complex needs (e.g. people with mental health needs, people who are homeless) as this is the cohort of people most likely to benefit from a more integrated system.

Whilst we have some excellent examples of integrated working across health & social care. More generally, patients, service users and carers have informed us that services are fragmented and do not always address the holistic needs of the individual.

Currently the system is not set up effectively to support individuals who have multiple or complex needs. Not all community services are available 24 hour a day 7 days a week and access criteria are not aligned.

The vision for our frail population is to more actively promote their ability to stay healthy and well by providing "whole person care", promoting independence and enabling people to fulfil their potential. Services will be seamless and better co-ordinated. They will be delivered at home or in community settings wherever possible, avoiding unnecessary attendances at A&E, admissions to hospital and to long term care. Services will offer more choice and more flexible support to enable a person centred approach. Organisations will work together to achieve better outcomes for people, and make the best use of available resources.

It is our intention that the model of care around frailty will look very different. GPs (as the profession with responsibility for co-ordinating care around elderly frail) will be supported in their role by a multi-disciplinary team (MDT) wrapped around clusters of practices. In order to develop this MDT we will build on the existing Integrated Primary Care Teams (IPCTs), embed them more with Practice staff and extend their scope to cover all frail people registered at those practices.

We will increase the capacity and skill mix within the integrated teams and extend the membership of the multidisciplinary team to consistently incorporate mental health/substance misuse and social care staff and facilitate a more formal involvement of independent care providers and the community & voluntary sector in the partnership. Links to other council colleagues will be developed (e.g. housing, public health, communities team) to make sure people receive a suitable response, and to make best use of the skills and resource in local areas

We will reshape the model of care by bringing relevant staff out from the acute setting and embed them in the community team so that their remit is to in-reach to hospital when people require an acute stay. These core teams based around clusters of GP Practices will have rapid access to specialist support when required. Each frail person will have a designated "care co-ordinator" drawn from within the Integrated team. Depending on the specific needs of the frail person the care co-ordinator could be from any profession within the MDT – including the third sector. For specific cohorts of frail people e.g. homeless residents the model of care will be bespoke to their needs and will include greater use of out-reach models of care and support with housing related issues.

In order to facilitate this new model of working staff from a range of organisations will come together into one team with a single line management structure, shared patient records and single assessment processes. We have agreed with all our partners in the City that we will pilot this integrated model in 2014-2015, bases around a cluster of practices covering a registered population

of 20,000, in order to test out the model and ensure lessons learned inform the full roll out across the whole city in 2015/16.

Finance and Activity

The table below shows the investments and savings associated with the Better Care Plan in 2014/15 (More detail is contained in Appendix 6 – Finance Schedule):

Table 1: Better Care Plan Investments and Savings

Better Care Fund 13/14		2014/15		
		Invest	Save	Net
Community	Carers Enabling and Befriending Service	40		40
Community	Additional Therapy in IPCT's	288		288
Community	CSTS - 7 Day Working Model for Therapies	45		45
	Pilot Frailty Model	350		350
	Developing Personal Health Budgets	70		70
Total Better Care Fund		**793**		**793**

Outcomes

The table below shows the outcome improvement targets associated with the Better Care Plan:

Table 2: Better Care Plan Outcome Measures

Outcome Measure	Baseline 12/13	Target 14/15	% Improvement
Admissions to residential and nursing care	816.9	764.9	6%
Effectiveness of reablement	0.86	0.88	2%
Delayed transfers of care	240.3	232.1	3%
Emergency admissions	134.9	129.3	4%
Dementia Diagnosis Rate	0.44	0.67	23%

The Better Care Plan will also contribute to the delivery of the following outcome ambitions by implementing strengthened self-management and case management (contribution to achievement has been calculated based on Urban Any Town model):

Table 3: Better Care Plan Contribution to Outcome Ambitions

Outcome Ambition	2012 Base-line	Target 2014/15	Target 2015/16
1. Securing additional years of life for the people of England with treatable mental and physical health conditions	2141.3	2091.62	2041.94
2. Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions	73.5	74.24	74.98
5. Increasing the number of people having a positive experience of hospital care	129.9	129.9	129.9
6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	5.9	5.72	5.54

6.3 Integrated Diabetes Service

Diabetes mellitus is a complex condition that has a profound impact on the quality of life of people living with the condition. Diabetes can have a major impact on the physical, psychological and material well-being of individuals and their families, and can lead to complications such as heart disease, stroke, renal failure, amputation and blindness.

From the time of diagnosis to the development of severe complications, the person living with diabetes receives input from a wide spectrum of health and social care professionals. When the care pathway is fragmented, this it results in duplication, inefficiency and a poor health experience.

Diabetes is a costly disease and as prevalence increases, those costs will rise further which places greater pressure to address some of the local service fragmentation issues in Brighton and Hove. National diabetes audits have identified local issues such as high numbers of patients with Diabetic Keto-Acidosis (DKA), foot complications, excessive lengths of stay for diabetic patients, low rates of day-case treatment and above average prescribing errors.

The service proposal is based on best clinical practice, with reduced duplication and increased patient empowerment to self-manage. The outputs of the city-wide stakeholder consultation, discussions with the Diabetes Clinical Reference Group and other clinicians delivering current services, and clinically led working groups have been used to formulate this proposal.

An Integrated Diabetes Service would deliver high quality specialist care for all those with diabetes, within a community multi-disciplinary team that interfaces general practice and specialist acute services. The integrated diabetes service will deliver a ‘one-stop shop’ service, delivered within a community setting, covering Brighton and Hove. The service will be a consultant-led MDT service, with specialist medical and nursing support. The workforce consists of diabetes specialist nurses, podiatrists, specialist dieticians, and psychological support. The service will deliver an education and training programme to primary care on diabetes management and will provide flexible support to primary care clinicians based on skills, to support them to deliver high quality diabetes care in their practice. A high proportion of people with diabetes suffer with psychological problems such as anxiety and depression, so this service aims to integrate physical and mental health care into a seamless pathway for patients.

GP practice based services will have primary responsibility for the person with diabetes. Specialist acute services and the community Integrated Diabetes service will have responsibility for care provided in those settings. Each GP Practice will organise their own workload, structures and resources, which may result in collaboration with other practices, to ensure an equitable service is delivered to all patients across the city. Self-care, self-management and delivering seamless integrated diabetes care across the community and primary care has been shown to have a major impact on improving patient quality of care, freeing up capacity in secondary care to treat appropriate referrals requiring specialist care, and supporting reduction in hospital admissions.

Finance and Activity

Finance and activity schedules will be available following sign off of the business case.

Outcomes

The outcomes of the service will be:-

- Reduction in emergency admissions
- Reduction in complications
- Prescribing formulary to address insulin prescribing

The detailed trajectories will be developed alongside the service specification.

The Diabetes Plan will also contribute to the delivery of the following outcome ambitions:

Table 4: Diabetes Contribution to Outcome Ambitions

Outcome Ambition	Measure	2012 Base-line	Target 2014/15	Target 2015/16
1. Securing additional years of life for the people of England with treatable mental and physical health conditions	Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare per 100,000 popula-tion	2141.3	2091.62	2041.94
2. Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions	Average health status (EQ-5D) score for individuals who identify themselves as having a long-term condition	73.5	74.24	74.98
3. Reducing emergency admissions	- Emergency admissions for acute conditions that should not usually require hospital admission.	1772.6	1683.97	1666.244

6.4 Mental Health Summary QIPP Summary

Introduction and Strategic Context

Improving mental health and wellbeing is a key priority for the CCG and identified as one of the 5 priorities in the JHWS. We are striving to ensure that mental health has equal status to physical health. The City has high levels of mental health need both in terms of numbers and degree of complexity. Major transformational change has taken place within mental health services over the last few years with the aim of providing preventative care and support as early as possible. This strategic approach aims to prevent problems escalating and make the best use of our available resource. Recent Improvements that have been made to mental health services include:

- More services are available in community settings and there is greater accessibility for example a self-referral option to the Wellbeing Service;
- Increased provision by the community and voluntary sector, for example day services; psycho-social and employment support;
- Strengthened working arrangements between GP practices and providers of mental health services, for example the Wellbeing Service and Seriously Mentally Ill Enhanced Service;
- Enhanced crisis support service;
- Increased capacity in terms of supported accommodation, helping to prevent unnecessarily long stays in hospital.

Key Transformational Programmes

Improved Integration of Physical and Mental Health Services

A key strategic priority for the CCG is to develop pathways which improve integration of physical and mental health services. The CCG will continue to ensure that all pathways that are redesigned

are done so in a holistic way that improves the integration of physical and mental health.

We will do this by ensuring that all newly commissioned services integrate physical and mental health needs and we will amend all existing specifications to reflect parity of esteem over the coming years.

Mental Health Payment by Results

The national Payment by Results programme for mental health is continuing to develop and we will use the opportunities it presents to further advance transformational change through joint work with other CCG commissioners in Sussex, provider organisations and service users and carers.

Whole System Mental Wellbeing Strategy

Whilst the CCG will continue to focus on ensuring our mental health services deliver the best possible outcomes; moving forwards the strategic approach will broaden in line with the national strategy No Health Without Mental Health. During 2013 the CCG has been working with Brighton and Hove Council to develop a whole system Mental Wellbeing Strategy that will be implemented from 2014-15 onwards. The strategy aims to promote wellbeing, build resilience and will provide a framework for further improvement to mental health services. It will also address the wider determinants of mental health and wellbeing including housing, education, leisure and employment. This broader approach aims to support the mainstreaming of mental health and wellbeing into all parts of the CCG's and BHCC's business as well as the community. By making the promotion of mental wellbeing part of everyone's business we anticipate it will help reduce some of the stigma associated with mental health.

In 2014-15 the CCG will focus on monitoring the changes that have been made; to ensure they deliver the anticipated outcomes and make any further adjustments where necessary, for example in response to patient and carer feedback and changing patterns of demand. We will also deliver further service improvements including:

Mental Health and Substance Misuse

We will develop an integrated model of care for people with a dual diagnosis of mental and substance misuse issues for people with more serious mental illness. This will form part of the Substance Misuse procurement process being led by Brighton and Hove City Council. The new model of care will be in place form April 2015.

Eating Disorder Pathway

We will commission a local comprehensive eating disorders service covering the spectrum of mild to severe disorders; improving physical health care as well as maintaining the health of those with more severe disorders. The new service will be in place from April 2014.

Psychological Support for Survivors of childhood sexual abuse

We will review pathways for psychological support for survivors of childhood sexual abuse with a view to developing improved streamlined care pathways.

Money Advice

We will review the current arrangements for provision of Money advice and ensure that we commission a comprehensive service across inpatient and community settings.

Pro-Active Crisis Prevention Pathway for Adults with Learning Disability

We will explore the development of an intensive response service for adults with learning disability

with complex needs, for example with behavioural challenges and/or mental health conditions. The aim is to provide more preventative support in the community, preventing unnecessary use of out of area hospital placements.

Finance and Activity

The table below shows the investments and savings associated with the mental health QIPP Programme in the two year period 2014-2016 (More detail is contained in Appendix 6 – Finance Schedule). In summary the mental health QIPP programme will be cost neutral with the savings being released from the renegotiation of the accommodation contract reinvested to meet identified need in other areas.

Table 5: Mental Health QIPP Investment and Savings

	Invest (£'000)	Save (£'000)	Net (£'000)
Eating Disorder Service	100		100
SMI LES	13		13
Money Advice	50		50
Childhood Sexual Abuse	70		70
Mental Wellbeing Strategy Implementation	100		100
Young People - Emotional Health & Wellbeing	105		105
Peri-natal service	19		19
Autism diagnostic pathway	19		19
Accommodation Contracts	717	(1,083)	(366)
Crisis Response Pathway - BURS	391	(391)	-
Dual Diagnosis	10		10
Learning Disability Crisis Support	150	(300)	(150)
Total Mental Health	**1,744**	**(1,774)**	**(30)**

Outcomes

The Mental health QIPP plan will also contribute to the delivery of the following outcome ambitions:

Table 6: Mental Health Contribution to Outcome Ambitions

Outcome Ambition	2012 Base-line	Target 2014/15	Target 2015/16
1. Securing additional years of life for the people of England with treatable mental and physical health conditions	2141.3	2091.62	2041.94
6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	5.9	5.72	5.54

6.5 Dementia

Introduction and Strategic Context

Brighton and Hove CCG have jointly developed with Brighton and Hove City Council a Dementia Plan. It sets out the Brighton and Hove strategic vision for improving care and support to people with dementia and their carers in line with the national dementia strategy. The central aim of the plan is to increase awareness of the condition, ensuring early diagnosis and intervention as well as improving the quality of care for people with dementia and their carers.

Key Transformational Programmes

With increasing number of people with dementia our strategic approach to improving dementia care is largely about mainstreaming i.e. ensuring generalist health and social care staff in all sectors from the hospital to care homes have the necessary training and support to provide high quality care rather than developing specialist dementia services. A number of key improvements to dementia care have been made including the development of a new memory assessment and support service to increase the rate of diagnosis, the development of 7 day a week specialist dementia care including crisis support and the development of a specific care home in-reach team. In 2013-14 an updated Dementia Joint strategic Needs Assessment (JSNA) has been undertaken and this will inform the next phase of the local implementation plan. Specific areas for development including

- On-going development of the Memory Assessment Services to increase early diagnosis and intervention in line with the national target of 67% by March 2015
- Support voluntary and community groups in making the city a more dementia friendly community
- Develop services for people with young onset dementia and for those with an early diagnosis
- Embed the care pathway for people with dementia at the end of life. By promoting "This is me bag" , providing supporting information to public and professionals and continue to develop training for professional
- Continue to support to people with dementia admitted to general hospitals, by expansion of dementia champions role, supporting the adoption of the butterfly scheme and ensuring older people mental health liaison address the need of people with dementia
- Support care homes through care home in reach and ensuring tailored training is available.

Finance and Activity

The approach in terms of early intervention aims to make more cost effective use of the overall resource and through the new investment we anticipate being able to reduce future expenditure across the system for example through reducing the rate of emergency hospital admissions and delaying admissions to care homes. The CCG were successful in bidding for £1million of national Environmental Funding which we have used to invest in a range of environmental improvements across the care system which has included the development of a dedicated dementia unit at the Royal Sussex County Hospital as well as dementia friendly environment in GP surgeries.

The table below shows the investments and savings associated with the Dementia Plan in the two year period 2014-2016 (More detail is contained in Appendix 6 – Finance Schedule):

Table 7: Dementia Investments and Savings 2014/15

	Invest (£'000)	Save (£'000)	Net (£'000)
Memory Assessment Service	32		32
Primary Care	8		8
Total	**40**		**40**

Outcomes

The table below shows the outcome improvement targets associated with the Dementia Plan:

Table 8: Dementia Outcome Measures

Outcome Measure	Baseline 12/13	Target 14/15	% Improvement
Dementia Diagnosis Rate	44%	67%	23%

The Dementia Plan will also contribute to the delivery of the following outcome:

Table 9: Dementia Contribution to Outcome Ambitions

Outcome Ambition	Measure	2012 Baseline	Target 2014/15	Target 2015/16
1. Securing additional years of life for the people of England with treatable mental and physical health conditions	Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare per 100,000 population	2141.3	2091.62	2041.94
2. Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions	Average health status (EQ-5D) score for individuals who identify themselves as having a long-term condition	73.5	74.24	74.98
3. Reducing emergency admissions	- Emergency admissions for acute conditions that should not usually require hospital admission.	1772.6	1683.97	1666.244
5. Increasing the number of people having a positive experience of hospital care	Rate of survey responses of a 'poor' experience of inpatient care per 100 patients	129.9	129.9	129.9
6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	Poor patient experience of primary care in GP services and GP out-of-hours services	5.9	5.72	5.54

6.6 Urgent Care Summary QIPP Summary

Introduction and Strategic Context

The CCG supports the four emerging principles for urgent care:

- Provides **consistently** high **quality** and **safe** care, across all seven days of the week;
- Is **simple** and guides good choices by patients and clinicians;
- Provides the **right care** in the **right place**, by those with the **right skills,** the **first time;**
- Is **efficient** in the delivery of care and services.

Key Transformational Programmes

System Wide Urgent Care Plan

In the light of the recent recommendations of the national review of urgent and emergency care, we will work with our local acute hospital to optimise patient pathways in the Emergency Department including:

- The development of a non-admitted care pathway for those patients whose care cannot be completed with the 4 hour A&E standard but who do not need to be admitted to hospital
- The agreement of plans to address process delays within A&E
- The development of acute surgical and medical assessment pathways.

We will continue to work in collaboration with our local acute hospital via the Urgent Care Working Group and Assurance Meetings to ensure the delivery of the improvement plan to achieve sustainable improvement in the 4 hour A&E standard and in ambulance handover delays.

We will continue the excellent joined up working in the system around resilience and winter planning led by our Urgent Care Working Group. In April, we will be reviewing learning from 13/14 with a view to signing off comprehensive plans by the summer of 2014. These will include transparent plans about the use of any funds retained from the marginal rate rule and readmissions rules.

Supporting patients and the public to access care

We know the urgent care system in Brighton and Hove is complex and difficult for patients and professionals to navigate and generates confusion among patients about how and where to access care. In response to this we will continue to develop and implement our local communications strategy building on the work already started via the “We Could be Heroes” campaign.

Reducing Conveyance

We will work with other CCGs in Sussex to develop a local approach to contracting and commissioning of ambulance services including 999 and NHS 111 that is much more responsive to local need and priorities. This will include:

- Building on the findings of the supported conveyance/permission to convey pilots to secure tangible reductions in the number avoidable conveyances to hospital
- A focus on the continuous improvement of the NHS 111 service

GP Out of Hours

We will work with the other Sussex CCGs to implement the new specification for GP out of hours from April 2014. In Brighton and Hove the service will continue to be delivered from the Royal

Sussex County site. We will continue to commission redirection pathways to Out of Hours Services (OOHs) from adult and paediatric A&E and weekend review clinics. We will work with the OOH provider to implement a range of actions in the Service Development Improvement Plan (SDIP) including and the changes to the General Medical Services (GMS) contract which gives GPs a role in monitoring the quality of out of hours services.

Integrated Urgent Care Centre

We will commence a major programme to develop an integrated primary care led urgent care centre model in the city, in line with the recommendations of the national review for urgent and emergency care. We will be aiming for implementation 2015/16 and we will contract on an outcome based model which will include within its scope the walk in centre, GP out of hours and A&E minor injury and illness. During 2014/15, following the piloting of the primary care navigator and GP in A&E roles, we will be seeking to implement a primary care stream in A&E minors.

Finance and Activity

The table below shows the investments and savings associated with the urgent care QIPP programme in the two year period 2014-2016 (More detail is contained in Appendix 6 – Finance Schedule). In summary the plans will release £3.4m of acute spend through renegotiation of the urgent care pathway and associated tariff and via prevention of admission due to strengthened integrated community and primary care services.

Table 10: Urgent Care Investments and Savings 2014-16

	Invest (£'000)	Save (£'000)	Net (£'000)
OOHs reprocurement	1,495	(2,550)	(1,055)
Reducing conveyance		(566)	(566)
Primary care stream redirection	350	(381)	(31)
Non admitted pathway		(1,154)	(1,154)
24/7 urgent care model		(560)	(560)
Total Urgent Care	**1,845**	**(5,211)**	**(3,366)**

The plan will reduce non elective admissions by 4.4% in 2014 and a further 3% in 2015/16.

Table 11: Urgent Care Activity Assumptions 2014-16

Year	FOT	Plan	Var	Var %
2014/15	25,565	24,435	-1130	-4.60%
2015/16	24,435	23,707	-728	-3%

Outcomes

The table below shows the outcome improvement targets associated with the Urgent Care QIPP Plan:

Table 12: Urgent Care Outcome Measures

Outcome Measure	Baseline 12/13	Target 14/15	% Improve-ment
Delayed transfers of care	240.3	232.1	3%

6.7 Planned Care Summary QIPP Summary

Introduction and Strategic Context

We will continue to build on existing work to ensure that planned care services are high quality, accessible, timely and value for money.

Key Transformational Programmes

In 2014/15 we will recommission two major planned care pathways: Musculoskeletal Services and Dermatology.

Musculoskeletal Services (MSK)

Brighton and Hove, along with other CCGs, will conclude the procurement of a new integrated musculoskeletal service in 2014. This service will be contracted on a prime provider basis with the financial envelope including all MSK activities including secondary care spend. The CCGs will be looking to implement the new service from October 2014.

Dermatology

Following completion of the procurement process, we will be commencing the implementation of an Integrated Dermatology Service in July 2014. This service will include all dermatology activity currently provided via the integrated dermatology service plus outpatient paediatric dermatology.

Finance and Activity

The table below shows the investments and savings associated with the planned care QIPP programme in the two year period 2014-2016 (More detail is contained in Appendix 6 – Finance Schedule). In summary the planned care programme of work will release £1.8m of savings through the re-procurement of MSK services, renegotiation of new to follow up ratios and SRC payments and redesign of the COPD pathway.

Table 13: Planned Care Investments and Savings 2014-16

	Invest (£'000)	Save (£'000)	Net (£'000)
Review of Assisted Conception Pathways	150		150
MSK	8,808	(9,933)	(1,125)
New to Follow Up Ratios		(475)	(475)
COPD Pulmonary Rehab		(160)	(160)
SRC		(246)	(246)
Dermatology	54	(54)	-
Total Planned Care	**9012**	**(10,868)**	**(1,856)**

The delivery of the planned care programme of work will reduce follow up attendance by 3.8% in 2014. Elective inpatients (including daycases) will rise slightly (by 0.5%) to meet increases in demand and the introduction of new procedures and best practice guidelines.

Table 14: Planned Care Activity Assumptions 2014-16

	FOT	Plan	Var	Var %
Follow Up Appointments	188,804	1841,468	-7336	-4%
Elective Inpatient Attendances	30,163	30,310	147	0.5%

Outcomes

The Planned Care Plan will contribute to the delivery of the following:

Table 15: Planned Care QIPP Contribution to Outcome Ambitions

Outcome Ambition	Measure	2012 Base-line	Target 2014/15	Target 2015/16
1. Securing additional years of life for the people of England with treatable mental and physical health conditions	Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare per 100,000 population	2141.3	2091.62	2041.94
2. Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions	Average health status (EQ-5D) score for individuals who identify themselves as having a long-term condition	73.5	74.24	74.98
5. Increasing the number of people having a positive experience of hospital care	Rate of survey responses of a 'poor' experience of inpatient care per 100 patients	129.9	129.9	129.9

6.8 Cancer QIPP Summary

Introduction and Strategic Context

Around 1,175 people in the city are diagnosed with cancer each year; of these over half are for the four main cancers (185 female breast, 135 prostate, 143 lung and 136 colorectal cancers).

For lung cancer the one year survival rate in both Brighton & Hove and Sussex is significantly lower than the England average and has a considerable way to go in all areas before reaching International best practice.

The 2010 national patient experience survey showed that care and treatment at Brighton & Sussex University Hospital trust (BSUH) could be improved, particularly in terms of timeliness of first hospital appointment, and communication (written and verbal) about diagnostic tests, results, diagnosis, and treatment.

Preventing early death and increasing years of healthy life is a key theme within the joint health and wellbeing strategy, NHS Mandate and NHS Outcomes Framework. As set out in ' Everyone Counts: Planning for Patients 2013/14' specific measures from the NHS Outcomes Framework have been identified as best placed to provide assurance in planning and delivery, these measures include the under 75 mortality rate from cancer.

The Health and Wellbeing Strategy includes three areas for focus to make a difference:-

- Continue to invest in reducing the avoidable causes of cancer and support cancer survivors to lead a healthy lifestyle.
- Continue to invest in raising awareness of cancer signs and symptoms and providing support to primary care to encourage earlier presentation and referral, particularly in the more deprived areas of the city.
- Maintain continued implementation of former Sussex Cancer Network's delivery plans.

We as a Clinical Commissioning CCG are responsible for commissioning services for patients with the following common cancers with the exception of radiotherapy, chemotherapy and the specialist interventions as identified in The Manual for Prescribed Specialist Services.

- Bladder and kidney cancer (except specialist surgery)
- Breast cancer
- Germ cell cancer (initial diagnosis and treatment)
- Gynaecological cancers (Initial assessment of all cancers; treatment of early stage cervical and endometrial cancers)
- Haematological cancers and associated haemato-oncological pathology
- Lower gastrointestinal cancer
- Lung cancer (including pleural mesothelioma)
- Prostate cancer (except specialist surgery)
- Sarcoma (soft tissue where local surgery is appropriate)
- Skin cancer (except for patients with invasive skin cancer and those with cutaneous skin lymphomas)

Key Transformational Programmes

The CCG will establish a local Brighton and Hove Cancer Commissioning Team to support local priorities around cancer care. The CCG endorses and will support The all parliamentary group on cancer which have identified 5 domains:-

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

The CCG will also support and be aligned to the Strategic Cancer Network (SCN) strategy for improving cancer detection and cancer care and work to reconnect the commissioning responsibilities for the whole cancer pathway alongside our partners in the Local Area Team and Public Health.

The SCN has agreed to set up some Tumour Site events which would start to define what an ideal cancer pathway should look like from primary care to secondary care and beyond and will re-establish the Cancer Action Group. The SCN agreed to focus initially on Lung, Colorectal and Breast and events will start to take place from May onwards.

Brighton and Hove CCG will focus largely on improving early diagnosis and evidence based interventions to ensure we focus on service improvements which can significantly improve outcomes. The programme of work will be structured around the following key themes:

- Early Diagnosis in primary care
- Pathway design with secondary care (Colorectal and Lung)
- Educations of GP,s Health Professional, Patients and Carers
- Reducing diagnosis in A&E
- 2WW referral to conversion rates
- 2WW audit

This will include strategies to promote and improve awareness and efficient diagnostic pathways (lung and colorectal pathways and improved access to brain MRI, flexible sigmoidoscopy and

endoscopy). Good access and uptake to screening programmes will be promoted to facilitate more timely intervention; this is something the CCG is working closely with Public Health on.

We will continue to ensure a whole system approach to planning and performance management of cancer issues by giving these specific and regular focus at Single Performance Conversation with BSUH attended by specialised and CCG co-commissioners.

Finance and Activity

The CCG will invest £75k in 2014/15 for additional diagnostic testing associated with cancer. During 2014 we will further develop our cancer programme and associated finances.

Outcomes

Improving early detection:

(a) Develop early detection pathways for colorectal, lung, Prostate and Breast. Once completed and signed off, these pathways will be built into the best practice commissioning pathways.

(b) GP access to diagnostic testing will be improved by ensuring that specific direct access tests are available universally and effective access will be monitored by the Cancer Commissioning Team

(c) Development of an endoscopy commissioning strategy as part of early detection for colorectal cancers– this will be completed by the end of December 2014 with a view to developing provider implementation plans in mid 2015 for delivery in 2015/16.

Improving the consistency in 1 and 5 year survival rates across the city:

(a) Implementation of the four best practice commissioning pathways (colorectal, lung, prostate breast)

(b) Reduce unwarranted variation in care along pathways – to be monitored through the implementation of the best practice commissioning pathways

(c) Improving services for people living with and beyond cancer, including implementation of the National Cancer Survivorship Initiative (NCSI) recommendations. The NCSI has a focus on implementing a small number of deliverables – Holistic Needs Assessment, Treatment Plan, Treatment Summary (offered to 50% of patients by March 2014).

(d) Improving communication between secondary/tertiary and primary care – (over and above NCSI

The Cancer QIPP Plan will also contribute to the delivery of the following outcome ambitions:

Table 16: Cancer QIPP Contribution to Outcome Ambitions

Outcome Ambition	Measure	2012 Base-line	Target 2014/15	Target 2015/16
1. Securing additional years of life for the people of England with treatable mental and physical health conditions	Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare per 100,000 popula-tion	2141.3	2091.62	2041.94
2. Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions	Average health status (EQ-5D) score for individuals who identify themselves as having a long-term condition	73.5	74.24	74.98

Outcome Ambition	Measure	2012 Baseline	Target 2014/15	Target 2015/16
5. Increasing the number of people having a positive experience of hospital care	Rate of survey responses of a 'poor' experience of inpatient care per 100 patients	129.9	129.9	129.9
6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	Poor patient experience of primary care in GP services and GP out-of-hours services	5.9	5.72	5.54

6.9 Women, Children and Young People QIPP Summary

Introduction and Strategic Context

Strong collaborative working on shared agendas is essential to ensure children and families receive joined up care. During 2014/15 we will be reviewing our section 75 arrangements to ensure they are fit for purpose and will undertake a series of service reviews to inform suture commissioning.

Key Transformational Programmes

Child and adolescent mental health services (CAMHS)

We will undertake a multi-agency review of young people's mental and wider health issues. This will focus on early intervention, prevention and resilience building. Key to these developments will be effective working between children's and adult's services and improved and smoother transitions processes. We will continue to support initiatives such as online counselling and seek to engage further with digital and social media.

We will undertake further work with adult services to develop the available support for children and young people who have experienced sexual abuse, recognising the long term impact of such abuse and the importance of early intervention.

A limited additional psychological resource from CAMHS has been provided to work within the children's hospital to support the wellbeing of unwell children and those with long term conditions. Joint work with the children's diabetes team has led to the development of a screening tool to help identify those children that require psychological input. An evaluation intended to take place in 2014 will inform the further roll out of a model for integrating physical and mental health, particularly for children with long term conditions.

Service Reviews

- Transition (adolescent services)- We will undertake a review with key stakeholders to map transition from children's diabetes to adults. Engagement work with families and patients will be a key part of this.
- Joint work to define the transition pathway from community paediatrics to adult hospital/GP services will be undertaken.
- We are working with the Children's hospital to review their adolescent services with the local voluntary group for young people - Right Here.
- Children's Community Team (Hospital at Home)- A joint review of this team based at the children's hospital will enable a specification with key performance indicators to be

developed for this service and help to understand the gaps and how to improve integrated pathways with the community.

Women's Healthcare - Maternity Services

One of the clear strategic approaches for the CCG over the next 2 years will be to refocus on the role of general practice in maternity care. The Kings Fund research paper published in provides an overview of the reduction in the role of GPs in maternity care over time and concludes that GPs should not undertake intrapartum care but should be more involved in antenatal care, with particular responsibilities during the first trimester. The GP should be part of an effective team in which the roles, responsibilities and lines of communication are clear. Collaboration, co-operation, communication and competence are key. In order to enhance continuity and a provide a joined up holistic approach to women's and their families care the CCG needs to work with maternity services to ensure a more integrated approach.

Maternity Services in Brighton and Hove are provided by Brighton and Sussex University Hospitals Trust. There is an Obstetric Led Unit at the Royal Sussex County Hospital site. Women can also choose to have a Home Birth and locally these account for about 5% of births. Brighton does not currently provide full choice of birth place as it does not have a midwifery-led unit. Proposals for such a unit have been delayed in recent years but there are now plans being developed that will ultimately provide for increased capacity, a co-located birth centre and a women's health centre for both ante natal and gynaecology outpatients. The current timescale for the completion of all this work is 2015.

Women's Healthcare - Gynaecology Services

Most common gynaecological conditions can be successfully managed, at least initially, by GPs, especially where there is good communication with the local secondary care services.

A Working Party Report September 2012 by the Royal College of Obstetricians & Gynaecologists (RCOG) - Tomorrow's Specialist identified that Women need a specialist workforce that is able to work in integrated clinical teams, providing care locally where possible.

The collaboration between primary care, community sexual and reproductive health care and obstetrics and gynaecology specialist care must be central to the development of effective women's healthcare services.

A major focus for the CCG in 2014/15 will be to review the current provision of services in light of proposed plans to develop a Women's Health Centre in a community setting. It is proposed that this will cover both antenatal and low risk gynaecology care.

Assisted Reproductive Technologies (ART)

It is estimated that infertility affects 1 in 7 heterosexual couples in the UK and a greater proportion of people are now seeking help for such problems. If a woman does not become pregnant after treatment with medical and surgical techniques, usually provided in secondary care settings, she may choose to undergo more complex procedures, called ART, these are usually provided in tertiary settings. Examples of ART include in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI), cryopreservation and intra-uterine insemination (IUI).

Brighton and Hove currently operates a clear pathway and eligibility criteria for referral of women and couples from primary care through to secondary and tertiary care for sub fertility problems. A

number of significant factors including: the transfer of commissioning responsibility to CCGs for ART; Nice Guidelines (CG156) on fertility published in February 2013; and the Equalities Act (effective from October 2012) have led to a major review of this policy.

This review has been undertaken by the Health Policy Support Unit (HPSU) originally working across Kent and Sussex. It has been a rigorous and transparent process involving key stakeholders in order to ensure that it provides a robust framework for decision making by CCGs. The financial context taken for this review was that there is no additional funding available and as far as possible the CCG will not reduce the current level of ART service provision unless this is recommended by NICE and there is compelling reason to. The results of this review have only just been made available and the CCG will need to consider the financial and service impact before developing policy and guidelines to take forward during 2014/15.

6.10 Medicines Management QIPP Summary

Introduction and Strategic Context

We will continue to build on the excellent work achieved with partners across Sussex and in our local health community to promote medicines optimisation.

The Medicines Management Team will continue to provide expert input to the commissioning of services and will also deliver a Medicines Optimisation Project which will outline the key work plans for 2014/15 aligned to the following priorities:

- Promoting efficient medicines use by focusing on GP practice and clinical variation;
- Medicines optimisation in care pathway redesign, and further integrating the medicines management team with the commissioning teams;
- Local decision making and managing innovation;
- Quality and safety improvement; e.g. working with GP Practices to ensure patient's prescribing record includes medications prescribed elsewhere.
- Continue to build on the work on blueteq with partners to manage the Payment by Results Excluded Drugs;
- Collaboration with partners through the Brighton Area Prescribing Committee.

Key Transformational Programmes

Wound Care Project

We will roll out a new system and work with the community trust to tighten up the formulary choices. We will monitor the use of dressings and work collaboratively with our partners in the local health economy to optimise the use of dressings. This will help reduce wastage and improve adherence to the dressings element of the formulary.

Continence, stoma and Catheter supplies

We will embark on a project to optimise the use of these items and collaboratively develop guidance on appropriate choices and quantities. We will explore different procurement and ordering options and scope the options available. We will then implement the most efficient system throughout the CCG.

Care and Nursing Homes Medicines Management Support

We will continue to commission the medicines management reviews to our care and nursing homes.

We will build on this year's work and look to address systems issues highlighted in last year's and this year's work. We will continue to deliver QIPP savings without compromising on high quality care for the residents.

The wound care project and continence project will help underpin the work in the care homes.

Primary Care Prescribing Project

The CCG will continue to provide support to GP practices (including dedicated practice-based technicians) across the city to ensure optimisation of efficiencies in standard prescribing through the use of script switch and other projects in 'Better information for better decision making'.

Finance and Activity

The table below shows the investments and savings associated with the medicines management QIPP programme in 2014/15 (More detail is contained in Appendix 6 – Finance Schedule):

Table 17: Medicines Management Investment and Savings 2014-16

	Invest (£'000)	Save (£'000)	Net (£'000)
Nursing Home Project		(300)	(300)
ScriptSwitch		(300)	(300)
Patent endings		(150)	(150)
Switches/Tech Action Plan		(260.5)	(260.5)
PrescQIPP Drop list		(52.5)	(52.5)
Other		(100)	(100)
Total		(1,163)	(1,163)

6.11 NHS Continuing Health Care

Introduction and Strategic Context

We are committed to meeting our obligations under the National Framework for Continuing Health Care - in particular to provide assessments within the 28 day standard and to conduct regular reviews. The CCG has struggled, however, to meet the standards defined within the Framework given the increasing numbers of referrals and growing caseload as a result of the retrospective requests for assessments of eligibility for cases during the period 2004-12. In response to this we have invested in additional nurse assessment capacity to address the backlog of patients during 2014/15 and to ensure we meet standards on an on-going basis.

Key Transformational Programmes

Personal Health Budgets

From April 2014 we will be offering the choice of personal health budgets to all adults and children eligible for CHC. We are investing in the development of our assessors to enable them to work with patients and carers to support and build confidence in the clients to hold personal healthcare budgets and to have choice in the delivery of their support need. In order to deliver PHBs, a project manager, will be employed to work in partnership Brighton and Hove City Council and the voluntary sector to develop the infrastructure and systems necessary to offer and respond meaningfully to patients requests for PHB.

The NHS Funded Healthcare team will also undergo a restructure to enable them to work in locality teams in line with the CCG locality structure. They will develop relationships with the integrated primary care teams, in order to provide a reflexive service which can meet the needs of the localities

population, regularly assess clients alongside the service providers and support the CCGs commissioning responsibility around the assurance of high quality and cost effective service delivery.

Finance and Activity

The continuing health budget will include growth and additional funding for identified cost pressures.

Outcomes

PHB outcomes improving shared decision-making and responsiveness to individual needs for clients in receipt of PHB packages

- improving health outcomes through co-production;

For all CHC clients developing alternative, less-costly packages of care

- For all CHC clients reducing overall service use through greater prevention and integrated working

6.12 Primary Care Development

Introduction and Strategic Context

A high quality and sustainable model of general practice is essential not only because it provides for 90% of patient healthcare needs as delivered through the NHS but also because a strong and sustainable model of primary care is the bedrock of our transformational programmes and moving from a model of re-active bed based care to more proactive, preventative and holistic models of support.

During 2013 we have established a Primary Care Development Team, including three Locality Member Group (LMGs) each with a General Practitioner (GP) Chair supported by three Practice Nurses, four Practice managers and more recently six locality patient representatives. We will continue to engage with members of the public through our public events to ensure that we are driving changes in care that are patient centred at all times.

We will work closely with the Area Team to develop a Primary Care Development Strategy in 2014.

Key Transformational Programmes

Building work force capacity

The CCG recognises that transformation of the delivery of care, improved and expanded primary care and delivery of more services in the community requires a clear and consistent attention to workforce development and transformation.

The programme of transformation will require an expansion of the workforce, a review of the current skills set and knowledge across all professionals. This will support enhanced team structures and relationships to develop.

B & H CCG will work with all providers of health and social care to support these aims by

- Requiring frontline staff to be integral to the development of the frailty pathway
- Committing to building a program of support to enable staff to change ways of working based on their knowledge of the present system and the barriers to productive quality services
- Working with provider organisations and HEKSS and educational providers to ensure that workforce development is planned with the whole system requirements considered rather than in traditional professional or organisational silos

- Ensuring that every opportunity to educate and support staff is provided as multi-professional, multi organisational programmes.
- Ensuring that patients and users of services and their experiences inform the development needs of the staff to ensure that patient experience is improved
- Ensuring that every opportunity to build a flexible empowered workforce is taken
- Developing a career structure that provides opportunities for career progression in community and primary care

IT systems

We aim to develop IT systems across General Practice to enable a sharing of data – details are contained in the IM&T section of this plan (Section 12.2)

Reducing health inequalities and supporting outcomes

We will develop and work with charity partners such as Macmillan Cancer Support to pilot initiatives with National Early Detection & Awareness Initiatives (NAEDI).

We will utilise the data from the Primary Care Audit Tool & indicators and develop locally agreed outcome indicators to incentivise best practice. We will explore differing models of commissioning and supporting best practice in quality improvements in primary care.

We will develop a systematic way to quantify those patients with unmet needs and those in the community whose risk has not yet been detected.

Finance and Activity

The table below shows the investments associated with the primary care development plan in 2014/15 (More detail is contained in Appendix 6 – Finance Schedule):

Table 18: Primary Care Development Investment 2014-16

	Invest (£'000)	Save (£'000)	Net (£'000)
Enhancing quality and outcomes in primary care	500		500
Better Access to Better Information - Across the B&H Health Economy	543		543
Connected Information for Integrated Care - Across the B&H HE	666		666
Information about me and my care (Online Access to GP Recs and Servs)	287		287
Proactive Care of Older People	1,505		1,505
Total	**3,501**	**-**	**3,501**

Outcomes

The outcome measures associated with primary care will be developed with the strategy and following the results of the preventing premature mortality audit in Spring/Summer 2014.

7. Commissioning for Excluded Communities

Introduction and Strategic Context

Brighton and Hove is a diverse city. We have a large Lesbian, Gay, Bisexual and Transgender population and growing local communities of Black and Minority Ethnic people and Older people. The CCG has inherited a positive position from the Primary Care Trust in terms of the local NHS relationship with, and commissioning for, these well recognised, traditionally challenged, communities. Our five year plan details the unique population and needs of the city and outlines how we will work with all of these identified Groups.

In terms of the highest levels of need, local research (Public Health needs assessments and others) has shown that the most acute and worrying needs exist for Traveller, Transgender and Homeless people. The outcomes of these pieces of research have led to the CCG having a series of city wide targets and commitments to ensure that the needs of these most excluded communities get addressed. These, therefore, became the key priorities for the CCG in terms of its work to address inequalities.

Key Transformational Programmes

7.1 People from Traveller communities

At the time of the 2011 census there were 198 recorded traveller people in Brighton & Hove. Some of these will have been travellers who have chosen to settle in permanent housing. It is likely that a proportion of local travellers did not complete the census due to their itinerant lifestyle, being pitched on unauthorised encampments and their often low levels of literacy. Some 'van dwellers' (non-ethnic travellers parked in camper type vans on the highway) are most likely to have declared their actual ethnicity rather than using the Traveller category. In addition a proportion of Irish travellers are likely to have listed themselves under the 'White Irish' category rather than the 'White Traveller' category.

The City Council provides a transit site at Horsdean in the north edge of the City. This site allows travellers to temporarily park their caravans on 23 pitches. The likely occupancy of this site (based on an estimated 2 adults and 4 children per caravan) is 46 Traveller adults and 92 Children.

The City's Traveller Commissioning Strategy 2012 proposed a permanent site for Travellers to permanently pitch their caravans. This will increase the number of pitched caravans in the Brighton and Hove area by 16. The typical occupancy of this site (based on 2 adults and 4 children per caravan) is 32 Traveller adults and 64 Children. The Council has been consulting on the preferred permanent site prior to seeking planning permission.

Thus, by 2014 the CCG can expect to plan health care for a minimum of 234 Travellers (78 adults and 156 children).

The typical health needs of this community were defined in the Brighton & Hove 'Traveller Commissioning Strategy 2012' they include:

- Poor oral health especially among children
- Obesity
- Alcohol and substance misuse
- Poor mobility among older people
- Poor mental health especially among women and settled travellers
- Urinary tract infections and constipation due to poor toilet facilities
- High rates of miscarriage and stillbirth
- Lung cancer due to high levels of smoking
- Ageing prematurely and early deaths

The CCG's overarching commissioning objectives for Traveller people are:

- The CCG will ensure the delivery of Traveller cultural awareness training for Clinical Commissioners, GP staff, lead clinicians and Practice Patient Groups. The CCG will aim to deliver this with the support of a local voluntary sector organisation.
- The CCG will ensure ethnic monitoring undertaken by the CCG and its commissioned services includes the Council Traveller options.

- The CCG will work with NHS England's Local Area Team to ensure it continues to commission a specialist GP service for excluded communities including the Traveller and Homeless communities at Morley Street in Brighton.

7.2 Transgender people

The Trans Mental Health Study 2012, undertaken by the Gender Identity Research and Education Society (GIRES) was based on an online survey that generated responses from 889 people who had personal experience of transgender healthcare.

The Study showed that:

- 42 % had waited at least a year to be seen within a gender identity clinic
- 58 % felt that waiting had led to a worsening of their mental health or emotional wellbeing
- 46 % of those seen at a gender identity clinic had experienced difficulties that included administrative errors, restrictive protocols, problematic attitudes and unnecessary questions/tests
- 20 % had wanted to harm themselves in relation to or because of involvement with a gender identity clinic or health service

The Study reinforces the case for offering speedy and benign treatment:

- 85 % were more satisfied with their body since undertaking hormone therapy
- 74 % felt that their mental health had improved as a result of transitioning

The CCG's overarching commissioning objectives for Transgender people are:

- The CCG commission a programme of training for GP practices and Practice Patient Groups.
- The CCG will investigate options to deliver an online resource and printed resource to provide information for patients about the gender identity care pathway.
- The CCG will work with the local Area Team to consider commissioning a Gender Identity Clinic to provide a Brighton & Hove satellite service

7.3 Homeless people

Brighton and Hove CCG, in partnership with the City Council, Public Health, the Third Sector, Primary Care, Community Healthcare, Mental Health and Substance Misuse Services and Secondary Healthcare providers are keen to pioneer a person centred model of health, social care and housing support to homeless people in the City.

We have chosen this cohort of individuals as they are some of our most vulnerable individuals, often with a combination of physical ill-health with mental illness and substance misuse (drug and alcohol), complex health needs and premature death. The City is seeing a year on year rise in homelessness. Homeless people are more likely to use A&E, spend time in hospital and to be heavy users of mental health and substance misuse services. Despite some beacons of good local practice and innovation there has never been a strong enough focus on a multi-agency personalised joined up approach in the City. We are aware that some of our current services can operate within rigid boundaries – geographical, cultural, organisational, systemic and legal frameworks – and therefore prevent homeless people from accessing the healthcare and support they require.

There has been a sharp increase in the number of recorded rough sleepers in the City. In November 2011 the official rough sleeper street count was 37, up from 14 the previous year. This is

an increase of more than 160% compared with a national increase of 23%.

Our aim is to provide a high quality primary care focused model of support for homeless people in the City (as part of our Better Care Programme), shifting the focus from crisis management to preventative, proactive care, service co-ordination and case management. This will not only provide a better quality intervention and health outcome for the person concerned but these models have been shown to be cost effective to the health economy including reducing hospital admissions and in-patient stays. Additionally, targeted health interventions for homeless people have been shown to reduce the amount of time that people are homeless.

Our model will offer a single point of access with a common assessment framework. Care will be integrated horizontally through the establishment of a co-located primary care led MDT with patient centred care planning at the heart of the model and continuity of care across service provision, namely: primary care, community nursing and therapy services, mental health, substance misuse and alcohol services, social services, learning disability services, third sector and housing support. We would ensure vertical integration with secondary care through clear integrated pathways of care and a model of in-reach and strengthen our Intermediate /Respite Care in order to avert unnecessary secondary care.

All partner agencies are committed to co-locating staff within a newly established MDT and working within a whole system governance framework. We have a history of successful integrating of service provision in the City which we can draw on including multidisciplinary Hospital Rapid Discharge Team at the front door of A&E comprising Social Workers, Therapy and Nursing staff, Integrated Primary Care Teams (nursing, therapy, and social workers) configured around clusters of GP Practices and integrated health and social care services in adult mental health, dementia services and substance misuse.

8. Supporting Programmes of work

The QIPP section of the plan describes significant programmes which are key elements of our commissioning intentions and Operating Plan for 2014-16. In addition to these large scale transformation programmes we will also undertake a number of smaller redesign projects. These additional commissioning intentions are outlined in Appendix 5 and 6.

9. Reducing Inequalities

Embedded in the CCG plans are a range of high impact, evidence based interventions to improve health outcomes and reduce health inequalities in 2014/15 and beyond. These include the high impact interventions detailed in the Any Town Commissioner Pack. For ease of reference the high impact interventions are mapped to the relevant QIPP scheme in the table contained in Appendix 8.

In addition to the commissioning plans described in the previous section, the CCG plans to commission a range of high impact, evidence based interventions to improve health outcomes in 2014/15 supported by improved Business Intelligence tools and facilitated GP audits.

The type of evidence based interventions being considered are summarised in the table X below. These will be prioritised for investment following the outcome of the local Preventing Premature Mortality Audit (PPMA). The CCG has identified £0.5m investment funding to implement the outcomes of the PPMA.

Table 19: Evidenced based interventions to improve health outcomes

Indicator	Action
Cardiovascular disease: Secondary prevention	Four treatments (beta blocker, aspirin, ACE inhibitor, statin) for all patients with a previous CVD
Additional treatment for hypertensives with no previous CVD event	Additional hypertensive therapy Statin treatment for hypertensives with high CVD risk.
Treatment for heart attack	Primary angioplasty (PCI) for heart attack.
Anticoagulant therapy (Warfarin) for all patients over 65 with atrial fibrillation	Review and improve provision of anti-coagulation services in Brighton
Diabetes	Reducing blood sugars (HbA1c) over 7.5 by one unit
Chronic obstructive pulmonary disease	Statins to address CVD risk among COPD patients
Reducing smoking in pregnancy	Eliminating smoking in pregnancy (infant deaths averted)
Harmful alcohol consumption	Brief intervention for 10% of harmful drinkers
Lung cancer	Increasing rates of early presentation
Smoking cessation clinics (setting a quit date)	Increasing rates of early presentation

10. South East Coast Strategic Clinical Networks

The CCG works collaboratively with the South East Coast Strategic Clinical Network (SCN) to improve care for cancer, heart, stroke, diabetes, renal, maternity, children and young people, mental health, dementia and neurological conditions.

The figure below summarises the SCN work plan and outcomes.

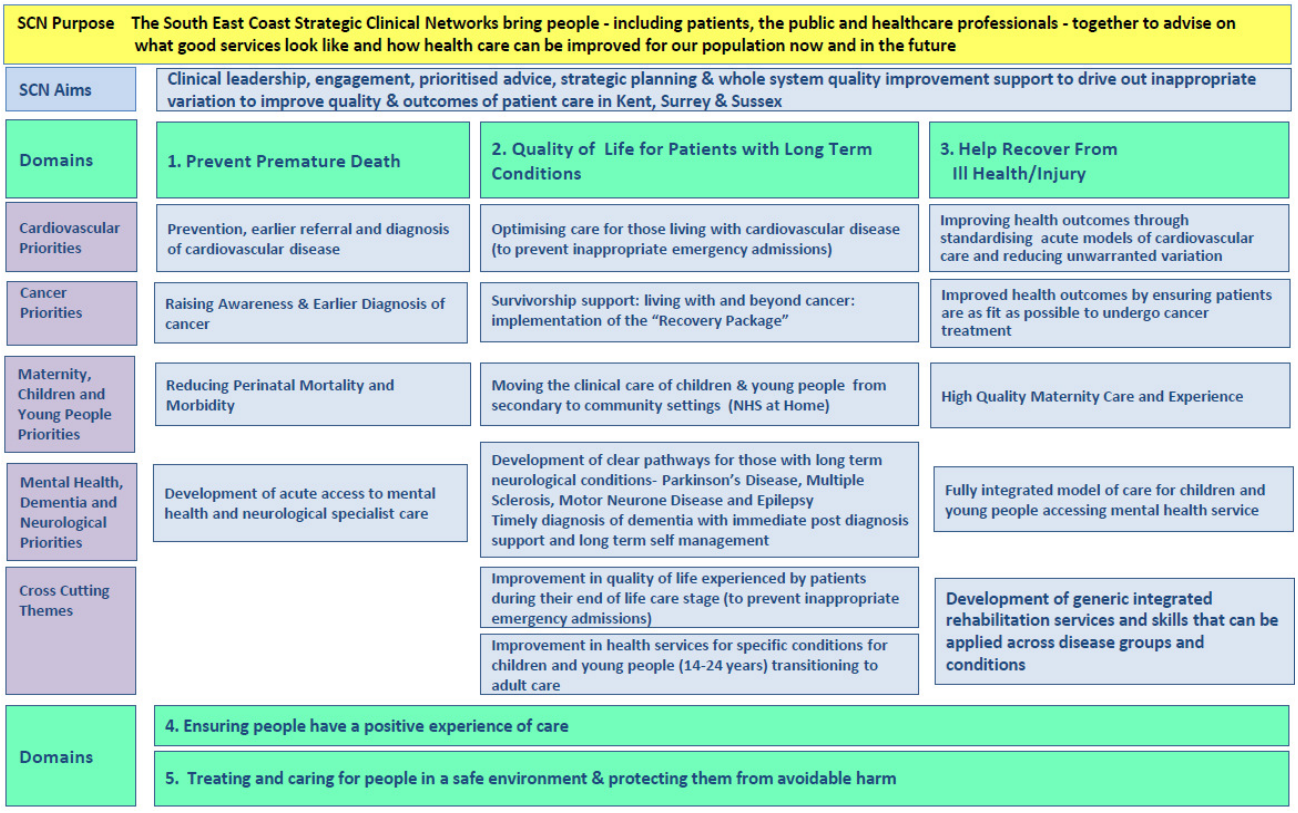


Figure 3: SCN work plan

The role of the SCN includes using national and local data as baselines, agreeing a clinical consensus on standards and developing options for implementation. We have used the SCN recommendations to inform several elements of our commissioning plan and will continue to work closely with the network to further improve and develop the services we commission.

11. Summary of QIPP

11.1 Finance

The CCG financial plans comply with the financial framework we have been set and are summarised below:

Table 20: Financial Planning Assumptions

	14/15	15/16
% Allocation Growth	2.14%	1.70%
Tariff Deflator (Estimate)	-1.50%	-1.80%
Activity Growth	2.35%	2.35%
CQUIN	2.50%	2.50%
Prescribing Inflation	5.00%	5.00%
CHC Inflation	3.50%	3.50%
Contingency	0.50%	0.50%
BCF (Estimate)	0.00%	3.00%
Non-Recurrent Expenditure Reserve	2.50%	2.00%
Planned Surplus	3.50%	2.50%

Table 21: Summary Financial Plan 2014-2016

	14/15	15/16
	£'000's	£'000's
Growth	7,264	5,869
Return of Prior Year Surplus	5,269	14,556
Additional Surplus	6,969	-
QIPP & Efficiency Savings	5,955	8,888
Total Funding Available	**25,457**	**29,313**
Cost Pressures	4,753	2,000
Growth / Inflation / Tariff / CQUIN	4,354	5,803
Contingency	1,794	1,859
BCF (Estimate)	-	10,357
Planned Surplus	14,556	9,294
Total Funds Utilised	**25,457**	**29,313**

Non-Rec Expenditure Reserve	**8,486**	**6,902**

The CCG has identified the QIPP savings required for 14/15 (~£6m) but more work is required on the investment required to release savings in future years. Of the QIPP target for 15/16 (~£8.8m) £6m has been identified. During 2014 we will refine our plans to more accurately reflect the savings that they will deliver in 2015/16 and beyond.

Appendix 6 contains the detailed financial schedule for 2014-2016.

The CCG has built up a 'war chest' to ensure that it moves from 2013/14 into 2014/15 in the strongest position it can be in. This gives the Brighton health and social care system the ability to be ambitious with its transformational schemes. Following the finalisation of the suite of schemes in both years a thorough risk assessment will be undertaken, appropriate interventions identified and the service and financial plans amended if necessary to reflect actual delivery.

The table below shows the financial impact (£'000) by health sector and reflects our plans to reduce acute spend and invest in community and primary care services. During 2014/15 we plan to reduce hospital spend by ~£4.7m and increase community and primary care spend by ~£2.3m and ~£2.4m respectively:

Table 22; Financial Impact of QIPP by Health Sector 2014-2016

Health Sector	14/15 Plan
Community Care	2,303
Primary care	2,441
Hospital Care	(4,730)
Medicines Management	(1,000)

11.2 Acute Activity

The overall impact of the QIPP schemes on acute hospital activity is contained in the table below. In summary the QIPP schemes will reduce non elective admissions by 4.4% and follow up attendances by 3.8% in 2014/15. In 2015/16 non-electives will be reduced by a further 3%. This change in activity reflects the shift to strengthened community and primary care services.

Table 23; Activity Impact of QIPP 2014-2016

CCG Activity	Elective Admissions	Referrals	Non-elective Admissions	First Outpatient Attendances	Subsequent Outpatient Attendances
2014/15 Total	30,290	90,484	24,430	63,802	181,527
2013/14 Forecast Outturn	30,163	90,838	25,565	63,664	188,769
Forecast growth in 2014/15	0.4%	-0.4%	-4.4%	0.2%	-3.8%
2015/16 Total	30,414	90,158	24,659	63,986	182,085
Forecast growth in 2015/16	0.4%	-0.4%	-3%	0.3%	0.3%

A full activity schedule is contained in Appendix 7.

12. Enabling Strategies

12.1 Quality and Safety

Quality and safety in the delivery of health services, is the fundamental core of every commissioning and provider organisation. Within Brighton & Hove Clinical Commissioning Group (CCG), quality is defined as clinical effectiveness, patient experience and patient safety. We are committed to ensuring patient focussed outcomes arising from the standards should be embedded in service redesign, planning and commissioning and that all contracts are robustly monitored, in order to provide assurance that the quality standards and outcomes are being met.

We take full regard of the recommendations from the Francis Report (Department of Health 2013), and will seek assurance from providers that;

- fundamental standards and measures of compliance are always met
- they demonstrate openness and candour
- they promote and provide compassionate, caring and committed clinical staff
- they promote strong healthcare leadership
- they provide information and data that is transparent to service users and the public

We formally monitor the quality and patient safety of our three main NHS providers by meeting with them monthly. For Brighton and Sussex University Hospital NHS Trust we are the co-ordinating commissioner and fulfil this role for our partner CCGs and NHS England. Sussex Partnership NHS Foundation Trust (SPFT) and Sussex Community Trust (SCT) co-ordinating commissioners are Costal West Sussex CCG and Horsham & Mid Sussex CCG respectively. We have a robust framework assuring information sharing and joint decision making regarding quality and safety issues with both these partner CCGs.

We are committed to building relationships with other smaller providers and developing a work program to monitor quality and patient safety relative to the scope and risk of each of the contracts.

Our focus over the next two years will be to:

Table 24; Quality and Safety Work Streams

Workstream	Description
Patient Safety	We are hosting the Patient Safety Team for all the Sussex CCGs, building on the benefits of the pan Sussex approach to managing Serious Incident and Never Event reporting and learning. B&H CCG is committed to ensuring the use of NICE Guidance in its decision making and has committed to work with the local NICE Field Agent to support the development of NICE guidance.
Patient Safety Champions in Primary Care	Working with the NHS England Area Team and the Local Member Group practice nurse representatives and practice nurse forum we will be supporting the development of primary care patient safety champions. Developing a culture and capacity in the workforce to support the ethos of patient safety throughout the pathway of care, building confidence in the system and sharing good practice.
Infection Prevention and Control resources	We will host the jointly commissioned Infection Control Practitioner with Costal West Sussex CCG. This post will lead on infection control and prevention, survey, review and analyse healthcare associated infections (HCAIs) and support cross agency working to facilitate standardised approach to infection prevention and control. Clostridium Difficile (C-Diff): We will be working with provider organisations and across the pathway of care alongside our medicines management team to ensure the reduction in avoidable C-Diff cases. Methicillin Resistant Staphylococcus Aureus (MRSA): There is a zero tolerance to avoidable MRSA. We will continue to work with providers and monitor the outcome of the investigation of any cases.
Decontamination Advice	We jointly commission, with Costal West Sussex, a decontamination expert in order that B&H CCG has access to technical advice and guidance. This will support the CCG to manage the safety of patients in current and newly commissioned services.
Quality monitoring	There will continue to be a program of formal quality and patient safety monitoring and challenge through quality review meetings with the 3 large NHS providers. There is a program of meetings with local Care Quality Commission and Health-watch representatives to share intelligence. Local General Practitioners are also responsible for feeding patient experience and issues in to the system via a dedicated email address.
Safer staffing and Workforce Development	We will ensure that individual providers maintain a process of assurance that service redesign and development has Chief Nurse and Medical Director agreement that patient safety will not be compromised. B&H CCG will engage through membership of the Lead Nurse network with

Workstream	Description
	the National review of safe staffing underway at present.
Patient Experience	We commit to assure that patient feedback drives the development and improvement of services. The Friends and Family Test is mandatory in acute settings and maternity settings and will form a part of the quality review information. Patient experience feedback will also inform the quality monitoring though CCG held public events, national patient surveys, GP practice patient forum and Local member group patient representative feedback
Safeguarding	Protecting vulnerable adults and children is a multi-agency responsibility and depends of excellent communication and information sharing. Adults: Our Lead Nurse and Director of Clinical Quality & Primary Care is the Executive Lead for Safeguarding. All Quality and Patient Safety managers will also have level 3 adult safeguarding training and are able to undertake Health Investigations. It is anticipated that during the year 2014-15, Adult Safeguarding will become a statutory requirement and will require additional resource both in the form of named doctor (part time) and a financial contribution to the Adult Safeguarding Board running cost. Children: Our Lead Nurse and Director of Clinical Quality & Primary Care is the Executive Lead for Safeguarding and sits on the B&H Local Safeguarding Children's Board (LSCB) We have a Designated Safeguarding Children's Nurse We commission a Designated Doctor to support the CCGs strategic responsibilities and planning, and we have a Named GP to support primary Care.
Winterbourne View Concordat	B&H CCG has been working in partnership with the City Council through a section 75 agreement to deliver improvements in the care for individuals with learning disabilities and are in a placement out of the area. Repatriation is the aim where possible. All individuals have a dedicated case manager to support this aim.
Clinical pathway redesign	All Clinical Quality and Patient safety managers employed in the quality governance team will be working with commissioning managers, and primary care clinical leads to support the development of care pathways and service redesign, assuring a focus on the quality and safety of services
Facilitating partnership working across the system	We will continue to support and facilitate the Nursing Home forum. Bring together clinicians and mangers from the private sector, the acute, community, mental health and primary care providers in order to develop an shared understanding of the challenges and pressures, facilitate the sharing of good practice, and to support the development of partnership working in order to ensure the best outcomes for in particular but not exclusively older people and those who are vulnerable.

12.2

12.3 Information Management and Technology (IM&T)

The ability to access and share accurate data is a key enabler supporting the delivery of the CCG vision and QIPP schemes. The table below summarises the IM&T work streams:

Table 25; Clinical Informatics Work plan

Workstream	In 2014 we will implement:	In 2015 we will implement:
Empowering Patients: We will develop patient centered information systems, around the GP record. We will develop information and knowledge systems which enable and empower patients to become proactive partners in their health and care.	Online prescription renewals, online appointment booking Telecare[1] pilot Results[2] reporting pilot Pilot of combining patient GP record access with Provider and Social Care data	Telephone, email and videoconference consultations Telecare roll-out Results recording roll out Patient access to GP Detailed Care Record [3] Patients prescribed Apps[4] to support self-care e.g. weight loss, medicines management
Clinicians Managing Care We will aim to avoid islands of information and instead make relevant and real time clinical patient-centered information available along the care pathway and across care boundaries to provide seamless high quality and safe care.	EPaCCS[5] delivers improved End of Life Care Co-ordination Project 'ROCI' [6]delivers single view of Health and Social Care data across Brighton and Hove SCR[7] viewing across all Urgent Care Settings MIG[8] viewing across some settings shares GP patient data with acute, community and health and social care Informatics to support integrated Health and Social Care integration planning and pilots Clinical Correspondence [9]roll out to GPs and Providers beyond BSUH Electronic prescriptions pilot GP Online results ordering Enhanced Summary Care Record	e-Referrals [10]roll out, incremental improvements as led by HSCIC[11] Full Health and Social Care integration Full Clinical Correspondence roll-out to all significant providers and all BSUH services and new AQP[12] Coded CDA [13]pilot for prescriptions recorded elsewhere, Diabetes, estimated date of discharge etc. (subject to HSCIC approval and engagement) BSUH Electronic Patient Record (EPR [14]) roll-out SCT new Patient Administration System roll-out completes
Informing Future Plans: We will improve the quality of management	Improved CCG access to Business Intelligence [15](BI)	Further dashboard development inte-grating more providers and patient feed-

[1] Telecare: http://en.wikipedia.org/wiki/Telecare
[2] Results reporting : allow patient to record results e.g. Blood Pressure at home and save into GP record
[3] GP Detailed Care Record: More detailed information from your GP record than in the Summary Care Record, but less than the full GP record (likely to exclude text fields, for example)
[4] App: SmartPhone application: http://en.wikipedia.org/wiki/Mobile_application_software
[5] EPaCCS: Electronic Palliative Care Co-ordination System
[6] Project "ROCI" – Read Only Clinical Information -
[7] SCR: Summary Care Record www.nhscarerecords.nhs.uk/
[8] MIG – Medical Interoperability Gateway – another way to share GP Records between GPs and other care settings, see www.healthcaregateway.co.uk/
[9] Clinical Correspondence: http://medical-dictionary.thefreedictionary.com/clinical+correspondence
[10] E-Referrals: http://systems.hscic.gov.uk/ers
[11] HSCIC: Health and Social Care Information Centre http://www.hscic.gov.uk/
[12] AQP: Any Qualified Provider; http://www.nhs.uk/choiceintheNHS/Yourchoices/any-qualified-provider/Pages/aqp.aspx
[13] Coded CDA (technical) http://en.wikipedia.org/wiki/Clinical_Document_Architecture
[14] Electronic Patient Record (EPR): The definition of an EPR is fluid, see http://www.ehi.co.uk/news/ehi/8587/big-epr-survey-reveals-components-of-epr and http://www.himssanalytics.org/emram/emram.aspx
[15] Business Intelligence: http://en.wikipedia.org/wiki/Business_Intelligence

Workstream	In 2014 we will implement:	In 2015 we will implement:
information and reduce costs by deriving it from linked clinical information to provide an integrated picture of service provision, quality and patient experience. We will deliver a single point of reference for clinical and commissioning knowledge and guidance to help deliver care that is based on best practice clinical knowledge.	Data Warehouse [16]and dashboard tools, including Social Care Primary Care data consolidated in Centers of Excellence to support ad-hoc analysis Primary Care Dashboard [17]including patient Long Term Condition management dashboards, Workload, PbR[18]-like dashboard and updated population risk stratification	back
Delegated IT Functions We will establish governance processes to ensure we can work collaboratively with the local health community and continue to support the business needs of the CCG. We will maintain common IT communication infrastructure across Sussex.	Establish GP System Centres of Excellence Re-establish GP EPR [19]accreditation to audit GP record data quality Support for GP practices collaboration for improved outcomes Planned refresh of GP PCs established Windows 7 upgrades N3[20] capacity planning for GP surgeries Pop Up Practice infrastructure in place COIN Migration	Ongoing COIN[21] migration More support for GP practices collaboration for improved outcomes

12.4 Working with the Community and Voluntary Sector (CVS)

Brighton and Hove has a vibrant and robust CVS, who are key stakeholders alongside statutory partners in developing our vision for higher quality care for the local population in Brighton and Hove.

The CCG will continue to work with Community Works, ensuring that their members receive relevant information about local NHS developments and opportunities to be involved in delivering commissioning plans. Work will continue to be progressed to ensure that the CVS is central to the CCG's engagement mechanisms

12.5 Co-ordinating Commissioner Role

BHC CCG as co-ordinating commissioner for BSUH has an agreed negotiating strategy with neighbouring CCGs and associate signatories to the contract. The baseline assumptions include growth based on forecast population increases and reflect seasonality. The following section summarises the key elements of the negotiation and subsequent contract with BSUH:

In December 2013 an A&E audit suggested that a proportion of admissions could have been avoided or better managed through a non-admitted pathway. In order to ensure delivery of the new

[16] Data Warehouse: http://en.wikipedia.org/wiki/Data_warehouse
[17] Dashboard (Business Intelligence): http://searchbusinessanalytics.techtarget.com/definition/business-intelligence-dashboard
[18] PbR: Payment by Results: http://www.hscic.gov.uk/article/2047/Introduction-to-Payment-by-Results
[19] GP EPR Accreditation: This is a data quality standard for GP Practices see http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/links/gpelec2011.pdf
[20]N3: NHS New National (Data) Network; N3 is the NHS's private data network, see http://n3.nhs.uk/technicalinformation/n3networkoverview.cfm
[21] COIN: (Networking) Community of Interest allows different sites to join more effectively http://n3.nhs.uk/n3cloudconnect/coins.cfm

model of care a Commissioning for Quality and Innovation (CQUIN) has been linked to this pathway change.

In 2013/14, the maternity pathway currency and national prices were mandated for use. To mitigate the financial impact of the new pathway payment approach, providers and commissioners were asked to share any resulting estimated financial gain or loss in 2013/14. These provisions for sharing financial risk will continue in 2014/15.

Sussex Rehabilitation Centre is currently purchased on a block contract basis. The CCG has proposed that this move to a cost per case pricing model to ensure fair reimbursement of services provided.

The BSUH contract is lacking comprehensive service specifications for the services provided. By the end of 2014/15 within the contract there will be 40 specifications agreed between clinical colleagues for the highest volume procedures and reasons for referral

12.6 Delivering NHS Constitution Rights and Pledges

The NHS Constitution establishes the principles and values of the NHS in England; sets out the legal rights of patients, public and staff, and the further pledges which the NHS is committed to achieve; and sets out the responsibilities of public, patients and staff.

We are committed to meeting the obligations and expectations placed upon the CCG by the NHS Constitution. We will also do all we can to promote patient rights, address concerns where these are brought to our attention, and support our providers in doing the same.

The CCG built on the strong local performance of previous years by meeting most nationally-mandated targets in 2013-2014 (see appendix 2).

Access to elective services continued to improve with 93% of planned inpatient cases and 97% of outpatient waiting less than 18 weeks. We also continued to deliver the 6 week diagnostic waiting time target with less than 0.5% of patients waiting longer. In addition all cancer access targets were achieved by year end.

Access to urgent care - specifically the 4 hour A&E waiting time – remains a concern for us. We continue to work with and support our local acute trust to improve performance in this area.

Performance against maternity targets and standards at Brighton has improved steadily in the last 2 years. Recent additional investment in midwifery posts has seen an improvement in the midwife: birth ratio, bringing it down to 1:30 from 1:34;it will also impact on the homebirth rate as a 24/7 Home Birth Service has been implemented. Caesarean section rates, however, provide a very variable picture from month to month despite work to promote a culture of normalising birth. An audit of the Birthing Choices Clinic is proposed in 2014 to understand in more detail the choices women make with regard to child birth.

Brighton and Hove CCG will continue to monitor all maternity key performance indicators for our local population and work with our parent – led Maternity Services Liaison Committee to ensure that local women continue to have a positive and safe experience of maternity services.

We have rigorous processes for monitoring performance and have developed, in conjunction with our CSU colleagues, better early warning systems so that action can be taken proactively rather than retrospectively.

13. Monitoring Performance and Managing Risk

13.1 Project Management Office (PMO)

CCG projects, contracts and National and Local targets are reviewed on a six week rolling programme by the project management office to ensure they are being delivered in accordance with best practice and in line with agreed timescales. The group tracks milestones, key performance indicators, risk registers, patient engagement in service redesign, information governance, finance and activity delivery against plans and compliance with the duties set out in the Public Sector Equality Act primarily through ensuring Equality Impact Assessments are completed at the on-set of projects and that any mitigating actions identified through this process are undertaken.

Issues identified through the PMO process are escalated to The Operational Leadership Team (OLT) and to the Governing Body through monthly reporting.

13.2 Risk management

Risk management is a fundamental part of quality and safety assurance and the CCG has an integrated Risk Management Framework covering clinical, financial and corporate risks.

The organisation has an established risk management system which identifies and tracks project and team level risks which feed into a corporate risk register which is updated monthly. The Corporate risk register brings together the risks collected from team and project risk registers and maps them to the principal organisational risks identified by the Governing Body and partners across the city. This process is described in our Assurance Framework. Relevant information is presented to the Quality Assurance Committee, Operational Leadership Team (OLT) and Governing Body, and there are clear mechanisms through which quality and patient safety risks are escalated and resolved. The Operating Plan risk register is contained in Appendix 8.

13.3 Procurement Schedule

Details of our approach to procurement are contained within our 5 Year Plan and in more detail in our Procurement Strategy. Current assessment of our plans suggests we will be considering procurement options in the following areas over the next two years:

- Integrated Diabetes Service
- Anti-coagulation Service
- Community Bladder and Bowel Service
- Integrated Community Equipment Store
- Substance misuses services
- Integrated Urgent Care
- Continence, stoma and catheter supplies
- Pro-active crisis prevention for adults with learning disabilities
- Information Management and Technology (including clinical informatics systems)

14. Organisational Development

During 2013, the CCG undertook a significant revision of our Organisational Development Plan. In doing so we:

- conducted a series of workshops with staff and clinicians and assessed ourselves against the competencies outlined in the national CCG Assurance Framework;
- with support from Foresight Partnership, conducted a 360° feedback with internal and external partners to assess our strengths and identify areas for development;
- collated the Personal Development Plans of staff and clinicians, reviewed the feedback from coaching and mentoring programmes and drew on external audit findings to identify key development themes for the organisation.

A wealth of information was gathered from these exercises, all of which is available as separate more detailed reports. For the purpose of the OD refresh however, we elected priority areas over the coming 18 months and structured our plan around three key areas:

14.1 Our Outcomes

We need to ensure that, through our efforts, we are having the necessary impact on the health and wellbeing of our population and commissioning for a sustainable health system.

In 2015 we will continue to refresh our 5 year Strategy and commissioning plans focusing particularly on those areas where we know we are not having the necessary impact on health outcomes or effectively addressing health inequalities.

Commencing in May 2015 we will work with NHS IQ for a 9 month period on a whole system programme of OD support for large scale change aligned to our Better Care Frailty Transformation Programme.

We will fully implement the Social Value Act and embed its principles within our commissioned pathways, governance structures and procurement processes.

14.2 Our Processes

We need to ensure our business processes are robust, our systems, governance and decision making are clear and well understood, our accountability to member practices is optimised and we have effective systems for engaging with provider bodies, the public, stakeholders and partner organisations.

With Foresight Partnership we will continue our programme of Governing Body development focusing specifically on streamlining our governance arrangements and strengthening two way accountability with member practices.

We will refresh our patient and public engagement strategy and revise our constitution to strengthen the governance arrangements around PPGs.

We will strengthen our own business continuity arrangements and resilience and work in a co-ordinated way with our providers and partner agencies to strengthen and streamline escalation processes.

14.3 Our People

Our people are our greatest asset. We need to ensure we invest in our staff and clinicians to develop and maintain the necessary skills and expertise to do their jobs effectively, to feel valued and supported in the work that they do and to be able to demonstrate that they are making a difference.

We will continue to have a very significant emphasis on clinical leadership and continue with our coaching programme for clinical leads. We will commission a further year of the University of Sussex Commissioning course for the next cohort of Practice Leads and commission ongoing themed sessions three times a year for "graduates" of the university course.

We are keen to invest in future generations of clinical commissioning leaders and commissioning managers and aim to become an accredited placement for MTS students (we currently have an MTS student placed in the CCG), have signed up to a rolling programme of apprenticeships with City College and GP registrars will be offered a 6 month placement as part of their training programme with the CCG – our first GP registrar will start in April 2015.

We have compiled a very extensive programme of training and development for all members of the CCG ranging from E&D training to report writing, practical commissioning skills to accredited management/leadership courses. We will continue to strengthen our mechanisms for acknowledging and rewarding good practice.

We will also continue to have a specific focus on promoting health and wellbeing in the workplace. In 2015 we will implement our "Work Well Plan"and amongst other things offer yoga and mindfulness sessions for staff during lunch time.

15. Sustainability

The CCG is committed to being a Sustainable Commissioning organisation. Our sustainability plan commits us to actions under the following three headings:

15.1 Commissioning for Sustainability:

- Ensuring our clinical pathway designs address prevention, quality, innovation productivity and integration.
- Delivering our duties under the Social Value Act of 2012 and embedding social value and community assets in our procurement practice.
- Fully utilising contractual levers to ensure sustainable practice within commissioned services.

15.2 Being Sustainable as an Organisation

- Ensuring we have energy efficient business processes;
- Paying our staff the City's living wage;
- Providing a workplace which facilitates health and wellbeing.
- Striving for the CCG and Primary Care to become paperless

15.3 Leading our Member Practices

- Supporting general practice with energy audits and top 10 high impact actions;
- Addressing areas such as medicines wastage;
- Facilitating enablers such as the roll out of electronic prescriptions;

- Agreeing a programme of work with member practices and developing a “sustainability pledge” for members.

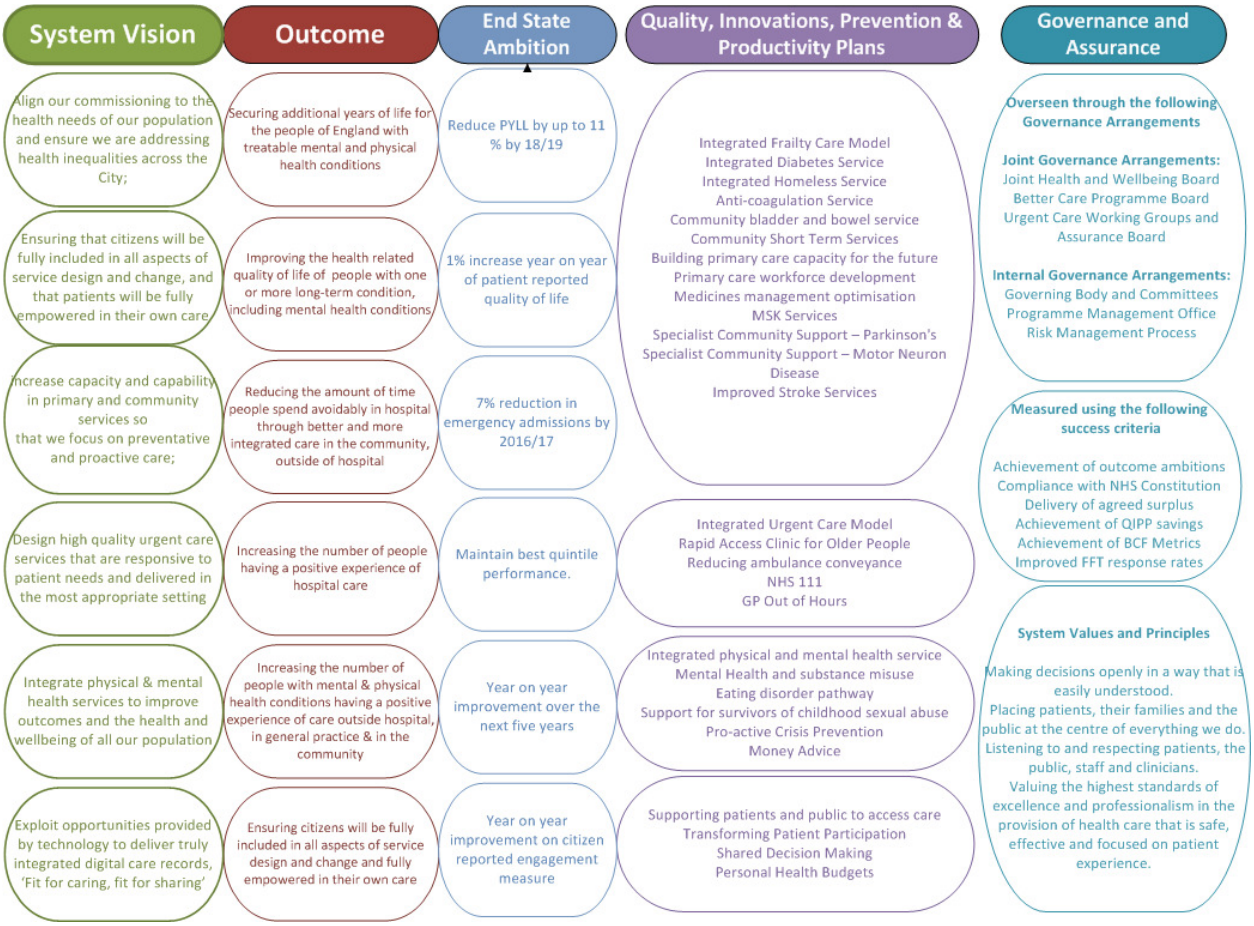
16. Conclusion

The CCG is confident that through delivery of the plans outlined in this document we can deliver services that meet the needs of the people of Brighton and Hove whilst delivering financial stability and driving forward our strategic objectives over the next two years.

17. Glossary

AQP	Any Qualified Provider
BSUH	Brighton and Sussex University Hospital Trust
CAMHS	Children and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRRS	Community Rapid Response Service
CSG	Clinical Strategy Group
CSU	Commissioning Support Unit
CVS	Community Volunteer Sector
DES	Direct Enhanced Service
GP	General Practitioner
HCAI	Health Care Acquired Infection
IAPT	Improved Access to Psychological Therapies
JHWB	Joint Health and Wellbeing Board
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LES	Local Enhanced Service
LMG	Local Member Group
LTC	Long Term Conditions
MDT	Multi-disciplinary Team
MSK	Musculoskeletal
NICE	National Institute for Health and Clinical Excellence
OOH	Out of Hours
PBR	Payment by Results
PPG	Patient Participation Group
PROMS	Patient recorded outcome measures
PSED	Public Sector Equality Duty
QAC	Quality Assurance Committee
QIPP	Quality, Innovation, Productivity and Prevention
ONS	Office of National Statistics
QOF	Quality Outcome Framework
RACOP	Rapid Access Assessment Clinic for Older People
RSCH	Royal Sussex County Hospital
SCT	Sussex Community Trust
SPFT	Sussex Partnership Foundation Trust

Appendix 1 – Plan on a Page



Appendix 2 – NHS Constitution Measures

NHS Constitution	This Period					Year to Date				
	Latest Period	Plan / Target	Actual	Var	RAG / Change	Plan / Target	YTD	YTD Var	RAG	Info
A and E - Monthly										
Percentage of patients who spent 4 hours or less in A&E	Feb 14	>=95.0%	89.8%	-5.2%						
Cancer - Monthly										
All cancer two week wait	Jan 14	>=93.0%	84.9%	-8.2%		>=93.0%	93.8%	0.8%		
Two week wait for breast symptoms (where cancer was not initially suspected)	Jan 14	>=93.0%	100.0%	7.0%		>=93.0%	97.8%	4.8%		
Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis	Jan 14	>=96.0%	95.5%	-0.5%		>=96.0%	97.6%	1.6%		
31-day standard for subsequent cancer treatments-surgery	Jan 14	>=94.0%	100.0%	6.0%		>=94.0%	98.7%	4.7%		
31-day standard for subsequent cancer treatments-anti cancer drug regimens	Jan 14	>=98.0%	100.0%	2.0%		>=98.0%	100.0%	2.0%		
31-day standard for subsequent cancer treatments-radiotherapy	Jan 14	>=94.0%	100.0%	6.0%		>=94.0%	97.7%	3.7%		
Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer	Jan 14	>=85.0%	81.6%	-3.4%		>=85.0%	86.7%	1.7%		
Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service	Jan 14	>=90.0%	100.0%	10.0%		>=90.0%	93.1%	3.1%		
Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status	Jan 14	>=86.0%	100.0%	14.0%		>=86.0%	91.7%	5.7%		
Cancer - Quarterly										
All cancer two week wait	Q3 13/14	>=93.0%	93.9%	0.9%		>=93.0%	94.7%	1.7%		
Two week wait for breast symptoms (where cancer was not initially suspected)	Q3 13/14	>=93.0%	98.7%	5.7%		>=93.0%	97.5%	4.5%		
Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis	Q3 13/14	>=96.0%	98.1%	2.1%		>=96.0%	97.9%	1.9%		
31-day standard for subsequent cancer treatments-surgery	Q3 13/14	>=94.0%	96.1%	2.1%		>=94.0%	98.1%	4.1%		
31-day standard for subsequent cancer treatments-anti cancer drug regimens	Q3 13/14	>=98.0%	100.0%	2.0%		>=98.0%	100.0%	2.0%		
31-day standard for subsequent cancer treatments-radiotherapy	Q3 13/14	>=94.0%	98.3%	4.3%		>=94.0%	97.4%	3.4%		
Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer	Q3 13/14	>=85.0%	87.3%	2.3%		>=85.0%	87.3%	2.2%		
Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service	Q3 13/14	>=90.0%	100.0%	10.0%		>=90.0%	92.2%	2.2%		
Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status	Q3 13/14	>=86.0%	100.0%	14.0%		>=86.0%	90.9%	4.9%		

Diagnostics										
The percentage of patients waiting 6 weeks or more for a diagnostic test	Jan 14	<=1.0%	0.6%	-0.4%			<=1.0%	0.5%	-0.5%	
Infection Control										
No. of MRSA bacteraemia (Commissioner)	Feb 14	0	0				0	7	0.0%	
No. of Clostridium difficile infections (Commissioner)	Feb 14	4	5	25.0%			46	64	39.1%	
Mental Health										
The proportion of those patients on Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days	Q3 13/14	>=95.0%	98.4%	3.4%			>=95.0%	98.6%	3.6%	
Other Performance										
Mixed Sex Accommodation (MSA) Breaches	Jan 14	0	0				0	1	0.0%	
RTT										
The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period on an adjusted basis	Jan 14	>=90.0%	93.4%	3.4%			>=90.0%	92.9%	2.9%	
The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period	Jan 14	>=95.0%	96.1%	1.1%			>=95.0%	96.6%	1.6%	
The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period	Jan 14	>=92.0%	93.5%	1.5%						
The number of incomplete pathways greater than 52 weeks for patients on incomplete pathways at the end of the period	Jan 14	0	1							

Commentary

Category: Cancer - Monthly

Dec-13 — Frimley Park NHS Foundation Trust missed the submission date for uploading October 2013 data. Also, Hampshire Hospitals NHS Foundation Trust's figures for 31 days and 62 dyas are not complete for October 2013.

Aug-13 — Portsmouth Hospitals NHS Trust missed the submission data for uploading June 2013 data. Therefore the figures shown here do not reflect a true picture of the CCG's performance as patients sent to PHT are not included.

May-13 — Data for February and March 2013 was only available from the SHA due to Open Exeter withdrawing access for PCTs. This data from the SHA is not available down to provider level.

Category: Cancer - Quarterly

Sep-13 — Portsmouth Hospitals NHS Trust missed the submission data for uploading June 2013 data. Therefore the figures shown here do not reflect a true picture of the CCG's performance as patients sent to PHT are not included.

May-13 — Data for March 2013 was only available from the SHA due to Open Exeter withdrawing access for PCTs. This data from the SHA is not available down to provider level.

Appendix 3- NHS Outcome Domain Mapping

Title	Evidence for Change	NHS Outcome Domain
Better Access to Better Information - Across the B&H Health Economy	Patient and Public Experience	1-2-3-4-5
Connected Information for Integrated Care - Across the B&H Health Economy	Patient and Public Experience	1-2-3-4-5
Information about me and my care (Online Access to GP Records and Services, Remote Monitoring)	Patient and Public Experience	1-2-3-4-5
Further development of the Integrated Primary Care Teams	Patient and Public Experience	1-2-3-4-5-6
Development of Community Bladder and Bowel Service	Patient and Public Experience	1-2-3-4-5-6
Brighton and Hove Frailty Model	Patient and Public Experience	1-2-3-4-5-6
Further Development of Community Short Term Service	Patient and Public Experience	1-2-3-4-5-6
Multi-disciplinary Team for Homeless Health	JSNA	2-3
Transforming Local Infrastructure support for voluntary sector organisations	Patient and Public Experience	Blank
Gender Identity Satellite Clinic	JSNA	4
An Integrated Diabetes Model	JSNA	1-2-3-4
Dietetics Service	JSNA	2-3-4
Increasing availability of Pulmonary Rehabilitation for patients with COPD within the city	JSNA	2-4
2 Sessions Respiratory Consultant to work in community	Patient and Public Experience	2-3-4
Dysphagia Service for Speech and Language Therapy	Patient and Public Experience	2-3-4
Community Pharmacy Anticoagulation Monitoring service (CPAMS)	Patient and Public Experience	2-3
Specialist Nurse / Practitioner for Motor Neuron Disease	Outlier	2-4
Six Month Post Stroke Reviews	Outlier	1-2-3-4
Parkinson Disease Service	Outlier	2-3-4
Integrated Community Equipment Store	Patient and Public Experience	2-3-4
Carers Enabling and Befriending Service	JSNA	2-4
Well Being Strategy	JSNA	1
SMILES	JSNA	
Dual Diagnosis Multi-agency Training Programme	JSNA	2-4
Adult Learning Disability - Outreach Service	Outlier	2-4-5
Eating Disorder Service	JSNA	1-2-3-4
Psychological Support for Survivors of Sexual Abuse-adults and children	Outlier	2-4-5
Money Advice for People Experiencing Mental Health	Outlier	2
Brighton Urgent Response Service	Outlier	1-2-4-5
Young Peoples emotional health and well being -early intervention and prevention	Patient and Public Experience	1-2-4-5
Multidisciplinary Pain Management and Prescribing Clinic	Patient and Public Experience	1-2-3-5
Review of the Children's Community Nursing Service	Patient and Public Experience	4-5
Review of Assisted Conception Pathways	Patient and Public Experience	4-5
Community Gynae Services	Patient and Public Experience	4-5
Enhancing quality and outcomes in primary care -outcomes based approach to reducing health inequalities	JSNA	1-2
Investment in Community Development to support PPG's	Patient and Public Experience	2-3-4
Continuation and expansion of the Citizens Advice Bureau programme in GP practices	Patient and Public Experience	4
Investment in the Neighbourhood Care Scheme, linking in with PPG's	Patient and Public Experience	2-3-4
Commissioning Model for Integrated Urgent Care	Patient and Public Experience	4

Appendix 4- Outcome Ambition Trajectories

Outcome Ambition	Measure	2012 Baseline	Target 2014/15	Target 2015/16
1. Securing additional years of life for the people of England with treatable mental and physical health conditions	Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare per 100,000 population	2141.3	2091.62	2041.94
2. Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions	Average health status (EQ-5D) score for individuals who identify themselves as having a long-term condition	73.5	74.24	74.98
3. Reducing emergency admissions	- Emergency admissions for acute conditions that should not usually require hospital admission.	1772.6	1683.97	1666.244
4. Increasing the proportion of older people living independently at home following discharge from hospital	No indicator available at CCG level	-	-	-
5. Increasing the number of people having a positive experience of hospital care	Rate of survey responses of a 'poor' experience of inpatient care per 100 patients	129.9	129.9	129.9
6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	Poor patient experience of primary care in GP services and GP out-of-hours services	5.9	5.72	5.54
7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	No indicator available at CCG level	-	-	-

Appendix 5 – High Level Milestone Plan

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Community and Integrated Care								
Integrated Frailty Model								
New GP Contract								
Introduce Personal Health Budgets								
Commence 7 day working								
Pilot new frailty model								
Integrate clinical systems								
Stakeholder and Patient events								
Evaluate pilot								
Roll out new model								
Integrated Diabetes Service								
Pre procurement phase								
Formal procurement								
Contract Award								
Implementation								
Integrated Homelessness Service								
Agree governance and TORs								
Complete project plan								
Approval and service specification								
Implementation								
Integrated Primary Care Teams								
Recruitment phase								
Commence additional service								
Evaluate								
Anticoagulation Service								
Scoping								
Business Case								
Service Specification								
Community Short Term Services								
7 day a week therapy								
Recruit pharmacist								
Implement pharmacy service								
Implement bladder and bowel service								
Evaluate								
Specialist Community Support								
Parkinson's								
Motor neuron disease								
Pulmonary Rehab								
Respiratory								
Enhanced dysphasia								
Dietetics								
ICES								
Improved Stroke Services								
Scoping 6 month reviews								
Stakeholder event								
6 month review specification								
Approval and implementation								
Develop pan Suussex Acute Stroke Model								
Mental Health Services								
Mental health and substance misuse								
Steering Group Review								
Evaluation of pilot								
Implementation								
Eating Disorder Pathway								
Specification								
Physical tests pathway								
Recruitment phase								
Sub-contractor agreement								
Commence service								
Psychological support for survivors of childhood sexual abuse								
Money advice								
Pro-activity crisis prevention pathway for adults with learning disabilities								
Options appraisal								
Agree procurement process								

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Urgent Care Services								
Supporting patients and the public to access care								
develop local communications strategy								
roll out comms								
Non Admitted pathway								
Develop non admitted pathway								
Implement non admitted pathway								
Rapid Access Clinic for Older people								
Move to cost per case								
Full implementation of revise specification								
Reducing ambulance conveyance								
Develop local approach to contracting								
Develop plans to reduce conveyance								
Monitor through new contract arrangements								
Integrated Urgent Care Model								
Options appraisal								
Business Case								
Specification and approval								
Procurement								
Contract award								
Implementation								
Planned Care Services								
Musculoskeletal Services								
Contract award								
Implementation								
Dermatology								
Contract award								
Implementation								
Efficiencies and contractual levers								
Nurse follow ups								
Consultant to consultant referrals								
Children and Young People								
Child and adolescent mental health services								
Multi agency review								
review digital and social media options								
implement review recommendations								
Children's disability								
Increase use of personal budgets								
increase collaboration between acute and community								
improve access to therapies and equipment								
Psychological support for unwell children								
develop screening tool								
evaluation								
further integrate services								
map transition from children's diabetes to adults								
define pathway								
Medicines Management								
High cost medicines management								
Develop Blueteq system								
Implement CQUIN								
Implement challenge process								
Continence, stoma and catheter supplies								
develop guidance								
explore procurement an order options								
Implement most cost effective service								
Primary Care Development								
Strategy development								
Agreed vision and strategy outline								
Consult with members								
Engage with patients, public and stake holders								
Finalise strategy								
Approve and Implement Strategy								
Workforce development								
Pilot CEPN								
Identify nurse tutors								
train nurse tutors								
facilitate clinically led peer review								
Organisational Development								
6 month pilot of innovations forum								
Develop model for collaborative working								
implement collaborative model								

Appendix 6 – Finance Schedule

Cost Pressures / Investments		14/15 Invest	14/15 Save	14/15 Net
Community	IPCT - Continuation of 12 additional front line posts	504		504
Community	Development of Community Bladder and Bowel Service (Incl LUTS)	30		30
Community	CSTS - Pharmacy Gap	197		197
Community	Specialist Community Support - Parkinsons	33		33
Community	Specialist Community Support - Motor Neurone Disease	45		45
Community	Stroke - Six Month Reviews	90		90
Community	Speech and Language Therapy - Enhanced Dysphasia Service	107		107
Community	Dietetics	68		68
Community	Transforming Local Infrastructure support for Vol Sector Orgs	86		86
Planned Care	Review of Assisted Conception Pathways	150		150
Mental Health	Eating Disorder Service	100		100
Mental Health	SMI LES	13		13
Mental Health	Memory Assessment Service	40		40
Mental Health	Money Advice	50		50
Mental Health	Childhood Sexual Abuse	70		70
Mental Health	Mental Wellbeing Strategy Implementation	100		100
Mental Health	Young People - Emotional Health & Wellbeing	105		105
Primary Care	Enhancing quality and outcomes in primary care	500		500
Primary Care	Continuation/Expansion of the Citizens Advice Bureau Prog in GP Pracs	45		45
Primary Care	Investment in the Neighbourhood Care Scheme, linking in with PPG's	50		50
TOTAL Cost Pressures		**2,383**	**-**	**2,383**

Full Year Effects of 13/14 QIPP		2014/15 Invest	2014/15 Save	2014/15 Net
Mental Health	Peri-natal service	19		19
Mental Health	Autism diagnostic pathway	19		19
Mental Health	Accommodation Contracts	717	(1,083)	(366)
Mental Health	Crisis Response Pathway - BURS	391	(391)	-
TOTAL Full Year Effects		**1,146**	**(1,474)**	**(328)**

Better Care Fund 13/14		2014/15 Invest	2014/15 Save	2014/15 Net
Community	Carers Enabling and Befriending Service	40		40
Community	Additional Therapy in IPCT's	288		288
Community	CSTS - 7 Day Working Model for Therapies	45		45
	Pilot Frailty Model	350		350
	Developing PHB	70		70
Total Better Care Fund		**793**		**793**

Use of Non-Recurrent Funding		2014/15		
		Invest	Save	Net
Community	Frailty Model	150		150
Community	CSTS - CRRS expansion	100		100
Community	CSTS - Night sitting	130		130
Community	Additional Therapy in IPCT's	288		288
Community	Mutli Disciplinary Team for Homeless Health	472		472
Mental Health	Dual Diagnosis	10		10
Primary Care	Better Access to Better Information - Across the B&H Health Economy	543		543
Primary Care	Connected Information for Integrated Care - Across the B&H HE	666		666
Primary Care	Information about me and my care (Online Access to GP Recs and Servs)	287		287
	STS Admission Discharge	200		200
	Winter schemes	1,000		1,000
	NHSE held CHC provision	1,322		1,322
TOTAL Use of Non-Recurrent Funding		**4,149**	**-**	**4,149**

2014-16 QIPP Schemes		2014/15			2015/16		
		Invest	Save	Net	Invest	Save	Net
Community	Respiratory - Community Consultant	25		25			
Community	Development of Pulmonary Rehab	50		50			
Mental Health	Learning Disability Crisis Support	150	(300)	(150)			
Urgent Care	OOHs reprocurement	1,495	(2,550)	(1,055)			
Urgent Care	Reducing conveyance		(566)	(566)			
Urgent Care	Primary care stream redirection	350	(381)	(31)			
Urgent Care	Non admitted pathway		(1,154)	(1,154)			
Urgent Care	24/7 urgent care model			-		(560)	(560)
Planned Care	MSK	8,808	(9,933)	(1,125)	8,808	(9,933)	(1,125)
Planned Care	New to Follow Up Ratios		(485)	(485)			-
Planned Care	COPD Pulmonary Rehab		(160)	(160)		(160)	(160)
Planned Care	SRC		(246)	(246)			-
Planned Care	Dermatology	54	(54)	-	27	(27)	-
Med Man	Medicines Management		(1,000)	(1,000)		(1,000)	(1,000)
Community	Integrated Diabetes Model			-			-
Community	Integrated Community Equipment			-			-
Community	Frailty Model			-		(1,000)	(1,000)
Community	Community Pharmacy Anticoagulation Monitoring service (CPAMS)			-		(200)	(200)
	Referral Management Service					(700)	(700)
Community	BCF Savings - efficiencies					(2,843)	(2,843)
	BCF Savings – Care Homes					(1,300)	(1,300)
Total QIPP Schemes		**8,862**	**(11,936)**	**(3,074)**	**8835**	**(17723)**	**(8888)**

Appendix 7 – Activity Schedule

CCG Activity		Total Elective FFCEs	Total Referrals	Non-elective FFCEs	All 1st Outpatient Attendances	1st Outpatient Attendances following GP referral	All Subsequent Outpatient Attendances (All specialities)
2014/15	April	2,302	7,100	1,990	4,815	3,087	
	May	2,424	7,618	2,125	5,288	3,411	
	June	2,592	8,192	2,016	5,671	3,593	
	July	2,600	8,125	2,117	5,452	3,446	
	August	2,387	7,288	2,080	5,075	3,245	
	September	2,565	7,848	2,049	5,702	3,646	
	October	2,673	7,861	2,097	5,660	3,649	
	November	2,497	7,372	2,072	5,377	3,507	
	December	2,533	6,818	2,062	5,026	3,211	
	January	2,436	7,059	2,009	5,065	3,246	
	February	2,495	7,443	1,833	5,120	3,243	
	March	2,806	8,393	1,985	5,576	3,550	
	Q1						44,826
	Q2						46,190
	Q3						45,686
	Q4						44,766
2014/15 Total		30,310	91,116	24,435	63,827	40,834	181,468
2013/14 Forecast Outturn		30,163	90,840	25,565	63,656	40,719	188,804
Forecast growth in 2014/15		0.5%	0.3%	-4.6%	0.3%	0.3%	-4.0%
2015/16	April	2,430	7,484	1,926	5,076	3,253	
	May	2,431	7,629	2,055	5,295	3,415	
	June	2,601	8,205	1,951	5,680	3,599	
	July	2,614	8,157	2,047	5,473	3,459	
	August	2,520	7,683	2,011	5,350	3,420	
	September	2,462	7,520	1,983	5,464	3,493	
	October	2,571	7,549	2,028	5,435	3,503	
	November	2,768	8,160	2,004	5,952	3,881	
	December	2,426	6,519	1,995	4,805	3,069	
	January	2,444	7,070	1,944	5,074	3,251	
	February	2,634	7,846	1,842	5,397	3,418	
	March	2,571	7,677	1,921	5,100	3,247	
	Q1						45,644
	Q2						46,328
	Q3						46,051
	Q4						44,261
2015/16 Total		30,471	91,500	23,707	64,101	41,009	182,283
Forecast growth in 2015/16		0.5%	0.4%	-3.0%	0.4%	0.4%	0.4%

Appendix 8 – Operating Plan Risk Register

Risk Description	Severity	Likelihood	Total	Actions	Residual Rating
QIPP delivery – there is a risk that the CCG will not deliver the full QIPP plan. This would result in a financial pressure due to lack of savings generated and potential over performance against the acute contract.	4	3	12	The CCG has set attainable and deliverable plans agreed with partners. The CCG will undertake a further test of reasonableness based on provider feedback, historic performance and benchmarking.	4
National Targets and Standards – there is a risk that performance against targets may not be met in 2014/15 particularly in A&E and HCAI.	3	4	12	Robust assurance processes are in place and plans are currently being refreshed.	9
Patient Participation – PPGs are not fully developed and therefore there is a risk that the expectations set out in the engagement strategy may not be achieved.	3	3	9	The Engagement strategy is being refreshed in line with 'Transforming Patient Participation' and current best practice guidance.	6
Integration of Services – there is a risk that due to the scale and complexity of the integration programme that project milestones may slip resulting in lack of expected savings and services in 2015/16	4	3	12	Enhanced governance structures are being put in place to oversee the BCF programme and the HWB is being strengthened in line with its increased duty.	6
Addressing Inequalities – There is a risk that the expected reduction in health inequalities may not materialise as plans are refined in light of the outcome of the premature death audit.	4	3	12	Plans have evidence based interventions embedded within them which should be built upon by the results of the PPMA	6
Improving IT systems and system integration - there is a risk that due to the scale and complexity of the integration of health and social care informatics systems that delays will occur which could prevent full system integration in the given timescales.	4	3	12	The CCG has identified additional resource to work specifically on system integration over the next two years.	6
OD and CCG Resilience – There is a risk that due to the small size of the organisation that there is limited resilience against unexpected absence which could affect the organisations ability to deliver the aspirations set out in this plan.	4	2	8	The organisational development plan and business continuity plans address this issue to a degree. In addition resilience will be built into each team and reflected in staff objectives for 2014/15.	6

Appendix 9 – High Impact Interventions Mapping

High Impact Intervention	Local QIPP Plans 2014-2016
Early diagnosis *Early detection and diagnosis to improve survival rates and lower overall treatment costs*	JHWS Cancer and Cancer screening Integrated diabetes service NAEDI Community bladder and bowel services Improved stroke services
Reducing variability within primary care by optimising medicines use and referring *Reducing unwanted variation in primary care referring and prescribing*	Enhancing quality and outcomes in primary care High costs medicines management Area prescribing committee Primary Care prescribing project
Self-management: Patient-carer communities *Self-management programme for those suffering with a long-term condition*	Integrated Primary Care teams Integrated frailty pathway Integrated diabetes service Specialist community support Parkinson's and motor neuron disease Respiratory – Community consultant Pulmonary Rehab
Telehealth/Telecare *Health apps, telehealth and telecare equipment which help people to manage their own long term conditions in conjunction with their clinicians, introduced to empower people whilst at the same time ensure that their own actions remain embedded in the care they receive from the NHS*	Integrated frailty pathway Integrated diabetes service Better Access to Better Information
Case management and coordinated care *Multi-disciplinary case management for the frail elderly and those suffering with a long-term condition*	Integrated Primary Care teams Integrated frailty pathway Integrated diabetes service Specialist community support Parkinson's and motor neuron disease Respiratory – Community consultant Multi-disciplinary team for homeless health
Mental Health – Rapid Assessment Interface and Discharge (RAID) *Psychiatric liaison services that provide mental health care to people being treated for physical health conditions*	Crisis response pathway – EBURS Dual diagnosis
Dementia pathway *Fully integrated network model to improve health outcomes and achieve efficiencies in dementia care*	Community based Dementia services (2013/14)
Palliative care *Community based, consultant-led palliative care service*	Redesigned End of life model (2013/14)