DRAFT Version 7

NHS
South Cheshire
Clinical Commissioning Group

Operational Plan
2015 - 2016

Refresh

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Description	The Refreshed Operational Plan 2015-16 of NHS South Cheshire Clinical Commissioning Group outlines its Strategic objectives and commissioning intentions for the next 2 years and the approach to improving the health outcomes and quality of care for its population.
Action Required	N/A
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For recipients use	

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Foreword

This is a refresh of our plan published last year and we are now half way through delivering our 2 years plan. Our ambition remains the same to improve effectiveness of care services by rebuilding them around the personal needs and goals of those that use our services. Redesigning services so that the local population can say:

“I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me." (National Voices)

To do this we need to ;*" to improve the care delivered to many thousands of people in need, by many hundreds of care workers, nurses, doctors, therapists and others. These people work in hundreds of teams in scores of organisations. We need to improve this care in partnership with neighboring health commissioners, public health and local authority colleagues and at a time when money is tighter than it has ever been before. This situation is difficult and complex; when working in this web of interconnections, we know that no plan will ever be complete or perfect. The plan we are presenting this year will need to evolve and be improved. In fact we want the plan to grow, to be shaped by the voice of those that use the services and those that work on the “front line”. Our ambition is to learn how to do this better; redesigning services across our geographic area based the experiences of those that use health services, and the enthusiasm and dedication of staff that work in those services (taken from last years operational Plan forward)*

All of this needs health, social care both commissioners and providers to work collaboratively. To work collaborative with each other and to learn how to work collaboratively with communities and citizens.

That collaborative working is developing well, much of our ambition is held jointly with partners across health & social care and the communities across central Cheshire as part of the Connecting Care Programme. The Connecting care provider board has bought together social care, acute hospitals, community care, mental health care and General Practice federations to start to join up care. Over the next 12 months this partnership of provider organisations will deliver our 'integrated Community teams', multi professional teams working to help people to achieve their personal goals and helping deliver care closer to home when that is desirable. We will work with our providers to implement our integrated Urgent Care Services proposals, that will simplify the Urgent and Out of Hours offer to our population, streamline care and better meet the needs of those needing care.

These are the first steps that we have taken in designing care services around the person and not around orgnisations or professional groups, to deliver outcomes for our population together. Our efforts now need to go on delivering these teams and as importantly liberating those on the front line to think 'in systems' continuously improve the care they deliver, continually improving the outcomes that are meaningful to those using these services, restoring the pride of those workers. We continue to recognise that mastery, self-determination and the ability to deliver the best are strong motivators for health and social care workers, both clinicians and managers and we know that we need to continue to strive to commission in ways that support this, commissioning for outcomes, moving away from tick boxes and process.

As we move towards the collaborative commissioning of GP practices alongside NHS England the opportunities of this change appear in our plans. We wish to see strong, capable, organised GP provider providers that can deliver better care differently.. They will do this by building on the Starfield Principles that appear in the Connecting Care Strategy, to deliver holistic care, continuity of care, co-ordination of care and the care of all common problems and also use technology to deliver in new ways to access & deliver care. By working at larger scale we expect to see GP providers with new capabilities, better able to provide care flexibly to the highest standards and grow to start to provide

care alongside specialists that at present is hospital based developing into organisations recognised as the Multi-Professional Community Providers outlined in the Five Years Forward View.

I have saved my last words to talk about person centred care and the place of communities. I am passionate about many areas of improvement for health & social care but it is in these areas that I think we need to be looking to for the future. Person Centred Care (or Patient Centred Care as it is called by the Royal College of General Practitioners - RCGP 2015 ref) is a redefinition the relationship between patient and professional to an equal partnership, empowering the person, sharing decision making. Improving the way in which the individual controls and participates in their care in this way improves 'patient activation' (kings Fund 2014?15?) which improves outcomes while also reducing the use of services. We should implement these changes, learn from them and build on them evolving our health & care services into services run by and for the our communities to become the 'wellbeing service of the people'

We have already started to deliver this plan. I hope that you will see in this refresh our continuing passion to improve your care

[DN: INSERT PIC AND SIGNATURE]

Dr Andrew Wilson

Clinical Leader and Chair of the Governing Body

NHS South Cheshire Clinical Commissioning Group is a membership organisation comprising the following 18 practices:

SMASH Locality (Sandbach, Middlewich, Alsager, Scholar Green, Haslington):

- Ashfields Primary Care Centre, Sandbach
- Waters Edge Medical Centre, Middlewich
- Oaklands Medical Centre, Middlewich
- Cedars Medical Centre, Alsager
- Merepark Medical Centre, Alsager
- Green Moss Medical Centre, Scholar Green
- Haslington Surgery, Haslington

Nantwich & Rural Locality:

- Audlem Medical Practice, Audlem
- Kiltearn Medical Centre, Nantwich
- Nantwich Health Centre, Nantwich
- The Tudor Surgery, Nantwich
- Wrenbury Medical Centre, Wrenbury

Crewe Locality:

- Delamere Practice, Crewe
- Earnswood Medical Centre
- Grosvenor Medical Centre, Crewe
- Hungerford Medical Centre, Crewe
- Millcroft Medical Centre, Crewe
- Rope Green Medical Centre, Crewe

1. Introduction – Our approach to partnership and planning for 2015-16

In 2015/16 the commissioning system has been given greater focus on strategic goals articulated in *The Forward View into action*. These include better prevention of ill-health, empowering patients, engaging diverse communities, and stimulating the development of better models of care, supported by innovative use of technology and workforce.

As a commissioner of healthcare we need to provide assurance about our progress during the year around, for example, the expected increase in patients receiving personal health budgets, full delivery of patient choice entitlements, and/ or progress towards a paperless NHS.

The year ahead is also seeing a significant move towards "place-based" clinical commissioning. The CCG is being given the ability to influence an increasing proportion of the total local and regional NHS commissioning resources, including primary care. This puts us in a much better position to match investment decisions with the needs and aspirations of our local communities, for example to improve primary care and mental health services. Linked to this, we will be enhancing our joint commissioning arrangements with local government, for example through the operation of the Better Care Fund and for those national demonstrator sites the first steps on integrated personalised commissioning.

The Forward View into action confirms that 2015/16 will expect to see a continued focus on continuing to deliver NHS Constitution and Mandate requirements. This will be matched with a more differentiated approach to NHS England support, assurance and intervention in CCGs.

Last year the CCG developed a 2 Year Operational Plan, which included 2015-16. We have now taken the time to review and refresh the CCG Operational Plan for 2015-16 and have been sure to address a number of fundamental requirements, which include how we intend to continue to focus on:

- Improving outcomes;
- Improving access;
- A focus on quality;
- Innovation & research; and
- Delivering value.

In addition we have remained focused on the need to deliver the rights and pledges as set out in NHS Constitution, which include:

- NHS Constitution measures;
- NHS Constitution Support Measures;
- Activity measures;
- Infection measures,
- Mental health measures;
- Better Care Fund measures,
- The new Quality Premium measures ;and
- Primary care measures.

We have been sure to share our refreshed plan with our local partners, stakeholders and public as well. An outline of the engagement activity we have been involved in is presented in section [DN: insert section no,].

During this past year we have continued to work with and strengthen our working relationships with our local NHS Trusts and Local Authority partners to put into action our joint five year strategic vision – Connecting Care. Our strategic planning has taken a aligns to our main priorities

regarding the integration of health and social care. We have developed out Connecting Care Programme Board and introduced a Provider Board by way of enabling our providers to deliver service based on outcomes. Our GP Federation is a key partner on the Provider Board, recognising that in order to bring about the transformation and integration required across health and social care, our primary care partners need to round the table to help influence, shape and design the services needed.

An outcome of the collaborative leadership is the is the development of the Integrated Community Teams, that have been designed to provide patients with an holistic joined up healthcare system that improves the patient experience and quality of life for patients with multiple long term conditions. Over the last year the CCG has been working with the Connecting Care Board to develop a local solution to enable the delivery of Integrated Community Teams across South Cheshire. A "Provider Board" has been established with membership from the acute Trusts, Cheshire and Wirral Partnership Trust\mental health services, community and primary care services. The Provider Board has been working to develop a project team to enable the setup of these teams. Further work will now be undertaken to ensure the successful delivery of Integrated Community Teams.

We have welcomed this opportunity to enable us to take a longer term, strategic perspective of the direction of travel across the health and social care landscape. We will continue to develop and implement bold and transformative long-term strategies and plans to enable us to be financially sustainable and uphold safety and quality of patient care.

The refresh of our Operational Plan is intended to inform our local people, partners and staff about the progress we have made during the past year and the plans in place for the healthcare services that will be commissioned during 2015-16 on behalf of the population (173,000) covered by NHS South Cheshire Clinical Commissioning Group (CCG).

Underpinning the large amount of work represented in this plan is our commitment to ensure that our population receives high quality healthcare.

The CCG has spent time during this planning period to refocus the priorities needed for the year ahead. We have endeavoured to do this in a transparent manner, continuing to involve patients, carers, local people, clinicians, voluntary organisations, local authorities and other interested parties as we have been reviewing, developing and refining our plans and priorities.

It is important that we are seen as a responsive organisation that listens and takes into account a wide range of perspectives but at the same time keeps its core principles central to commissioning decisions, valuing:

- self-care;
- carers;
- quality of personal care;
- The family, community, voluntary and informal care structures.

We are committed to help improve the general health of the population, reduce health inequalities, ensure equitable access to healthcare and to work with our partners on the Health and Wellbeing Board and providers of care so that patients are treated with dignity and respect at all times.

At the heart of our work as a clinically led commissioning organisation is the focus on improving outcomes for our patients. Therefore we have taken the clear steer from the NHS Five Year Forward View and our own Strategic Vision within Connecting Care to articulate a set of **6 Strategic Priorities** and **Local Ambitions** that will support the delivery of improved outcomes for our population.

CCG Strategic Priorities:

Mental Health – recognising that this is a significant area of health need locally with a national focus on parity of esteem

Transformation of Primary Care – this will build on the transformation work that has already started in 2014-15.

Integration – the delivery of Integrated Community Teams and the transformation of community services (some of which will be delivered through the Better Care Fund).

Urgent Care – to bring a renewed focus on transforming the current system (some of which will be delivered through the Better Care Fund).

Person Centred Care – with a focus self-care, self-management and empowering communities and individuals.

NHS Constitution Standards - accountable for improving health outcomes , commissioning high quality care and best use resources

In support of our Strategic Priorities we have identified local levels of ambition, based on evidence of local patient and public benefit, against a common set of indicators that place our duty to tackle health inequalities front and centre stage. This will ensure that we can clearly articulate the improvements we are aiming to deliver for patients across the 6 Strategic Priorities.

CCG Local Ambitions:

To increase the levels of participation in national screening programs (bowel, breast and cervical) /to be in the top quartile nationally by 31.03.17

To Increase the proportion of children achieving school readiness by 5% by 2020

Reduce emergency admissions from respiratory diseases for the population of Winsford and Crewe by 50% by 20202 and to reduce cigarette smoking in Winsford & Crewe by 10% by 2017

Reduce the number of people with LTCs requiring crisis intervention by 2020

To close the gap in YLL in people with MH problems to the same rate as the general population in 10years

To reduce avoidable deaths to be in line with our ONS peers by 2020, as understood by close collaboration with PH

2. Who We Are

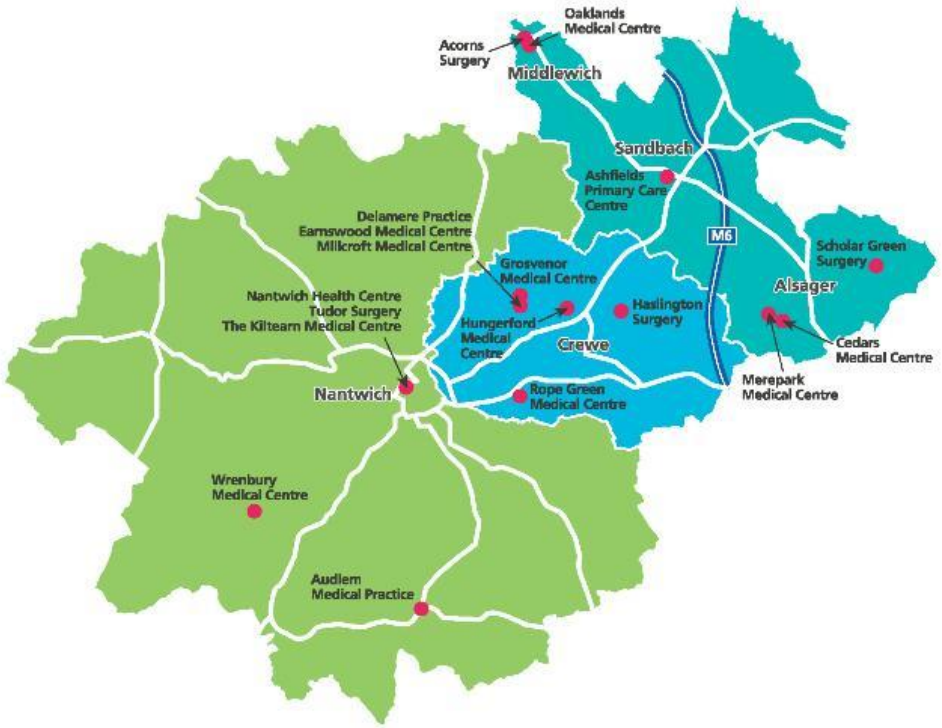
NHS South Cheshire Clinical Commissioning Group exists to improve the health and healthcare of the local population. Our aim is to use the local knowledge of our GPs and their Practice teams to develop the way that health services are delivered and help our patients to make full use of the services that are available.

We are a membership organisation comprised of 18 member practices (listed on page 7). The practices cover a geographical area of Cheshire stretching from Audlem in the south to Middlewich in the north. Crewe is the largest manufacturing town and much of the surrounding area is made up of smaller, rural market towns. The total registered population is 173,000.

NHS South Cheshire CCG geographic area falls entirely within the boundary of Cheshire East Council.

Close relationships exist between ourselves and NHS Vale Royal CCG, with whom we share a management team. We also working closely with NHS Eastern Cheshire CCG which lies to the east of our patch and with whom we share community health services and the Local Authority.

The acute general hospital, our main provider, is Mid Cheshire Hospital Foundation Trust (MCHFT), which is situated just outside Crewe. Mental health services are provided by Cheshire and Wirral Partnership Trust and East Cheshire Community Business Unit, which forms part of East Cheshire NHS Trust, provides community health services, such as district nursing, health visiting and therapy services



We have responsibility for designing and commissioning local health services and will do this by commissioning or buying health and care services including:

- Elective hospital care
- Rehabilitation care
- Urgent and emergency care
- Most community health services
- Mental health and learning disability services

We work with patients and healthcare professionals and in partnership with local communities and local authorities. On our Governing Body, in addition to GPs, we have a registered nurse and a doctor who is a secondary care specialist. We are responsible for arranging emergency and urgent care services within our boundaries, and for commissioning services for any unregistered patients who live in our area. All GP practices have to belong to a Clinical Commissioning Group.

Commissioning Support

We receive Commissioning Support Services from North West Commissioning Support Unit. (NWCSU) Commissioning Support Units to support CCGs and NHS England in undertaking their commissioning responsibilities and delivering the best possible outcomes for Patients.

We work with the CSU as a key partner. There is a Service Level Agreement established between the CCGs and the CSU to manage the quality of the services that the CSU provides and this runs until March 2016. The services that are provided to the CCG are:

- Technology Support (Information and Communication Technology)
- Business Intelligence and Data Management
- Process Centre and Governance Support (Individual Funding Requests, Information Governance, Compliance and Assurance Claims)
- Communications Support
- Human Resources Support
- Procurement advice and guidance
- Continuing Healthcare – during 2014-15 CW CCGs established a shared service to deliver the CHC service. The CSU continue to provide Contract Advice and Data Management Support for this service.

This support is developed through a locality model so that our services can be understood and accessed locally. Each of these functions has a locality lead. CSU and CCGs staff share office space to enhance the way that the two organisations work together.

During 2015/16, the CCG will have the opportunity to buy alternative provision of Commissioning Support. This can be achieved by utilising one of the nationally accredited organisations on the newly developed Commissioning Support Lead Provider Framework or alternatively by establishing a new CCG ‘shared service’. This will ensure that the CCG remain able to purchase the appropriate level of Commissioning Support that is both high quality and affordable. The Lead Provider Framework has been established by NHS England for use by CCGs and enables a quicker procurement route for Commissioning Support Services with some procurement and legal support provided by NHS England.

3. Our Vision and Strategic Priorities

Our Vision

To maximise health and wellbeing and minimise health inequalities, informed by local voices and delivered in partnership

Our Strategic Priorities

Mental Health – recognising that this is a significant area of health need locally with a national focus on parity of esteem

Transformation of Primary Care – this will build on the transformation work that has already started in 2014-15.

Integration – the delivery of Integrated Community Teams and the transformation of community services (some of which will be delivered through the Better Care Fund).

Urgent Care – to bring a renewed focus on transforming the current system (some of which will be delivered through the Better Care Fund).

Person Centred Care – with a focus self-care, self-management and empowering communities and individuals.

NHS Constitution Standards - accountable for improving health outcomes , commissioning high quality care and best use resources

Our Local Ambitions (which address some of our greatest health needs):

To increase the levels of participation in national screening programs (bowel, breast and cervical) /to be in the top quartile nationally by 31.03.17

To Increase the proportion of children achieving school readiness by 5% by 2020

Reduce emergency admissions from respiratory diseases for the population of Winsford and Crewe by 50% by 20202 and to reduce cigarette smoking in Winsford & Crewe by 10% by 2017

Reduce the number of people with LTCs requiring crisis intervention by 2020

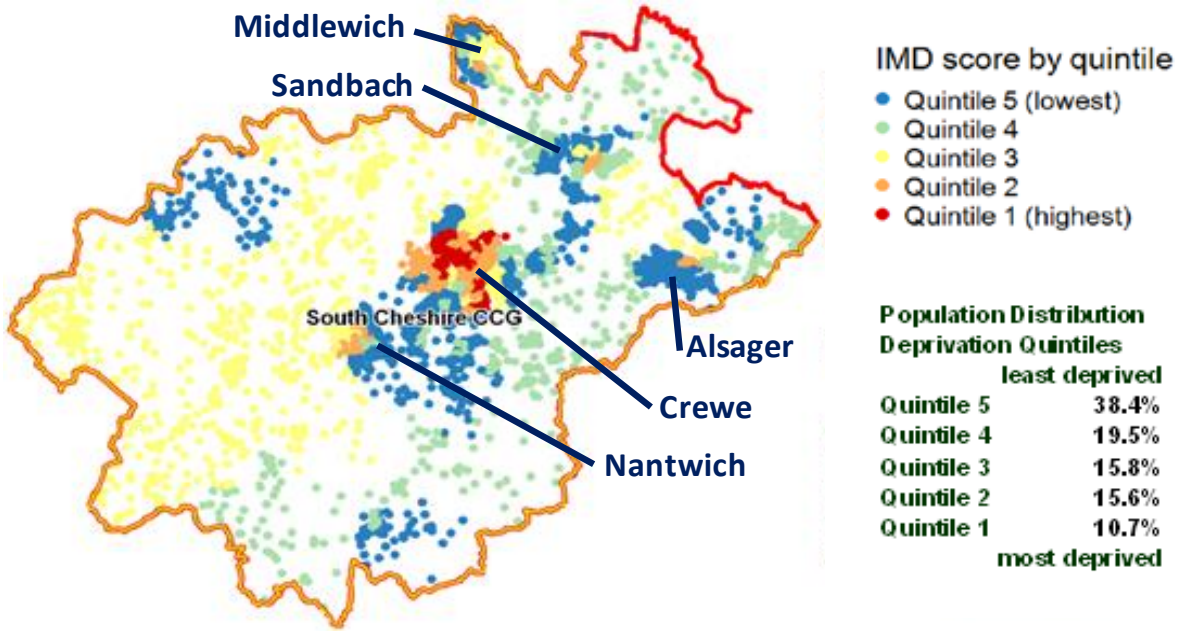
To close the gap in YLL in people with MH problems to the same rate as the general population in 10years

To reduce avoidable deaths to be in line with our ONS peers by 2020, as understood by close collaboration with PH

4. Overview of Health Needs and Health Inequalities in South Cheshire

Around 10.7% of our population across South Cheshire live in small areas (LSOAs) that are among the 20% most deprived areas in England. A further 15.6% live in the next most deprived fifth of areas in England. The map colours individual postcodes to illustrate geographical variations in deprivation. The areas of solid colour represent the towns, while areas with white spacing represent rural villages and rural communities. It shows that:

- Large parts of Crewe town are very deprived
- Each of the four other main towns contain some deprived areas
- All of the five main towns have a mix of affluent areas as well as deprived areas
- There is rural deprivation to the west and north of Nantwich, and from Sandbach to Alsager

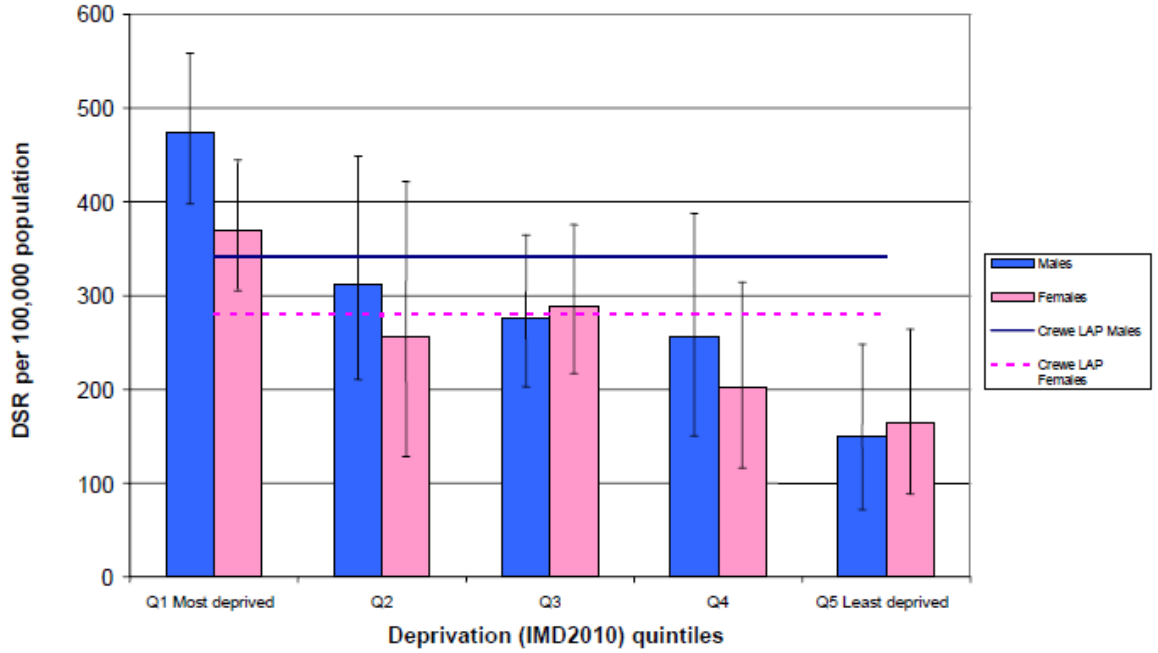


The Annual Report of the Director of Public Health has highlighted the stark difference that living in deprivation makes to premature death, with a twofold difference in death rates between the most deprived and least deprived areas in South Cheshire. The Joint Strategic Needs Assessment shows that there are similar differences in the incidence and prevalence of many acute and chronic diseases, and also in many of the lifestyle factors that are known to cause disease in both children and adults.

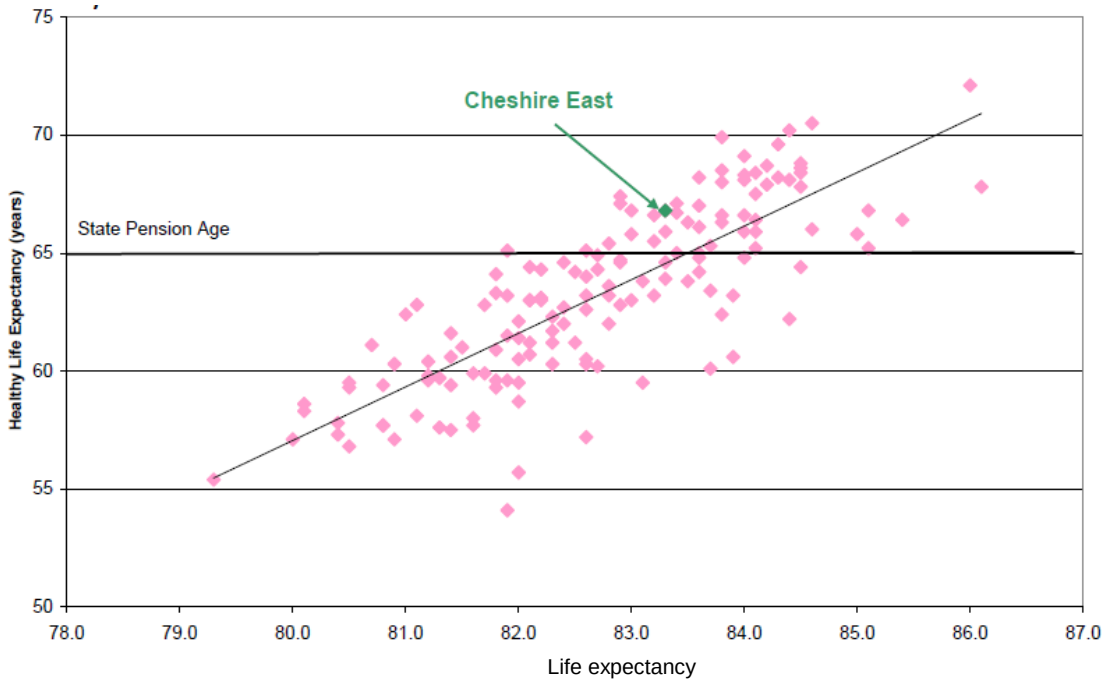
Within the area of the Crewe Local Area Partnership, there is a clear pattern of higher premature death rates among people experiencing higher levels of deprivation, whereas those who are less deprived have better health and a reduced risk of dying prematurely. There is also significant variation in Life expectancy and Healthy life expectancy across east Cheshire with people in the most deprived areas, in particular women living in Crewe, experiencing low life expectancy and a shorter time living without experiencing illness due to morbidity or disability. The significantly

worse health outcomes experienced by the people of Crewe adversely affect the average premature mortality rates for our population, and also for Cheshire East Council as a whole.

Directly Standardised Mortality Rates for All causes by deprivation quintile, Crewe LAP, aged under 75, Males & Females, 2009-11 provisional (using Mid2011 population estimates)



Life Expectancy and Healthy Life Expectancy for Women, 2009-11



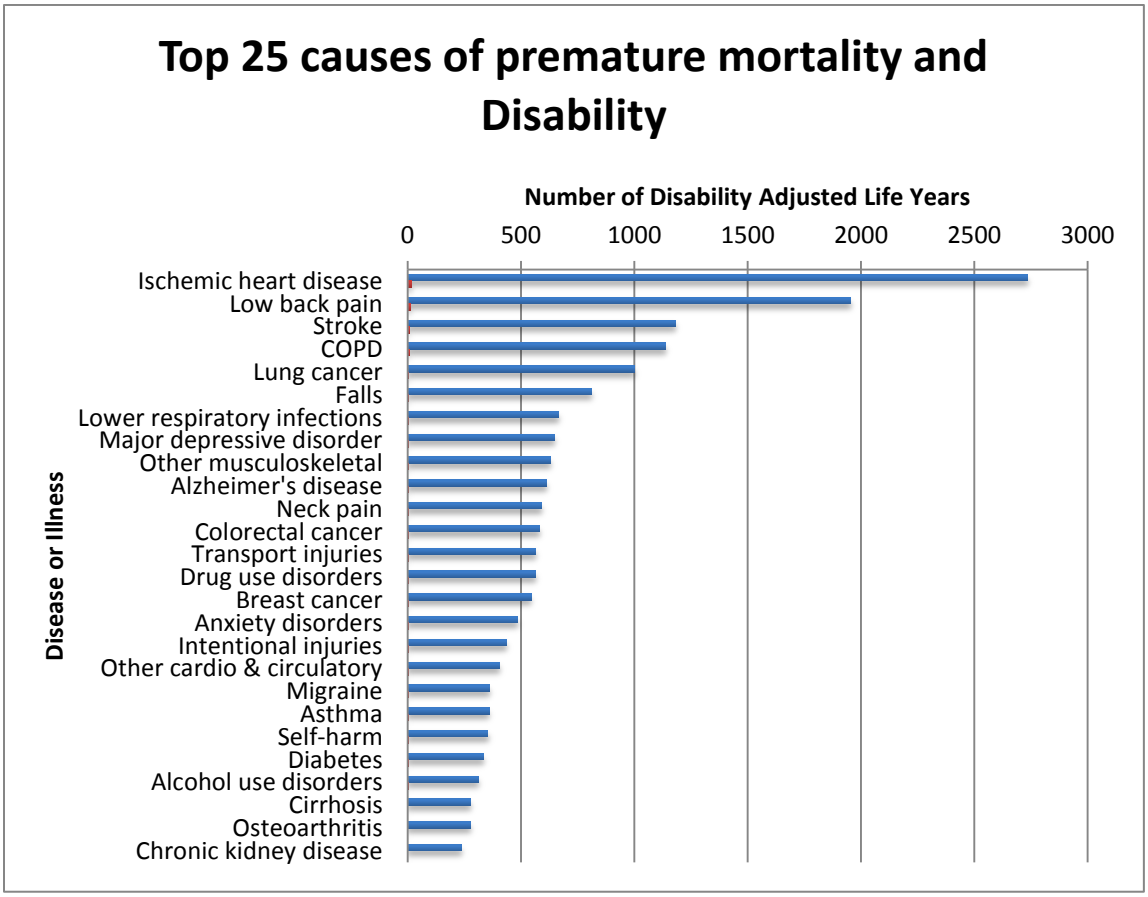
The pattern of health inequalities by deprivation and to some degree gender, is repeated across the major disease areas.

In terms of premature death from **cancer** (lung cancer and upper GI cancers - oesophagus, stomach and pancreas), the population of Macclesfield has high rates of male cancer deaths while in Crewe female mortality is 20% higher than that national average.

For premature deaths from **heart disease**, this has fallen by 40% (2001-2011) in men faster than women but this reduction stills mean that men and women who live in Crewe have a higher risk of **early death from CVD** than other people. This pattern of early death, levels of morbidity and disability due to different rates of disease and illness is repeated for **respiratory disease**, **liver disease** and **mental illness**.

Across east Cheshire we can examine the collective burden of early death and disability in one measure of the health– this is called 'Disability Adjusted Life years' (DALYs). One DALY is thus one lost year of healthy life. Using this measure of population health we can examine health inequalities according to the major causes of early death and the time spend living with a disability.

In South Cheshire, the main causes of DALYs include those illnesses we are familiar with such as **Heart Disease**, **Stroke**, **Cancer** or **Respiratory disease**, as well as those that cause significant disability, as highlighted in the table below:



The local variations in the burden of disease and disability are multi-factorial but are due in part to the health experience of people living in socioeconomically deprived areas. Local levels of socioeconomic deprivation affect early death rates in several possible ways. These include the health effects of material deprivation (e.g. through poorer housing, education and income), higher prevalence of harmful lifestyle behaviours (e.g. smoking and alcohol) and possibly reduced access to good quality healthcare.

Where differences in health exist, are measured, deemed to be inappropriate, and can be reduced through the actions of GP practices (primary care) or ourselves (either working alone or with partners), we can help to ensure that actions are targeted to all areas at a level that is appropriate to their needs. In so doing we will achieve maximum health gains within the available resources.

Some of the areas that can be used for targeting initiatives in South Cheshire include:

- 25 electoral wards with an average population size of 6,800
- 24 middle level super output areas (MSOAs) with an average population size of 7,100
- 109 lower level super output areas (LSOAs) with an average population size of 1,600
- 18 general practices with an average population size of 9,500

Although many interventions will focus on populations defined by GP practices and/or the super output areas, we recognise the importance of ward level action and the role of elected Councillors as a force for change locally within the wards they represent.

As already stated, the main towns across South Cheshire have communities that are affected by deprivation. Some areas of Crewe are in the 20% most deprived areas in England, and people's lives are up to nine years shorter than in other parts of the town. The main causes of premature death in these areas are **cancer**, **heart disease**, **stroke**, **respiratory** and **liver disease**.

Smoking

Unhealthy lifestyles and harmful environments can lead to adverse health effects at each stage of people's lives. Tobacco smoke is a major risk factor for poor health, and 25% of pregnant women in Crewe still smoke. In addition to the significant health hazards to babies and young children from being exposed to cigarette smoke, teenagers are at higher risk of becoming smokers if they live in a smoking household.

In some areas of Crewe around a third of adults are smokers. These areas also have the highest rates of children admitted to hospital with respiratory problems. Most chronic respiratory disease in childhood is caused by repeated exposure to cigarette smoke, and we have over 1,120 children with chronic respiratory disease. Preventing respiratory ill-health in future generations of children is a key health need and one of our local priorities.

Mental Health

General practices in South Cheshire provide care for over 40,000 patients with a chronic health condition, including 1,500 children. People with mental health problems have important but often hidden needs, and there are over 20,000 patients in South Cheshire with a history of depression, about forty percent higher than expected.

There are high rates of excess mortality among adults with serious mental illness in Cheshire East. The risk of death in this group of people is over four times higher than in the general

population. They need better detection and management of their risk factors by general practices working in partnership with local mental health services. ***Addressing mental illness is a key health need and one of our local priorities.***

Cancer

Crewe has higher than average cancer death rates among both men and women, and in this town there are fewer than expected numbers of people who have survived cancer. This may relate to lung, upper gastrointestinal and colorectal cancers. The priority actions for us (in conjunction with Cheshire East Council and other partners) are to increase colorectal, breast and cervical screening, increase public awareness of cancer symptoms, encourage people to present early with symptoms to general practitioners, and strengthen specialist cancer referrals from general practices.

Ageing Population

Our registered population of 173,200 people is forecast to increase by 0.6% annually to 177,400 by 2015, and to 183,000 by 2020. The increase in the number of people over 75 in South Cheshire will be around fifty percent higher than is occurring nationally, increasing by 3.6% annually from 13,700 to 18,800 in 2020.

Ageing populations have additional health and social care needs, and more people require support to remain independent and live at home. Some older people develop disabling sensory impairments including loss of hearing and loss of vision. Others may suffer from multiple chronic conditions. The number of people with dementia is increasing in South Cheshire, although more slowly than anticipated. In 2009/10, there were 925 people with dementia, which rose to 945 in 2010/11 and 984 in 2011/12. As fewer than 50% of patients with dementia are believed to be known to general practices, unrecognised dementia is becoming an important health need locally.

5. Our Achievements: What we did in 2014/15

2014/15 was the second operational year for NHS South Cheshire CCG and we are proud of what we have achieved. In 2013-14 a number of successful initiatives were carried out in partnership between ourselves, other local health commissioners, organisations that provide health services, social care and the voluntary sector. The following table summarises some of our achievements against the NHS Outcomes Framework Domains 1 – 5.

Domains

Domain One

Early diagnosis of cancer

Work has been undertaken to improve the cancer screening uptake in South Cheshire; we are now ranked in the top 20% of all CCGs in England. Educational sessions have been run within primary care to **raise cancer awareness** and to improve the local knowledge of the primary care workforce. Due to the excellent work undertaken over the last few years there has been a reduction in premature mortality in the under 75s down to 115 per 100,000.

Specialist Educational Needs and Disabilities (SEND)

Through partnership working we have implemented robust care pathways to ensure there is a thorough process for developing a single Education, Health and Social Care plan that will replace the Learning Difficulty Assessments for children and young people.

Learning Disabilities Mortality

The CCG has worked closely with NHS England to make national and local screening programmes more accessible. It is hoped that by undertaking these screening programmes undetected health conditions will be highlighted and treated accordingly to extend the life expectancy of this cohort of patients

Risk Stratification

The CCG has recognised that the use of risk stratification tools would help to identify patients at risk of developing long term conditions that could result in premature deaths. We have piloted potential risk stratification tools for South Cheshire and hope to introduce to all GP practices in the near future

Early Intervention- Domestic Abuse

We have funded an IDVA (Independent Domestic Violence Advocate) to work in our local hospital in A&E and maternity as well as across all wards to improve the early identification and provision of support to victims of domestic abuse.

We have rolled out the IRIS Programme (Identification and Referral to Improve safety) across GP practices – this education and support programme led by a clinical lead and a CCG funded Independent Violence Advocate will improve early identification of victims of domestic abuse in general practice, and has already demonstrated increased referrals to support services from GPs

Domain Two

Integrated Community Teams

Working with the Connecting Care Board, we have developed a local solution to enable the delivery of Integrated Community Teams across the South Cheshire locality.

Paediatric Pathways 0 – 5 Admissions

Recognising the high number of A&E attendances and the non-elective admissions for young children in South Cheshire we have engaged with minority groups and specific cohorts of parents to enable us to have a better understanding of how they use the current urgent care system. We have developed an "insights" report that details the parents\carers understanding of the system and have introduced "wheezy child" pathway for children with respiratory problems. It is hoped that by introducing more of these pathways that attendances and admissions into secondary care will be avoided.

Respiratory

The Medicines Management Team has worked with practices to maintain a focus on improving inhaler technique in patients with respiratory conditions such as asthma and COPD. In addition, there have been a number of new medicines launched in inhaler devices in 2014-15, and the local health economy formulary has been updated to reflect the place in therapy of each of these.

Children with LTC

Work has been taking place across several areas of the CCG to improve the care of children with long term conditions. This work includes looking into avoidable admissions, mental health service provisions, and respiratory projects within primary and secondary care.

Neurodevelopment Pathways

We have worked to support improved access to diagnostic assessments for children and young people with suspected Autism and ADHD.

Memory Services with Dementia

We have introduced a shared care arrangement for primary and secondary care, to ensure that patients living with dementia and their carers\families are well supported.

Personality Disorder

We have reviewed services for people suffering with a personality disorder and developed proposals for a multi-disciplinary complex care team This will increase the number of patients treated each year by offering a wide range of therapies to suit the needs of patients who suffer with this condition.

Primary Care Mental Health Team

We have developed proposals for the introduction of a new primary care mental health team (working as part of the Integrated Community Team). These teams will deliver high quality care that result in improved health and wellbeing and a better experience for adults with complex mental health care needs.

Military Veterans IAPT Service

The CCG reviewed services available for veterans of the armed forces and their families due to the high numbers of depression, anxiety and alcohol abuse in this cohort of patients.

Stroke Rehabilitation Pathway

The stroke rehabilitation pathway was reviewed and a specialist community stroke rehabilitation team has been implemented.

GP Care Homes Scheme

We have delivered a scheme to enhance the support offered to nursing homes from primary care.

Pain Management

The community pain management service has been reviewed and a revised service specification developed so that a new provider can be commissioned and in place for April 2015.

Third Sector Grants

The CCG has worked collaboratively with the Local Authority to review and improve 3rd Sector commissioning arrangements.

Domain Three

Intermediate and Transitional Care Services Review

The CCG has re-designed Intermediate Care services in partnership with the Connecting Care Board to create a vision for the future provision of intermediate care and reablement services to be known at Short Term Assessment, Intervention, Recovery and Rehabilitation Service (STAIRRS). STAIRRS seeks to bring together existing intermediate care, reablement and other community support services to shift the balance of provision from acute bed based services to community step up and home based health and social care support to improve patient outcomes and deliver more cost effective, sustainable care.

24/7 Urgent Care

We have reviewed current Urgent Care systems and developed planned outcomes for service re-design work planned for 2015/16.

Cancer diagnosis and treatment pathways compliant with NICE Guidance

In response to health inequality and population health need reports and 'Commissioning for Value' recommendations for both lung and upper GI cancer pathways we undertook a complete pathway review for both tumour groups. Specialised commissioning led the gynaecological review in 2014.

Cancer Pathways Review for Lund and Upper GI

A complete cancer pathway review took place for both lung and upper GI; introducing Community Health Needs Assessment clinics and a second Clinical Nurse Specialist to develop Primary Care partnerships.

Medical Emergency Response Incident Team (MERIT)

We commissioned specialised clinical teams that provide advanced medical care on scene at a range of emergency incidents, up to and

including major and mass casualty incidents.

Think Pharmacy

We extended our *Minor Ailments* service.

NHS111

We have supported the tendering and development of NHS 111 Services.

Domain Four

Citizens Advice Bureau

We commissioned the citizens advice bureau to provide a GP practice based health advice service with the aim of improving patients health and wellbeing by addressing the underlying issues affecting health outcomes that often relate to non-medical issues such as welfare and benefits.

Chemotherapy reform and acute oncology

In 2014 the CCG secured Macmillan funding to support the development of an acute oncology service to be provided in the community. A communications plan and education regarding the community acute oncology for primary care colleagues is planned for 2015.

Dementia Services for people at End of Life

We have piloted a dementia end of life service to enhance the quality of experiences from patients, carers and family members.

Co-ordinated End of Life Care

The end of life partnership was launched in April 2014 to support the delivery of high quality, co-ordinated end of life care pathways across all care settings that respects patients and carers choice. We supported the training of nearly 6,000 health and social care staff on end of life care and health and wellbeing. End of life care plans have also been implemented in line with national requirements across all care settings in South Cheshire.

Child Adolescent Mental Health Service Specification review

We have reviewed Child Adolescent Mental Health Service (CAMHS) and developed plans for 2015/16 to enhance the quality of care provided.

Electronic Palliative Care Coordination System (EPACCS)

We assisted in the delivery of data sharing agreements, ICT system development, communication and engagement activities to enable the introduction of “electronic shared care record” that can be accessed across the health care system. This will enable health providers to have access to patient records that will provide them with the most up to date information of the patient’s current health status reducing the need of the patient to replicate information relating to their illness.

Electronic Prescribing

We have enabled electronic prescriptions to be sent from GP practices directly to a pharmacy of the patients’ choice. 17 out 18 practices in South Cheshire have deployed electronic prescribing, or will complete the deployment by end April 2015.

Domain Five	**Quality, Nursing, Safeguarding and Patient Safety** • Developed a Quality and Safeguarding strategy • Introduced an Expert Reference Group; with primary, secondary care nurses Allied Healthcare Professionals alongside GP's, hospital and community doctors and patients to influence service change • Developed a Practice Nurse Membership Council/Assembly to empower the practice nurse, wider nursing and Allied Health Professional voice • Practice Nurses in 12 out of 30 GP practices have received training to be able to take student nurses and have started to take students **Safeguarding** We adopted and developed the National Safeguarding Audit Tool and ensured quality measures regarding safeguarding in all of our NHS Standard contracts.

Other achievements that the CCG has delivered during the past 12 months are presented throughout the plan and include:

- Primary care transformation with a focus on quality
- Quality Premium achievement
- Improved mortality with our local acute provider
- Development of GP federations
- Improved governance and decision making arrangements (Clinical Commissioning Executive)
- The development of our local pioneer footprint
- Techfund2 bid
- Continuing Healthcare
- System Resilience\winter pressures

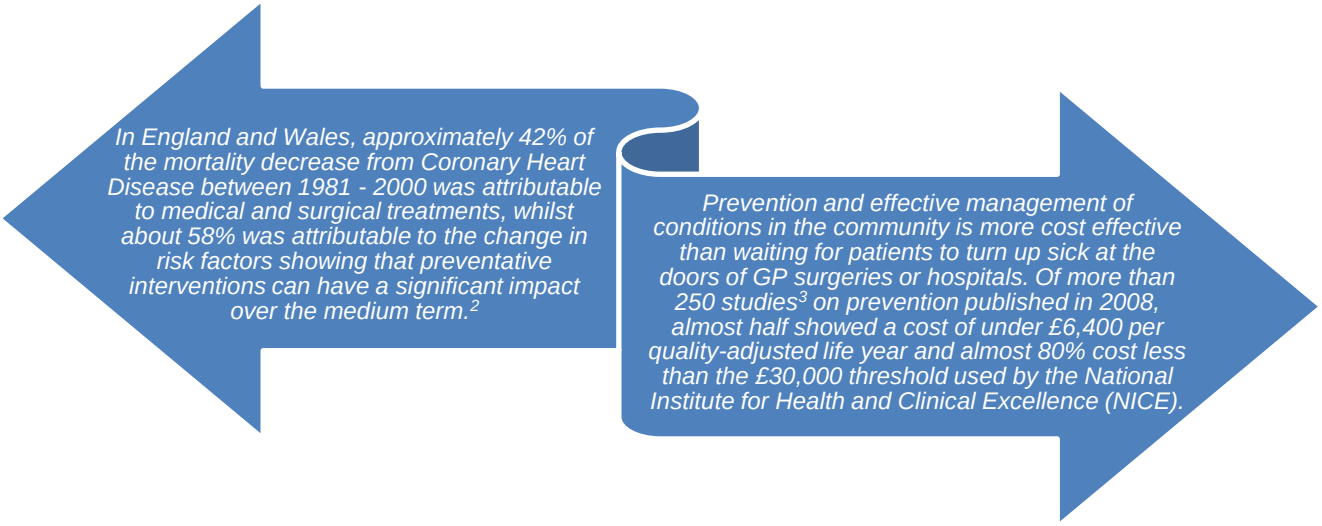
6. Creating a New Relationship with Patients and Communities

6.1. Getting Serious about Prevention

With an ageing population and increased prevalence of chronic disease NHS South Cheshire CCG recognise the need to shift health care commissioning away from the current emphasis on acute and episodic care towards prevention, personalised self-care, and more co-ordinated, integrated primary care.

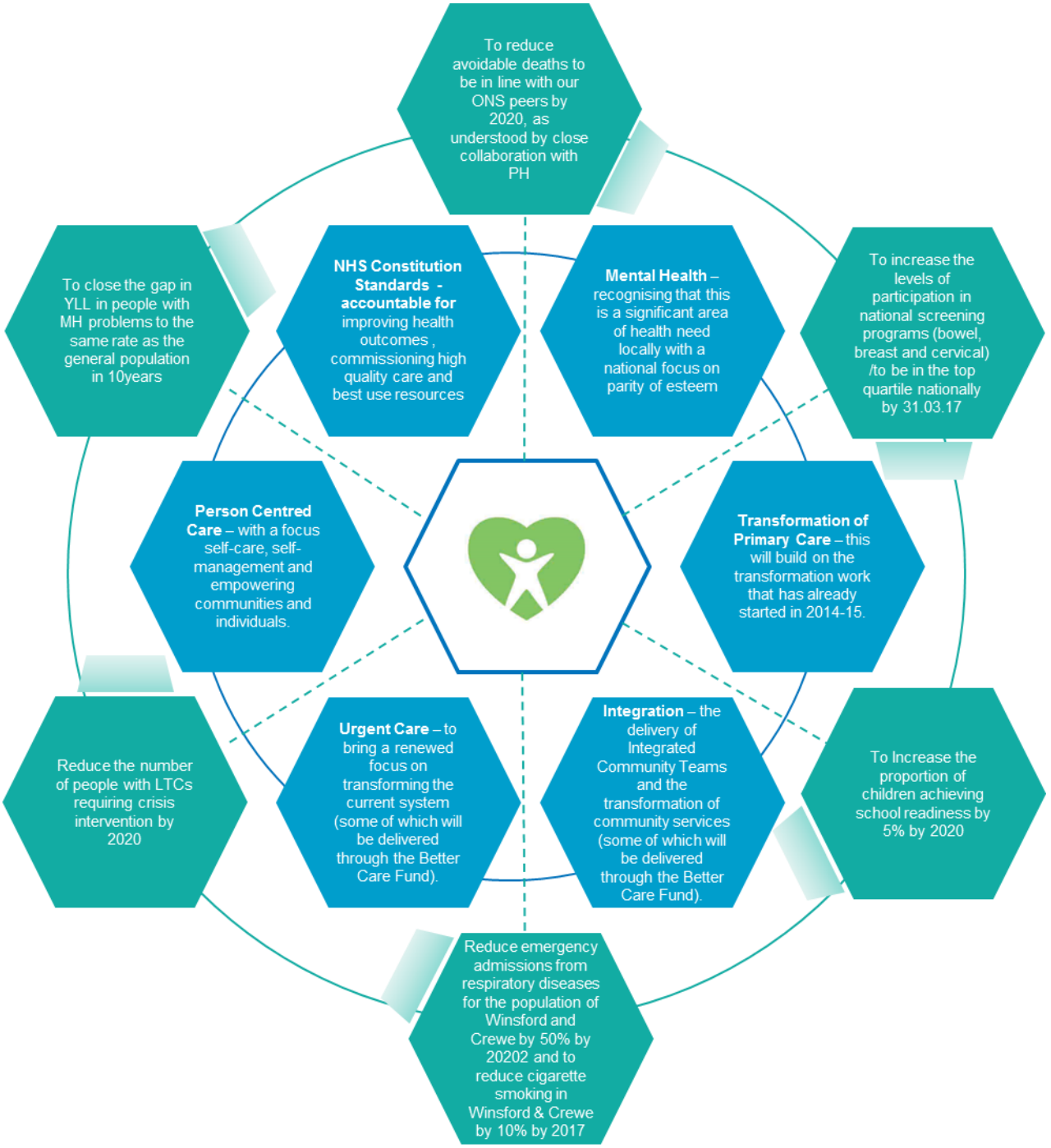
To achieve this NHS South Cheshire CCG will continue to engage with the public health agenda; working with Cheshire East Council (CEC) to address the wider determinants of health and ensure that commissioned services are used to help people make positive changes to their health and well-being.

Clearly patients would prefer to avoid getting ill in the first place or, if they do get ill, ensure that it is diagnosed at an early stage and that arrangements to manage the condition effectively are put in place as soon as possible to allow them to continue living independent and active lives.



Although some care interventions take many years to pay-off, others do not. For example, suicide prevention has an immediate impact and effective management of atrial fibrillation or hypertension can show results within a couple of years. Smoking cessation programmes can have an impact over the short term when targeted on Chronic Obstructive Pulmonary Disease patients at risk of acute admission.

Our local ambitions (which support our Strategic Priorities) will help focus our actions on addressing some of our greatest health needs:



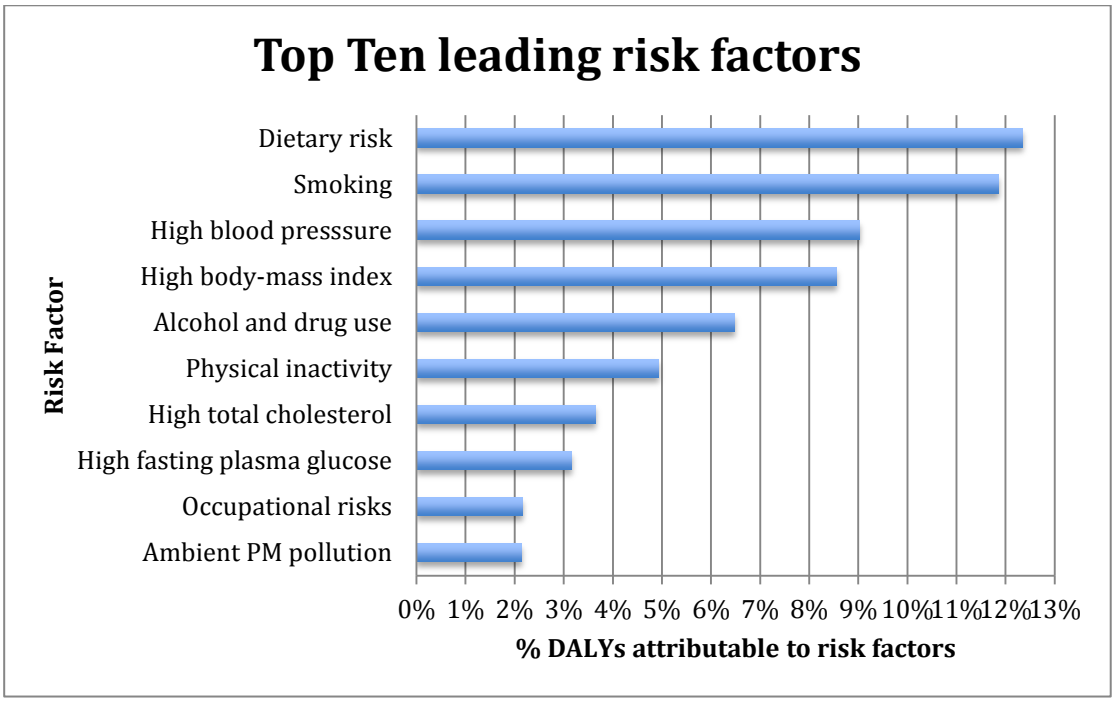
The causes of premature death are dominated by ‘diseases of lifestyle’, where smoking, unhealthy diet, excess alcohol consumption and sedentary lifestyles are contributory factors. Therefore by, investing in prevention and early intervention we could have a positive impact in reducing the incidence of disease and the risk of early death and thereby increasing the time spent living healthier for longer.

Overall, the three risk factors that account for the most disease burden in the East Cheshire (and NHS South Cheshire CCG) are:

- dietary risks (13%),
- tobacco smoking (11%), and
- high blood pressure (9%).

Reducing smoking rates, increasing physical activity, improving diet and weight management represents a huge challenge for the CCG and our public health partners at CEC.
The Public Health Annual Report outlines the key elements which need to be focussed on to reduce premature mortality and improve healthy life expectancy.
National comparisons reveal that Cheshire East has relatively low levels of premature mortality, ranked 38th out of 150 local authorities. The number of premature deaths locally has also fallen over the past nine years by 22%. However, further improvements in health and reductions in premature mortality are needed as:

1. Over 1,000 people die before the age of 75 each year.
2. Nearly 800 of these deaths are avoidable.
3. More men die prematurely than women in Cheshire East, though the number of men dying prematurely has been reducing since 2001.
4. The reduction in premature deaths in women has stalled since 2005-2007.
5. There are wide variations within Cheshire East, depending on where you live, on your risk of premature death.



Actions on prevention:

The CCG and our Public Health partners are supporting the development of two approaches:

- an integrated preventative services; and
- the benefits or cumulative impact of co-ordinated prevention across the life course

Our collective ambitions for prevention include working together to deliver integrated services that can offer a range of service to people (e.g. public health 'Integrated Wellbeing Service' – see below) as well as delivering interventions and joined up programmes throughout the life course in order to maximise the health gain associate with early intervention.
This will enable our combined efforts to not only deliver a new model of service to our patients but by joining up preventative activity across the life course we will be able to maximise the benefits of prevention on disease and illness within our population
The model of public health services that we will commission for starts from the value of investing in prevention and early intervention in order to secure the best possible health at each point in the Life course. We also recognise the cumulative benefits of investing in early transition points and setting different trajectories and maximising healthy life expectancy.

The model recognises the need to intervene beyond traditional service lines and deliver integrated services that recognise the needs of our population are not linear. The configuration of service user needs (both physical health and mental wellbeing) cannot be delivered not based around one service, for example our population will have multiple public health needs (i.e. a smoker requiring support with weight and alcohol).

The delivery of this model at one level may include clear referral pathways from one service to another service to ensure connection across services. However, this still treats users along linear lines and fails to respond completely to all the needs of the users.

An alternative service model demands the delivery of public health services within a public health centre offering support, interventions, management and exits from all needs of a user, e.g. lifestyle services, or child health services. This level of integration could be delivered at key transition points across the life course service.

Ambitions for an **'Integrated Wellbeing Service'** includes offering the following elements:

- Diet & nutrition, physical activity & weight management
- Stop smoking Service
- Alcohol and Drugs Service
- Mental Wellbeing
- Community Health Checks Service
- Health Improvement Training
- Prevention and Campaign Delivery

This new 'Integrated Wellbeing Service' model would:

- provide good, consistent healthy lifestyle advice for residents;
- improve access to wellness services for people in the town, particularly priority groups such as BME communities and people with disabilities;
- increase uptake of wellness services;
- enable more people to make positive lifestyle changes and become more physically active;
- reduce the number of residents at risk of developing long term conditions
- increase the uptake of NHS Health Checks (see below)

- establish effective referral pathways and increase referrals from primary and secondary care services;
- increase the number of staff trained to deliver brief interventions.

If the current level of need in our communities were to be converted into demand for our public health services, then this would be financially unsustainable. We therefore need to consider how to reduce demand for services consistently in terms of a reduction in the incidence of behaviours such as smoking or being sedentary and the prevalence of lifestyles factors that lead to increased risk of premature death and disability.

We are also concerned with reducing risk within our population due to multiple behaviours that lead to more complex presentations to services and require more intensive interventions. We will aim to offer services that reduce this type of demand as well as services that reduce constant demand due to population growth.

In order to do this we will ensure all commissioned services will have a clearly defined health promotion, prevention or self care budget within the service specification.

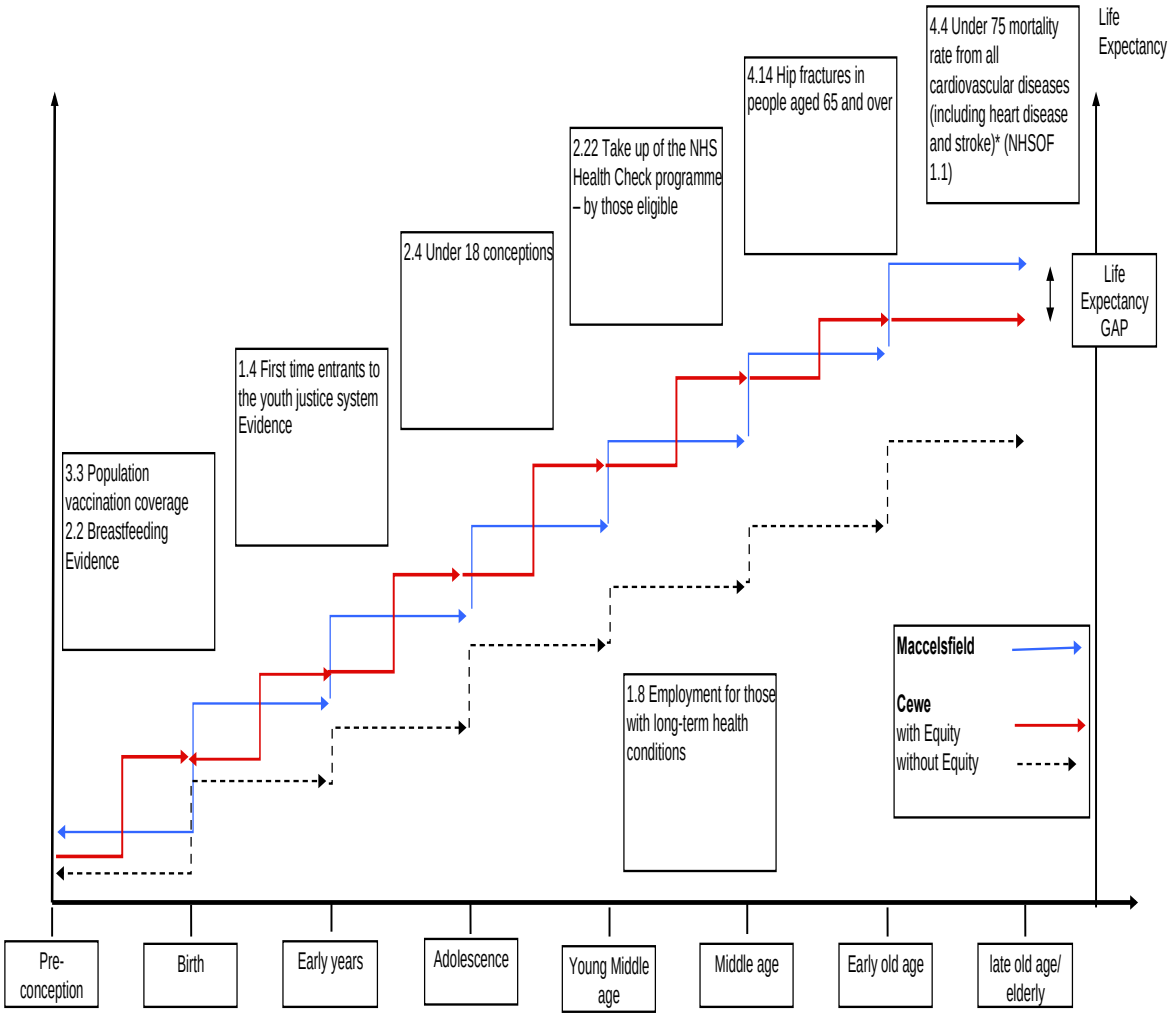
We will invest and support existing programmes such as making every contact count and workplace and sector based health promotion and wellbeing initiatives.

We will support providers with their marketing approach and ability to segment our population segmentation and provide clear messages using flexible multi media platforms to engage users and ensure information is available.

We will mandate all our providers will work together to coordinate health promotion and prevention activity through our contracts and ensure prevention campaigns are aligned, methods are joined up and targeted.

As well as our prevention work focusing on further integration and commissioning an integrated lifestyle service, the following section provides an example of the cumulative impact of co-ordinated prevention across the life course and how if we offer services across this life course. they can impact on the causes of inequality and inequity.

The Chart below illustrates an example ‘health trajectory’ of two populations, one in Macclesfield (**blue line**) and one in Crewe (**red Line**). The result of the underlying trajectory and associated transition points throughout the life course result in inequality and a difference in Life expectancy. The Chart provides an illustration of the impact of commissioning for equity to change both the underlying trajectory of each population and at each transition points. The result is a reduction in inequality throughout the life course not only at the end of life or in life expectancy. This approaches attempts to maximize health and opportunity throughout the life course.



Prevention of Alcohol Related Harm (an example of the cumulative impact of co-ordinated prevention across the life course)

The impact of interventions across the life course will have significant benefits. The tables below provide **an example** of an approach for reducing health inequalities due to alcohol related harm within each section of the life course:

Stage: Pregnancy Fetal Alcohol syndrome (FAS).	
Evidence: Pregnancy	
NICE and NTA Guidance	• At the first contact with a healthcare professional: information should be given on lifestyle advice, including smoking cessation, and the implications of recreational drug use and alcohol consumption in pregnancy[1] • Pregnant women and women planning a pregnancy should be advised to avoid drinking alcohol in the first 3 months of pregnancy if possible because it may be associated with an increased risk of miscarriage. • If women choose to drink alcohol during pregnancy they should be advised to drink no more than 1 to 2 UK units once or twice a week (1 unit equals half a pint of ordinary strength lager or beer, or one shot [25 ml] of spirits. One small [125 ml] glass of wine is equal to 1.5 UK units). Although there is uncertainty regarding a safe level of alcohol

[1] NICE clinical guideline 62: Antenatal care. June 2010

	consumption in pregnancy, at this low level there is no evidence of harm to the unborn baby. • New Women should be informed that getting drunk or binge drinking during pregnancy (defined as more than 5 standard drinks or 7.5 UK units on a single occasion) may be harmful to the unborn baby. • Use professional judgement as to whether to revise the AUDIT scores downwards when screening: women, including those who are or are planning to become pregnant[2], TWEAK and T-ACE are superior screening instruments for detecting alcohol misuse amongst pregnant women [three review articles] [3] • If someone is reluctant to accept a referral, offer an extended brief intervention.
Evidence	• There is limited evidence around psychosocial and educational programmes for increasing abstinence from alcohol in pregnancy. The intervention reviewed varied widely [Cochrane review 2009][4]. • There is a lack of research to draw a conclusion round pharmacologic interventions[5], psychosocial interventions[6] or Home visits for pregnant women with alcohol or drug problems
Gaps in Evidence	Although drinking in pregnancy can harm the fetus in first few months, there are, as yet no effective programmes to intervene or prevent a woman who is dependent on alcohol and pregnant from continue to drink excessively
Key priorities for impacting life course in this age band	
1. Prevent children being born with fetal alcohol syndrome. 2. Identify, diagnose and support those children that are born with the syndrome	

Stage: Birth to ten Findings: Neglected Child	
Evidence: Early years	
NICE	• There is a statutory duty under the children's act 2004 that services proving assessment to ensure that functions are followed to safeguard children. Therefore local services should follow local joint working arrangements as agreed by the local safeguarding children boards[7] • Talking to others (especially with those who have had similar experiences) was found to be helpful in terms of coping, making friendships and understanding more about alcohol misuse.[8] • Alateen is a programme which is suggested to support children of those with alcohol problems
Evidence	The harm to children should be part of the risk assessment for those in alcohol treatment3.
Gaps in Evidence	There is no guidance for the identification of children whose parents are alcohol dependent but are not in alcohol treatment. Need to generate and pilot specific interventions for the identification and support of children of families who have alcohol issues.
Key priorities for impacting life course in this age band	
1. Ensure that all professionals and community members in contact with young children,	

[2] NICE public health guidance 24: Alcohol-use disorders: preventing harmful drinking. June 2010
[3] National Treatment Agency . Review of effectiveness of treatment for alcohol problems. 2006
[4] The Cochrane collaboration.. psychological and/or educational interventions for reducing alcohol consumption in pregnancy women and women planning pregnancy. 2009.
[5] The Cochrane collaboration. Pharmacologic Interventions for Pregnant Women enrolled In alcohol treatments. 2009
[6] The Cochrane collaboration. Psychosocial interventions for women enrolled in alcohol treatment during pregnancy 2008
[7] Department of Health Models of care for alcohol misusers (MoCAM). 2006
[8] Alcohol-use disorders. The NICE guideline on diagnosis assessment and management of harmful drinking and alcohol dependence. 2011

Identify, support and safeguard children with a parent who is misusing alcohol.

2. Generate a programme of interventions intervene and support adults who have children and are missing alcohol

Stage: Eleven to Seventeen	
Evidence: Adolescence	
NICE	**Prevention** • Ensure alcohol education is an integral part of the nation science, PSHE and PSHE education curricula, in line with the department for children and families (DCSF) guidance (NICE guidance PH7). • Ensure alcohol education is tailored for different age groups and takes different learning needs into account (NICE guidance PH7). • Introduce a "whole school" approach, involve staff, parents and pupils and cover policy development to school environment (NICE guidance PH7). • Where appropriate offer parenting skills development information (NICE guidance PH7). • Where appropriate offer brief one to one advice on the harmful effects of alcohol use, where appropriate make a direct referral to external services, (NICE guidance PH7). • Form partnerships, to support alcohol education, ensure interventions are integrated in the community, consult with families about initiatives to reduce alcohol use and monitor and evaluate partnership working, (NICE guidance PH7). **Screening** • There is NICE guidance that children aged 10-15 should be supported, have detailed history recorded, and an appropriate and sensitive course of action if there is a reason to believe that there is a significant risk from alcohol related harm, there is no evidence available as to the format to which the course of action should take to make an impact2. • Discussions around alcohol use should also occur in sexual health2. • There is NICE guidance the young people ages 16-17 should be screened and offer extended brief interventions with young people, however there is no evidence as to the impact. • AUDIT was shown to perform more effectively in the identification of alcohol abuse or dependence than CAGE, CRAFFT or RAPS-QF in male and female young people[9] it is also proven to be the most cost effective. • Ensure an integrated approach across all services to ensure that an at-risk adolescent that has become known to a service is lost in referral process**Error! Bookmark not defined.** • Staff should have access to recognised, evidence based packs. These should include a short guide on how to deliver a brief intervention, a validated screening questions, a visual presentation (to compare drinking levels) practical advice on how to reduce alcohol consumption a self help leaflet. Inconclusive evidence on the effectiveness of brief intervention for young people. Although effective for adults for a range of measures**Error! Bookmark not defined.**. The social needs of young people that different to adults. Young people with drinking problems fall into one of two groups: those whose problems are largely related to intoxication and those whose drinking is better interpreted as a symptom of profound psychosocial disturbance3

[9] NICE. Screening and Brief Interventions for Prevention and Early Identification of Alcohol Use Disorders in Adults and Young People

	• If there is demand staff should be trained to deliver brief interventions. **<u>Treatment</u>** • Treatment of young people and adolescents is the same as the treatment for adults (see adult section) although there is no evidence base around treatment of alcohol issues in young people. **<u>Re-enablement</u>** • There is very little evidence to suggest the best programmes for ensuring long term relapse prevention and re-enablement into the community
Evidence	• There is limited evidence around psychosocial and educational programmes for increasing abstinence from alcohol in pregnancy. The intervention reviewed varied widely [Cochrane review 2009][10]. • There is a lack of research to draw a conclusion round pharmacologic interventions[11], psychosocial interventions[12] or Home visits for pregnant women with alcohol or drug problems
Gaps in Evidence	• There is no evidence for the efficacy of case management for children and young people • There is no evidence for the efficacy of assertive community treatment for children and young people • There is no evidence for the efficacy of the stepped approach for children and young people • Diagnosis and identification of withdrawal is difficult in children and young people, for this reason a lower threshold for admission for children and young people who misuse alcohol. • There is not evidence to support an ST regime for pharmacological treatment over and FD regime. • Treatment of children and young people is detailed in NICE guidance CG115
Key priorities for impacting life course in this age band	
3. Prevent alcohol related teenage pregnancies 4. Prevent misusing alcohol at this age band, screen to identify those misusing alcohol in this age band, provide brief intervention and refer to alcohol services to ensure the alcohol misuse does not impact on their life course	

Stage: 18-24yrs (young adult) Stage: 25-39 years Stage: 40- 59 years Stage: 60+ years
Evidence: Adults
<u>Screening:</u> • NICE guidance states that screening for alcohol harm should be an integral part of practice. This should be within new patient registrations, screening for chronic conditions, or carrying out a medicines review. • These discussions should also take place when seeing someone for an antenatal appointment and when treating minor injuries. • When screening everyone is not feasible professionals should focus on the increased risk groups e.g. those with physical conditions such as hypertension, those with relevant mental health problems, those who have been assaulted, at risk of self harm, who regularly experience accidents

[10] The Cochrane collaboration.. psychological and/or educational interventions for reducing alcohol consumption in pregnancy women and women planning pregnancy. 2009.
[11] The Cochrane collaboration. Pharmacologic Interventions for Pregnant Women enrolled In alcohol treatments. 2009
[12] The Cochrane collaboration. Psychosocial interventions for women enrolled in alcohol treatment during pregnancy 2008

or minor trauma, those who regularly attend GUM.
- The alcohol-use disorders identification test (AUDIT) is effective in the identification of hazardous and harmful drinking in adults

Brief intervention
- NICE guidance supports brief advice for adults identified through screening, if this can not be offered immediately offer an appointment as soon as possible.
- Use the evidence FRMAES principle (feedback, responsibility, advice, menu, empathy and self sufficiency).
- Where there is an ongoing relationship with the client routinely monitor their progress, where required offer additional session. Offer an extended brief intervention to help people address their alcohol use. This could take the form of motivational interviewing, follow up offering further sessions.
- Referral for specialist treatments for those with moderate or severe alcohol dependence who have failed to benefit from brief advice, extended brief advice or showing signs of alcohol impairments.

Treatment
- NICE guidance contains best practice for treatment and relapse prevention.

Re-enablement
- Although programmes ensure that adults are less likely to relapse, there is a gap around ensuring that the individual gains employment and finds way in which to integrate within the community, be it supporting others or achieving employment.

Settings:

GP

Screening
- Policy for Screening at next GP registration with a phased approach rather than using the next GP consultation [NICE PH24 quality of evidence not known]
- The alcohol-use disorders identification test (AUDIT) is effective in the identification of hazardous and harmful drinking in adults in primary care [three High quality study systematic review, High quality study (Finland) High quality study (UK) evidence]. Optimum threshold appeared to be greater or equal to seven in men [two High quality study systematic review evidence] and greater or six among women [High quality study systematic review evidence] and hospital inpatient [High quality study systematic review evidence]. Also AUDIT cheaper than laboratory tests [Moderate quality study (UK) Cost effectiveness evidence]
- Laboratory markers are of limited value [High quality study(UK), High quality study (Belgium) Moderate quality study (Germany) evidence] **Error! Bookmark not defined.**

Brief intervention
- Brief interventions given in primary care are effective in reducing alcohol related negative outcomes [6 High quality study systematic reviews evidence][13]

Costing within GP setting
- Very brief interventions are likely to be more cost effective than extended brief interventions. Life time QALY gain per individual is effective based on the 20,000 per QALY.
- Brief interventions are shown to be cost effective showing savings of £4.30 per £1 spent, £2000 per life pr year. In another study this saving was £123 per person.

Evidence
- There is no conclusive evidence as to the cost effectiveness of a tool to risk stratify patients by condition and potentially associated alcohol use.

[13] Cochrane collaboration. Effectiveness of brief alcohol interventions in primary care population. 2009.

A&E	<u>Screening</u> • Use validated screening tools appropriate to the setting, for example the Alcohol Use Disorders Identification Test (AUDIT). Where time is limited they can use an abbreviated version such as AUDIT-Consumption (AUDIT-C)[14]. <u>Brief Intervention</u> • Limited evidence of effectiveness of brief interventions in emergency care [two High quality study and Moderate quality study quality of evidence country unknown] inconclusive in inpatient and outpatients [High quality study review evidence] • There are benefits such as reducing death rate and alcohol consumption following admission to general hospital wards[15] <u>Costing within A&E settings</u> • Cost estimates of £3.81 per £1 spent. Cost savings of £47 per patient screened and £175 for each patient offered a screen. • In one study having an alcohol liaison nurse in a hospital to deliver brief advice that saved 10 times more in reducing repeat admissions than it cost. A similar programme of a link nurse also generated great savings.
Family Planning	There is no evidence for the use of screening or brief interventions in family planning or the impacts this may make. • (For preconception/pregnancy see earlier section)
Sexual Health	• NICE Guidance Discussions around alcohol use should also occur in sexual health[16] [17]. • Sexual health is a suggested specialist setting for brief intervention[18] • There is no evidence for the use of screening or brief interventions in sexual health or the impacts this may make.
Homeless	• There is evidence for holistic programmes of Intensive case management (ICM) and Community reinforcement approach3. • NICE guidance suggests consider offering residential rehabilitation for a maximum of 3 months. Help the service user find stable accommodation before discharge[19]. • Tier 1 interventions can be provided at residential provision for then homeless and tier 2 can be provided by homelessness services. •
House, Job Centre, Benefits Office	• There are no studies stating a format by which to screen or intervene with those who have alcohol misuse issues within a jobcentre, housing associate or benefits office setting. . However, NICE guidance does address that those who do not have stable employment or housing are more likely to require further support to deal with their alcohol misuse and/or alcohol withdrawal issues.
Crisis management e.g. divorce, bankruptcy	• There are no studies stating a format by which to screen or intervene with those who have alcohol misuse issues within a crisis managing setting.
Arrest, Probation, Prison	• There has been no research into the conduction of alcohol screening or brief intervention for the population who are in contact with the police probation or in prison different to that performed in the universal adult population.
Dementia	Due to the high risk of long-term brain injury and the potentially serious

[14] NICE. Services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults. Commissioning guide. 2011

[15] Cochrane collaboration. Brief interventions for heavy alcohol users admitted to general hospital wards. 2011

[16] Commissioning guide. Implementing NICE guidance. 2011

[17] NICE Services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults

[18] Department of Health. Signs for improvement – commissioning interventions to reduce alcohol-related harm. 2009

[19] NICE 115.

	consequences of WE, a high index of suspicion for WE should be adopted and thiamine prescribed accordingly[20]. • Low-risk drinkers without neuropsychiatric complications who appear healthy and are believed to take a reasonable diet – minimum thiamine 300mg, daily during detoxification or periods of particularly high alcohol intake. • High-risk heavy drinkers who are malnourished – thiamine 250mg daily as Pabrinex® IM or IV for 3–5 days. • Confirmed or strongly suspected diagnosis of Wernicke's – thiamine 500mg daily as in Pabrinex® IM or IV for 3–5 days. • However, relatively little is also known about the outcomes of the treatment of alcoholic Korsakoff syndrome.
Workplace	Screening There are no studies reviewing the best screening tool to use within an employment setting. Brief Intervention Two interventions in the work place reduced drinking by about 50% and improved climate with regarding to drinking in the workplace[21] • Apart from the above study there are no other studies showing impacts of staff "wellness" programmes.
College/ University	Screening There are no studies involving screening models for the college or university population specifically. Brief Intervention • Web based programmes appear to reduce peak blood alcohol content, drinking frequency, Quantity and binge drinking. Face to face had some effect but less broad[22].
Other	• Preoperative: Intensive preoperative alcohol cessation interventions may significantly reduce the postoperative complication rates, but no effect on mortality or length of stay[23]. • Insufficient evidence for interventions at the point of alcohol serving service [24] • Promotions at point of sale and affects on alcohol consumption among under age drinkers, binge drinkers and regular drinkers2.
Key priorities for impacting life course in this age band	
5. At every opportunity professionals should screen, briefly intervene and refer to alcohol support services 6. Embed the knowledge of alcohol misuse within the community by generating a wellness programme within the local authority, CCG and NHS trust.	

From 2015 Cheshire East Council will be investing more on preventing the risk of poor health and specifically targeting the main risk factors that cause early death and disability. The challenge will be to ensure the cumulative impact of prevention work is seen across the life course, both in terms of sustained partnerships work and also sustained investment so the benefits of prevention can be realised.

[20] NTA review of effectiveness of treatment

[21] Bennett J..,Patterson C..,Reynolds G..,Wiitala W..,Lehman W.. Team awareness, problem drinking, and drinking climate: Workplace social health promotion in a policy.
American Journal of Health Promotion, November;December 2004

[22] Cichrane Collaboration. Social norms interventions to reduce alcohol misuse in university or college students. 2010

[23] Cochrane collaboration. Preoperative alcohol cessation prior to elective surgery, 2012

[24] Cochrane collaboration. Intervention in the alchol server setting for preventing injuries. 2010

Smoking
Evidence from Tobacco Health Profiles and the CEC Joint Strategic needs assessment indicates that adult smoking prevalence is around 16/17%(2012) and less than the England average (19/5%). Smoking in pregnancy in Cheshire East is around 15%, which is higher than the national position of around 12.7%. Working collaborative our targets remain to reduce:

- Adult smoking prevalence
- Reduce regular smoking amongst 15 year olds
- Reduce smoking in pregnancy

Obesity
The prevalence of obesity in England is one of the highest in the European Union. In England just over a quarter of adults (26% of both men and women aged 16 or over) were classified as obese in 2010 (Body Mass Index (BMI) 30kg/m2 or over).

Obesity is directly associated with many different illnesses, chief among them insulin resistance, type 2 diabetes, metabolic syndrome, dyslipidaemia, hypertension, left atrial enlargement, left ventricular hypertrophy, gallstones, several types of cancer, degenerative joint disease, obstructive sleep apnoea syndrome, psychological and psychiatric morbidities. It lowers life expectancy by 5 to 20 years. Direct costs of obesity are estimated to be £4.2 billion.

By the end of 2015-16 the CCG will have introduced a new **Tier 3 (T3) weight management service**, offering multidisciplinary assessment and treatment in accordance with NICE guidelines.

This service will provide support to eligible patients to help them make long-term life-style changes to manage their weight, improve their health status and their quality of life. The service will:

- provide assessment, information and treatment for patients who meet the criteria for the Specialist Weight Management Service;
- support patients with severe difficulties or complex needs relating to their weight, to make appropriate lifestyle changes to lose weight and maintain weight loss; and
- empower patients to self-manage their weight loss and maintenance goals

NHS Health Checks
The NHS Health Checks programme brings significant benefits to individuals, with the potential to prevent up to 1,800 strokes and 9,700 cases of diabetes each year.

Cheshire East Public Health has worked with the CCG and with local practices to develop the use of the NHS Health Check to identify people at high risk of diabetes. All 18 of the CCG practices use the EMIS clinical system, and Cheshire East Public Health has developed an EMIS clinical template in conjunction with EMIS. This EMIS clinical template standardises and improves the sensitivity of the diabetes filter (and in future a validated diabetes risk engine), which will help to underpin our local preventative diabetes programme.

The Local Authority is also developing a new ‘integrated lifestyle / wellness’ service (see above) for people at high risk of diabetes identified by a Health Check, and will use EMIS to track and report improvements in their risk factors. The Health Check is being used to improve detection of the estimated 16% of diabetics locally who remain undiagnosed (Cheshire East Public Health Report 2013).

Diabetes Prevention
The CCG has commissioned a structured education programme for type 2 diabetes delivered by dieticians and practice nurse. There will be up to 4 sessions per month, at different times and

locations, to be flexible for the population. The aim is that this will encourage and support patient self-care and empowerment, using a range of interactive approaches.

Health Programme for employees Well-being
As part of the need to focus on a sustainable NHS South Cheshire CCG take seriously the need to ensure its workforce are supported to improve their physical and mental health and wellbeing. During 2015/16 NHS South Cheshire CCG will refresh the current HR Strategy to bring about a stronger focus on employee well-being and the development of sustainable health and workplace incentives to promote employee health. The CCG has already made a commitment to support people with mental health by achieving the 'Time to Change' award; therefore the strategy will build on this achievement and will include specific incentives around mental health. A revised HR Strategy will be in place by June 2015.

Prevention and Early Intervention- Joint Working for Children, Young People and families
NHS South Cheshire CCG works closely with partner agencies to plan and deliver improved outcomes for children and young people including the wider context of the family and community.

The CEC Children and Young People's Plan contains the locally agreed priority areas and outcomes agreed by the Children's Trust, in which the CCG is a fully engaged partner.

The Children and Young People's Trust Board has agreed to focus on a group of priorities developed around the following key themes:

- Children and young people at risk and providing help to families early
- Healthy and resilient young people
- Young People equipped and excited to enter adulthood
- Children, young people and young adults with special education needs and disabilities
- A borough that respects children's rights

The priority outcomes for 2014 -17 are:

1. Children and young people will be **actively involved in decisions** that affect their lives and communities
2. Children and young people **feel and are safe**
3. Children and young people experience **good emotional and mental health and wellbeing**
4. Children and young people are **healthy and make positive choices**
5. Children and young people **leave school with the best skills and qualifications they can achieve** and the **life skills they need to thrive** into adulthood
6. Children, young people and young adults with additional needs **have better chances in life**

The Children and Young People's Plan (CYPP) is a single strategic and overarching plan which sets out how partners across the Local Authority, Health Services, Education, Justice and the voluntary and community sector intend to achieve improvements in outcomes for the borough's children, young people, young adults and their families.

The Plan is strategically aligned to the work of the Cheshire East Health and Wellbeing Board and sets out how we as partners aim to support children to get the best start in life. It provides a strategic framework for local activity, setting out our ambition, our shared sense of purpose and direction supported by a range of underpinning strategies and action plans and reflected in the plans of partner agencies.

The CCG is developing a joint commissioning plan with the council to improve how we collectively plan and deliver services locally.

6.2. Empowering Patients

Patients empowerment is synonymous with high quality care

A key goal for NHS South Cheshire CCG is to achieve authentic patient participation and ensure patients and professionals 'co-produce' care in order to achieve true patient empowerment. We need to transform the way in which we listen and involve our patients, their carers and the public. In a time of unprecedented demand, the NHS has to turn to its service users and their communities to become active partners in planning and managing their own care.

In the development of a more engaged relationship with patients and their carers we aim to support people with long term conditions to manage their own health and care. We also aim to work with voluntary sector partners to invest in evidence-based approaches such as group based education and peer-to-peer support communities.

How we can learn and do more to support patient empowerment
How involved do people feel in the big decisions about their care, and are patients' voices heard when things go wrong and do we learn from this? There a number of simple things we plan to do to support patient empowerment.

Knowledge is power - Giving everyone the ability to see and interact with their medical records online gives people the knowledge to better understand their health and treatment.

Making shared decision-making the easy choice for clinicians - Partnership with patients needs to be the easy choice, which means making consultations smarter rather than longer.

Invest in supporting carers - For many people with long-term health problems, family members provide the vast majority of the care they receive. Giving these carers the skills to support their loved ones at home is a great investment in quality of life, and in affordable healthcare.

Groups of patients are a powerful asset - When patients come together they can be a powerful force for improving their own health and that of others. We've seen what peer support and education can do in the UK for years through the work of networks like the Expert Patient Programme and our South Cheshire PPG Federation.

Listen to what patients have to say - Patient stories have enormous power to challenge and change the status quo.

Access to Information
Access to good quality health information, and the support to use it, is fundamental to securing patient and public engagement. Whilst there are powerful legal and ethical incentives for providing quality information, NHS South Cheshire CCG believes access will enable people to better manage their health and wellbeing and make fully informed decisions about their treatment and care.

As part of the commitment to improve access to information, the CCG has been working with provider organisations to make progress towards achieving fully interoperable digital health

records across Cheshire from 2018. 2015/16 will see the development of a business case with implementation dependent on the successful award of the national Tech Fund 2 bid.

NHS South Cheshire CCG have also put in place measures to improve online access to primary care services. Patients will have online access to their GP records, GP appointment bookings, repeat prescriptions and access to Summary Care records during 2015/16. This is being planned for activation by 1st April 2015.

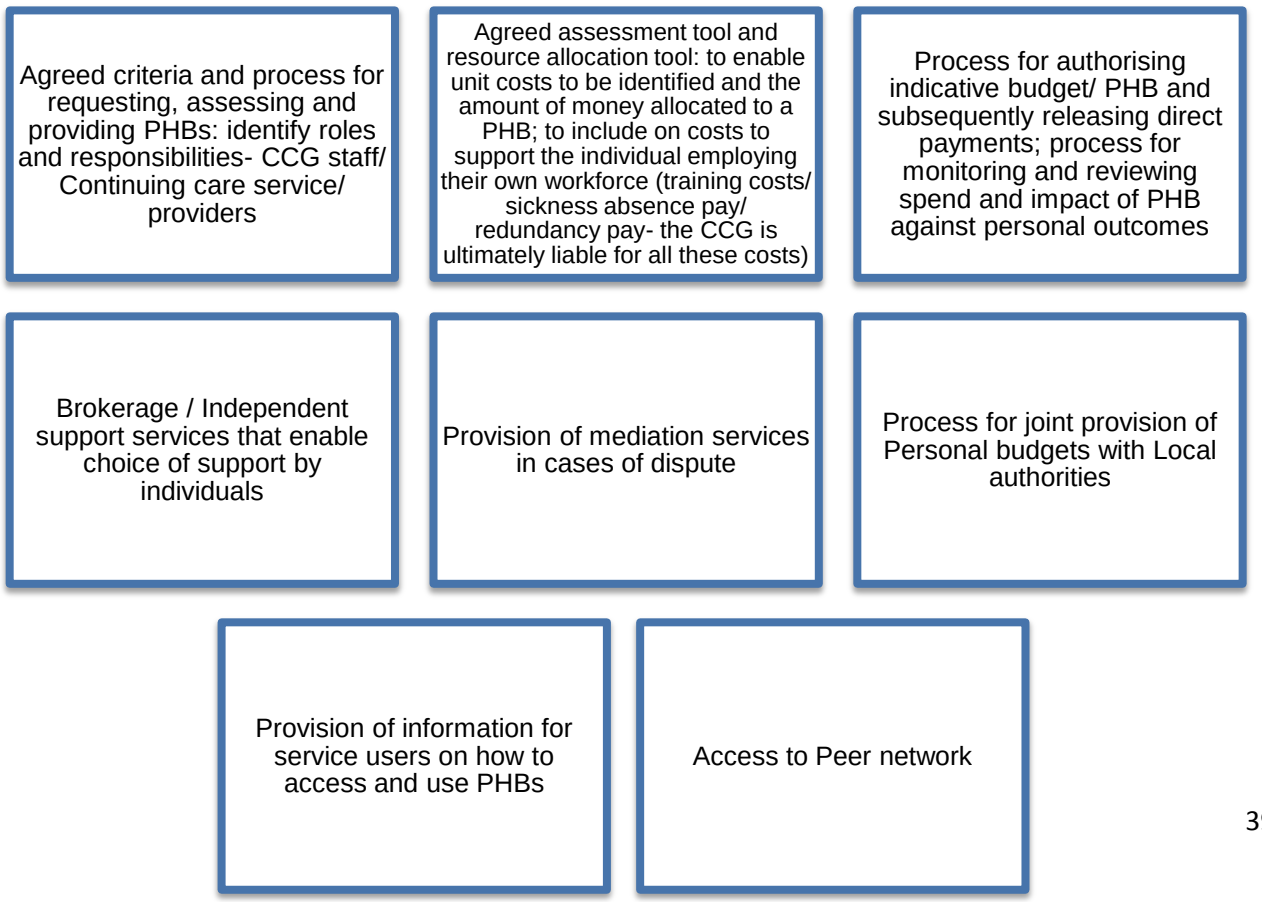
Personal Health Budgets (PHBs)

At NHS South Cheshire CCG we believe personal health budgets enable people with long term health needs to have greater choice, flexibility and control over the health care and support they receive in order to achieve agreed personal outcomes. During 2015/16 we aim to create a shared plan across the 5 CCGS in Cheshire and Wirral to develop an approach to the delivery of personal health budgets (PHB). This will ensure a consistency of approach, with shared criteria and standards as well as a shared commissioning approach.

Since October 2014 PHBs can be provided to adults who are eligible for Continuing Health Care and for children and young people who are eligible for Continuing Care. From April 2015 the provision will be extended to all patients (all ages, children, young people and adults) who have a recognised mental health need. By 2016 this will be extended to include people with a Learning Disability and Autism and by 2017 those with a Long Term Condition.

Under the Children and Families Act 2014, for Children and Young People (CYP) aged 0-25 years with Special Educational Needs and Disabilities (SEND), PHB may form part of their Personal Budget linked to their Education Health and Care Plan (EHCP) if they are eligible for an EHCP. We have worked with our local authority to put in place an agreement for PBs, ensured our continuing care teams inform parents/carers of their right to have PHBs and raise awareness with colleagues across the CCG of the requirements of PHBs.

During 2015/16 we will continue to implement our PHB Action Plan to ensure the following processes and standards are implemented:



During 2015/16 NHS South Cheshire CCG will engage widely with our local population and HealthWatch representatives to define goals on expanding PHBs.

The South Cheshire PHB Action Plan links closely to the work the CCG is undertaking to meet the requirements of the Children and Families Act 2014 - Special Educational Needs and Disabilities (SEND). The CCG SEND Project will see the delivery of a Joint Commissioning Strategy for CCGs and LAs to commission services that support children and young people with special educational needs and disability. The SEND Project will also ensure implementation of the single 'Education, Health & Care Plan', transitional Care Pathways between Children's and Adult services and introduction of Personal Budgets (see above). Finally, NHS South Cheshire CCG will, through the Designated Clinical Officer (DCO) role, gain a clear understanding of the number of children and young people receiving Education Health and Care (EHC) assessments and Plans. From this we will identify the levels of health provision required and ensure appropriate local provision is in place by 31st March 2016.

Working with the Third Sector

NHS South Cheshire CCG recognises the "added value" that the Third Sector can bring to public service provision in the form of the development of innovative solutions and the longer-term preventative agenda. We believe partnership working with the Third Sector can provide an essential link between CCG and the population of South Cheshire: building services tailored around the needs of the individual from organisations that are firmly rooted in our local community.

During 2014/15 the CCG has sought to address some of the issues around third sector commissioning. The work has examined issues of personalisation, self-directed care support and the development of a range of service choices. Underpinning this work has been an aim to ensure services are developed nurturing community and user-led organisations at a local level.

2014/15 saw the development of a Joint Commissioning Plan for voluntary and third sector grant funding: securing a collaborative approach to commissioning services in partnership with Local Authority partners.

From April 2015, some Third Sector contracts will be commissioned via the Local Authority, for example, advocacy contracts. During 2015-16 the CCG and the Local Authority will deliver shared priorities and a joint contract and performance management approach, in addition it will setting out a preferred model for Third Sector development. This expected to be completed by September 2015.

Some Third Sector contracts will be retained within the CCG and a review of these contracts will be undertaken to ensure they meet the needs and priorities of those communities they serve, for example the End of Life care packages. It is anticipated that this will form part of a wider review of End of Life services and so makes better use of resources if considered as whole pathway. The dementia advisor service is also being reviewed by the CCG, in order to take the opportunity to extend the service.

Choice for Patients

NHS South Cheshire CCG is committed to give patients choice over where and how they receive care and promote choice. We want you, and your family and carers, to be able to make informed choices about your healthcare. **In order to promote** real choice for our patients we aim to provide them with information that will help support them in making choices about their care.

Our NHS South Cheshire CCG Communications and Engagement Strategy details how we will work to help patients locally understand what rights they have under the NHS Constitution.

Any Qualified Provider

For an organisation to be accredited to supply a clinical service under the Any Qualified Provider arrangements they must be able to satisfy nationally agreed standards relating to the delivery of care, and to supply that care under a specification agreed by the CCG. This will allow a wider choice of provider and clinic location for patients in South Cheshire.

During 2015/16 NHS South Cheshire CCG intends to commission services under "Any Qualified Provider" for the following specialities:

- ENT
- Oral Surgery
- General Surgery
- Gynaecology
- Musculoskeletal / Orthopaedics
- Ophthalmology
- Urology

End of Life
NHS South Cheshire CCG is also currently working with care homes to actively promote patient choice around End of Life Care and for residents and family wishes to be fully documented and respected. GP's are also being asked to identify patients within last year of life and for them to have discussions about their preferred place of care in order that community support, future care plans and workforce education can be planned to support patients (and their families) who do not wish to go to hospital.

The CCG fully supports the patients' right to choose which hospital they are referred to if they to see a specialist. As a legal right, we will support the patient to you choose from any hospital offering a suitable treatment that meets NHS standards and costs.

We also support the patients' right to choose which consultant-led team, or clinically appropriate team led by a named healthcare professional, will be in charge of the patients' treatment for their first appointment at the hospital.

Choice in Maternity Services
NHS South Cheshire CCG has reviewed the choices locally available for women requiring maternity services and has considered what more can be done to offer meaningful choice.

In our commissioning plans we are considering how to balance the requirements to ensure sustainable maternity services for the CCG that offer personalised care and choice.

Locally, some women have chosen to have their baby with an independent provider of community midwifery services providing a case-loading midwifery model of care.

There is clear evidence that 'continuity of care 'models can deliver good outcomes for women as well as a positive experience of care.

Our intention is to commission a case-loading midwifery model as a 'choice' option and consider options for procurement. The specification will seek to target health inequalities locally.

Expected outcomes include improving relationships between women and midwives by personalising their care, reducing postnatal depression through earlier diagnosis as well as better support, improving breastfeeding rates and access to home birth.

Choice in Mental Health Services
At NHS South Cheshire CCG we believe that people who use mental health services should have more choice about where and how they get their condition treated in the NHS. We aim to give patients more involvement, greater control and choice over their care. Giving mental health equal

importance with physical health means giving people more choice over who provides their mental health care.

The NHS 5 Year Forward View mandates transformation within mental health to improve access to mental health services on a par with physical health. The changes in law endorses that patients with mental health problems now have the same legal rights as they have had in physical health services and is a significant step towards achieving parity between the two.

As commissioners, NHS South Cheshire CCG want to understand our population needs better to enable us to commission appropriate mental health services. We will achieve this through joint working with our Local Authority and studying our local Joint Strategic Needs Assessment (JSNA). During 2015/16 NHS South Cheshire CCG will work to achieve a "currency" for mental health using "The National Tariff" mechanism to support high quality outcomes and new levels of care. We aim to move away from existing unaccountable block contracts and will ensure Providers of mental health services meet the requirement to support patient choice. Service specifications will be developed during 2015/16 to reflect choice and demonstrate that parity has been addressed.

During 2015/16 the CCG will publish a Mental Health Communications Plan focusing on defining what "rights" mean for our population and when they will and will not apply. It is fundamental that choice is offered at specific points to enable patients to make decisions on Provider/Team and about what options are available. Patients will be informed of services, outcomes and of previous patient experience so they feel empowered to make educated decisions.

6.3. Engaging Communities

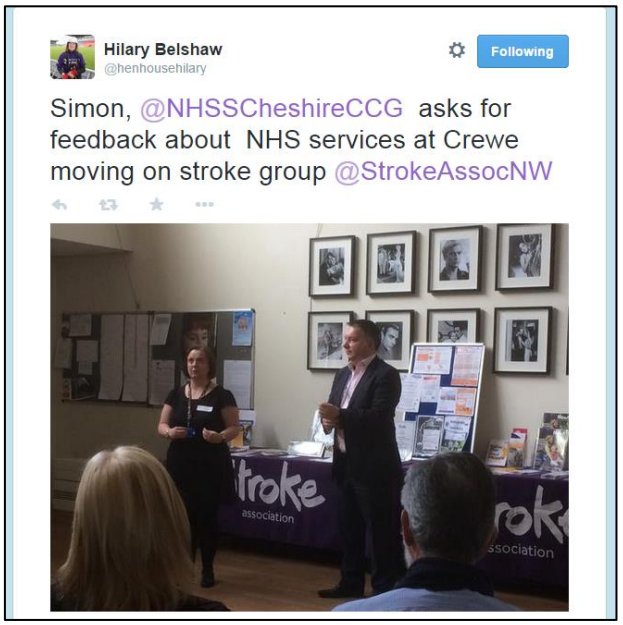
The CCG holds patient and public involvement in high regard and believes that true success occurs when we share, involve and engage with our local population. We have a real desire to make a difference to the communities of South Cheshire and want to enable all residents to have a voice in local health services and decision making. This is underpinned by our belief that understanding and reflecting on patient and carer experiences is critical in supporting us to improve quality and reduce variations in service and health inequalities.

2015/16 will be a year of un-precedented patient and service user engagement for NHS South Cheshire CCG. Our ambitious plans place patients are at the heart of the work we do, demonstrating that people have the opportunity to become involved in shaping the healthcare services for the future and a commitment towards reducing health inequalities in the South Cheshire area as well as supporting diverse commissioning.

We appreciate the value of face to face conversations with our local communities to listen to and understand the experiences of our patients, however we cannot use this as our only engagement opportunity; we will continue to develop and expand our use of social media and our website to enable us to reach out to patients and our stakeholders.

As our following on Twitter expands we need to ensure we are continuing to build meaningful and sustainable engagement by showcasing the work of the CCG in the local area and demonstrating its impact. Our governing bodies will always feature live twitter feeds, bringing the governance of the CCG into the public arena, showing how we conduct our business and the open and honest way in which we do it.

Our events and key activities will be featured on twitter and we will engage with our audience using pictures and images; our key partners will always be linked to us with their activity being re-tweeted to highlight the ways in which we work together and our priorities are linked and integrated.



Any information shared on our website will always be transparent, providing a real understanding of our work and giving a platform for patients to share their stories and feedback their experiences of local health care. Our website will act as the hub of on-line information, providing governance information as well as up to date news of the CCG, events and useful information key to the connected way in which we work with our partners. It is the website that will demonstrate engagement tools such as 'you said, together we did' showing how we listen to the feedback we receive, act up on it and deliver a difference.

The following table illustrates our current planned engagement activities and approaches for 2015/16. A revised edition is due to be taken to the CCG Governing Body in June 2015. [DN: hyperlink to Communications & Engagement Plan will be inserted in final Ops Plan]

Public engagement and communications activity during Year 1 2014- 15 and next steps for Year 2 – 2015-16

Outlined activity within the operational plan	Actual activity and outcome
Development of an engagement network	An engagement network has been established with partner organisations and wider stakeholders from the South Cheshire / Cheshire East locality region.
Next steps: During Year 2 this engagement network will be extended to include organisations which have joined the **Connected** scheme. By the end of quarter 1 a fully updated baseline of stakeholders will be developed.	
Carry out stakeholder analysis	Stakeholder analysis has been carried out to identify the primary organisations which deliver services through CCG contractual arrangements. This in turn is linked to the engagement network. This work needs completing on an annual cycle and is considered to be an ongoing area of work.
Next steps: the stakeholder analysis is a central component of the engagement network as discussed above.	
Encourage individual participation through patient stories and experiences	Year 1 has been a busy year with a significant number of individuals participating to share their own experiences in order to create their own patient stories. These patient stories have been used at Governing Body meetings, Quality Board meetings and at a range of local and national conferences. The patient stories bring a true human context to aiding a deeper understanding to patient's actual experiences of care.
Next steps: This work will be further developed during Q1 of Year 2, to embed a quality-assured process which also includes clear governance procedures. The outcomes of future patient stories will follow a triangulated approach where improvements and outcomes are clearly defined, measured and communicated to all.	
Embedding patient and carer feedback is a crucial part of the commissioning cycle.	Work is ongoing to ensure patient and carer feedback is truly included into the commissioning cycle. A notable development in Year 1 has been the contribution that patients have made to the Quality and safeguarding strategy, sense checking and reviewing actions. This will be re-visited during year 2. Service Delivery Mangers are now approaching the engagement and communications team in order to locate patient representatives to join their work.
Next steps: As part of the development of a new Engagement Strategy, the process of involvement with be clearly defined, so that colleagues may become empowered to lead this process themselves	
Build patient and carer insight into the expectations of our local providers to deliver accountable care systems around patient's needs.	Share best practice and make insight reports and findings available to all local stakeholders. In order to facilitate this, a close working relationship and sharing agreement has been developed with Cheshire East CVS and Public Health, which links to the JSNA.
Next steps: During Year 2 this engagement network will be extended to include organisations which have joined the **Connected** scheme. By the end of quarter 1 all Insight reports will be shared with partners.	
Collate information during 2014-2016 from public and patient voice activity into a monthly insight report, which will be issued to all Service Delivery and Clinical Project Managers and lead GP commissioning clinicians.	Quarterly insight report completed and shared through: • Health inequalities meeting • Governing body • Senior Management Team
Next steps: Development of the intranet to act as a portal for Insight Reports is required. The signposting to these reports will be clearly set-out by our ways of working which are being finalised as part of the Engagement Strategy	
Publish feedback from HealthWatch Cheshire East about our locality as and when it becomes available	Updates received from Healthwatch Cheshire East have been duly published within the public domain. However, due to a range of internal changes within Healthwatch locally, the number of reports and information made available has been limited in scope. In year 2, Healthwatch will become a member of the engagement

	network.
Next steps: In Year 2, Healthwatch will become a member of the engagement network. Bi-monthly meetings have also been instigated to develop the relationship further	
Invite patient/ public to be involved in specific service areas i.e. cancer/ stroke/ urgent care/ mental health or the transformational changes i.e. Integrated Teams, Connecting Care.	Group of patients in place (Federation members, Connected members and Tea & Talk groups) to be approached to support specific service area consultation and engagement work when it appears in the commissioning cycle.
Next steps: via the Connected membership scheme, members interests are being determined in order to create Expert groups to ensure that patients and public are able to contribute to areas where they feel most closely aligned	
Report back via You Said, We Did to ensure that engagement, involvement and communications activity has been effective and reflects the needs of local people	"You said, **together** we did" is an area which will be further developed during year 2. Initial 'reporting back on impact' activity has focused on the work undertaken by the Readers Panel, which has worked on Diabetes information and COPD/Chest x-ray information this year. The Readers Panel have indicated a high level of appreciation regarding the new approach.
Next steps: The You Said Together we did reporting is a statutory duty which as a CCG we must comply with. Further promotion of our achievements will be added to our website.	
Using a range of activities and approaches to ensure that the public voice visibly influences and is directly involved in the decisions made by the CCG, underpinned by our 'Making a Difference - Good Engagement Charter'.	On-going development of face to face engagement alongside other channels such as social media. Schedule of engagement created to involve and inform all protected characteristics and deliver strategic aims and objectives of the CCG –including Connecting Care
Next steps: Joint work with the Commissioning Service Unit (CSU), Equality & Diversity team to ensure that we comply with our statutory duties. There is a specific workplan, which follows a rolling programme.	
Effective management of the CCGs identity and house style is an important element in protecting the organisations reputation and it is important that the CCGs identity is not used inappropriately.	Working with the CSU, the CCG brand identity was refreshed during Year 1, which included a new visual identity as well as the development of the use of brand identity guidelines. A full suite of branded corporate documents and reporting templates has also been designed and is now used across the organisation.
Next steps: Whilst the brand identity was refreshed during Year 1, further work is now required during Year 2 onwards to develop brand behaviours which mirror the reputation of the CCGs.	
Proactive and planned internal and external communications assist NHS South Cheshire CCG to operate effectively and gain the support of staff and stakeholders needed to implement wider scale changes.	An aligned approach involving 'planning runways', regular meetings and planning sessions has developed across CCG & CSU teams. This is regularly updated and measured.
Next steps: A working action plan is currently being developed by CSU colleagues to both demonstrate the wrap-around service delivery which they will provide in order to ensure that vision set out by NHS South Cheshire CCG	
Membership Scheme (to commence June 2014)	The 'Connected' involvement membership scheme was launched during the summer of 2014, with current membership standing at 98 members. The membership is analysed on a bi-monthly basis alongside local population information, in order to compare how representative the voice of our local population is.
Next steps: During Year 2 the 'Connected' scheme will become the main channel by which patients, public and stakeholders are communicated from. Year 2, Q1 activity is to focus specifically on stakeholder involvement and engagement	
Use of electronic survey with registered patients	The use of the CRT Viewpoint terminals has proved to be a valued resource in collecting patient feedback in practice, with 15

	surveys being created and delivered, and approx. 1000 responses being gained. Year 2 will see the continued use of the terminals, and placements within other public locations, to reach further audiences. Option to develop this into the channel to capture Friends & Family responses in the future.
Next steps: The Practice Engagement Managers have placed a bid to fund each practice to have their own touch screen terminals. As part of the wider Communications and Engagement strategy and work plan, the touch screens will be utilized as a data capture method at public events.	

Year 1 - 2014-15 IMPACT:
In total 70 public engagement opportunities have been presented to members of the public between September 2013 - September 2014. These events have ranged from 1-1 individual participation opportunities to larger scale focus groups, consultations and patient conferencing.

The CCG provides a wide range of opportunities for patients and members of the public to be involved; however we recognise that true success from these events will only be achieved when as an organisation we firmly embed this engagement into the whole commissioning cycle.

Year 2 - 2015-16:
The NHS Five Year Forward View gives people far greater control of their own care among its top priorities for the health system (NHS England 2014e) and elsewhere NHS England Chief Executive Simon Stevens has stressed the 'renewable energy' that patients, carers and communities can offer (Stevens 2014, para 35). Health care quality experts agree that truly safe and effective care can only be achieved when patients are 'present, powerful and involved at all levels' (Berwick 2013, p 18).

Milestones for year 2 for public engagement and communications work include the following:

Priorities outlined for year 2	Drivers	Timescales for delivery
Continued development of the **Connected** involvement scheme to also encompass staff members, and stakeholders to ensure consistency of message and opportunity for all.	**Connecting Care:** Empowering our public and our workforce to lead the way **FYFV:** Stronger partnerships with charitable and voluntary sector organisations, better able to reach undeserved groups and are a source of advice for commissioners on particular needs	Jan/Mar 2015 – Build and maintain stakeholder Connected membership
Development and facilitation of a **Connected** forum, in order to provide a broader forum for engagement and involvement	**FYFV:** Engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services	By March 2015 to hold the first connected Forum including members and stakeholders
Continue to support the South Cheshire Federation of Patient Participation Groups to become a 'go to' bank of representatives for patient experts. Also to provide broader support to Federation to support practices in developing their own groups, where no currently exist.	**Connecting Care:** Empowering our public and our workforce to lead the way **FYFV:** Engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services **Kings Fund:** Evidence shows that when people are involved in	Federation to move to a Four meetings per year model from January 2015 onwards, with a greater emphasis to becoming a working partner to the CCG

Priorities outlined for year 2	Drivers	Timescales for delivery
	decisions about health and social care, then those decisions are better, health and health outcomes improve and resources are allocated more efficiently.	
Embedding patient and carer feedback into the wider commissioning cycle	**Connecting Care:** Empowering our public and our workforce to lead the way **Connecting Care:** Strengthening our assets – support our carers **FYFV:** Stronger partnerships with charitable and voluntary sector organisations, better able to reach undeserved groups and are a source of advice for commissioners on particular needs	Jan 2015 - Review methodology to deliver insight and feedback into the commissioning cycle Feb 2015 – as part of new Engagement strategy launch, formal process embedded
Renewed engagement strategy	**Connecting Care:** Empowering our public and our workforce to lead the way **FYFV:** Stronger partnerships with charitable and voluntary sector organisations, better able to reach undeserved groups and are a source of advice for commissioners on particular needs	**Jan 2015 – renewed Engagement Strategy shared in draft form** **Feb 2015 – new Engagement Strategy agreed and shared**
Renewed internal communications strategy	**Connecting Care:** Empowering our public and our workforce to lead the way **FYFV:** Stronger partnerships with charitable and voluntary sector organisations, better able to reach undeserved groups and are a source of advice for commissioners on particular needs	**Jan 2015 – renewed Internal Communication Strategy shared in draft form** **Feb 2015 – new Internal Communication Strategy agreed and shared**
Continued engagement and communication expertise and advice to the wider organisation	**Connecting Care:** Empowering our public and our workforce to lead the way **Transforming participation**: Listen and truly hear what is being said, proactively seeking participation from communities who experience the greatest health inequalities and poorest health outcomes **Kings Fund:** Putting involvement and participation at the forefront of policy and practice provides the opportunity not only to create an effective and sustainable health and care system, but also to contribute to a more equitable and healthier society	**Jan 2015 – renewed strategies shared in draft form** **Feb 2015 – new strategies agreed and shared**

Carers

The CCG has in conjunction, with its partner CCG and Cheshire East Council (CEC) developed actions around the support of carers, to include the new requirements of the Care Act 2015, which heralds huge changes for social care services and those in a caring role.

There are a range of activities identified from engaging with carers, supporting them, to providing information in a suitable format and increasing employment opportunities. This has been shared with the Carers Reference Group Forum, a group open to carers within the Cheshire East footprint, in which the statutory agencies, can engage with Carers, the voluntary sector and consult with their local carers and understand their needs.

In addition to the Carers Reference Group, the partners come together come together to discuss and progress matters relevant to local carers on a regular basis. In January 2015 the partners held a series of engagement events across the CEC footprint to share information on services for carers, give an overview of the Care Act 2014 and gain a greater understanding of their needs. These were well received and further quarterly sessions are being planned.

As part of the identified actions, the CCG and LA commission the local carers service to support GP practices to identify and support the carers within their practice. The service is currently working with all GP practices, (and with 8 practices across Cheshire East in particular, in an intensive and innovative way) to develop the understanding and knowledge of those in primary care, to identify carers, and keep them healthy and supported.

The Local Authority and the CCGs continue to jointly commission carers break services from the voluntary sector. This funding stream is procured through a bid process and successful services aim to cover all caring roles, open to all carers (while not being means tested).

The CCG has reviewed their internal HR polices to ensure that they are suitable in supporting staff with caring responsibilities and offers flexible working arrangements to accommodate staff where possible.

Key Areas of Action	By When	Update y When
Deliver the carer break application and commission activities for 2015-16	April 2015	Applications being sent out by CCG & LA.
Finalise reviewed Carers Strategy and ensure delivery of the 5 objectives: • To help and advice carers so that they are not forced to into financial hardship • To ensure carers will be respected as expert care partners and will have access to integrated and personalised services they need to support them in their caring role • To ensure children and young people are protected from inappropriate caring roles and have the support they need to learn, develop and train and to enjoy positive childhoods • To support carers to stay mentally and physically well and ensure they are treated with dignity • To support carers to have a life of their own alongside their caring role	April 2015	Strategy refined in line with the publication of the Care Act 2014 guidance.
Providing support within GP practices - to identify and support the carers within their practice population	April 2015	Pilot taking place 4 practices in South Cheshire, to review the support required.

Scope the potential to look at signposting for carers from community pharmacy	May- June 2015	
Carers champion event linking with carers week	June 2015	

HealthWatch
HealthWatch Cheshire East as "Consumer Champion" provides a voice for the residents of Cheshire East to help shape local health and social care services. Their role is to listen to and reflect the opinions of local people, and use this information to influence the design and delivery local services. The team work with local people and organisations as well as service providers so that individuals in Cheshire East get the best possible Health and Social Care services.

HealthWatch Cheshire East is a statutory organisation which delivers several key activities including:

- Providing information and advice about health and social care to the local community
- Gathering the views and experiences of the community and feeding these to decision makers to influence the design and delivery of local services
- Using the Enter and View process to scrutinise local adult health and social care establishments, ensuring that they are providing a good quality of life for the community.
- Representing the community on the Cheshire East Health and Wellbeing Board

HealthWatch Cheshire East has been working with NHS South Cheshire CCG to ensure that the community voice is heard and that the person is at the centre of the services delivered in South Cheshire. To achieve this HealthWatch have been feeding in local intelligence about the experiences of people accessing services that NHS South Cheshire CCG commissions and monitors. They have also been supporting the Connecting Care Programme, and during 2015-2016 will continue to support NHS South Cheshire CCG and other partners ensuring that the programme has effective engagement and involvement with the community.

HealthWatch Cheshire East have provided information and intelligence from the scrutiny work that they have been undertaking in South Cheshire. During 2015-2016 they will be working with the CCG to jointly develop their scrutiny programmes with the aim of creating a fully rounded picture of the quality of local services in South Cheshire.

During 2015-2016 they will be working closely with the CCG on an in-depth GP Access project. The aim of the review is to gather the views and experiences of the people utilising GP services, and identify the impact on the individual, their carers and family, if they are experiencing barriers. This evidence will be used to identify good practice and identify any necessary service improvements in Cheshire East.

NHS South Cheshire CCG values its relationship with HealthWatch Cheshire East and is committed to continue joint working during 2015-2016.

6.4. Equality & Diversity

As Commissioners we know and understand that demographic and financial challenges the NHS faces and that there is clear evidence that people's health, their access to health services and experiences of services are affected by the nine protected characteristics.

To enable the CCG to make fair commissioning decisions we will seek to ensure that we:

- Understand our requirements under the Equality Act 2010
- Undertake Equality Assessments on key areas of change and in designing new models of care

- Fully understand the needs of communities by protected characteristic
- Communicate, involve and consult with communities and stakeholders
- Continue to work in partnership with our key providers via the quality contract schedule to improve equality performance
- Continue to undertake EDS 2 to address barriers and health inequalities
- Engage and involve communities

NHS South Cheshire CCG has undertaken key pieces of work over the last year that demonstrates we consider our exacting duties including:

- Opening up equality assessments on key pieces of work: including Policies of Low Clinical Value, Urgent and Intermediate care and a high level Equality Analysis of the CCGs 5 year Connecting Care Strategy.
- Delivery against our Strategic Equality Objectives Plan: Working closely with key providers to ensure equality requirements are key component of the quality contract process, improving the equality performance of our providers and working together to resolve issues and close any gaps and undertaking a Equality Delivery System 2 (EDS2) self-assessment.

The Equality Delivery System 2 is one of the ways NHS South Cheshire CCG demonstrates it is under taking work that supports its delivery against the Public Sector Equality Duty (PSED). We are currently implementing a plan to implement EDS2 from January to April 2015 to seek the views of communities who face 'barriers' in relation to accessing services and are more likely to experience health inequalities. Once the information has been collated we believe the will be better able to understand the gaps and barriers certain communities face, take action to improve access and outcomes for patients and communities with protected characteristics and improve the equality performance of our key providers.

The CCG as a Progressive Employer
The introduction of the first NHS workforce race equality standard from April 2015 fits with the fact that the CCG has identified equality and diversity as a priority area in 2015/2016.

We are developing an Equality and Diversity Action Plan, setting out annual equality and diversity objectives which will be effective from April 2015. The Action Plan will provide assurance that NHS South Cheshire CCG is meeting our responsibilities under the Public Sector Equality Duty and in summary will include action for:

- **Policy proofing** – reviewing policies to ensure the fundamental elements of the Equality Act 2010 are incorporated and all policies have been through an equality impact assessments.
- **Monitoring** – enhancing current monitoring processes to include other key areas such as recruitment, selection, review and performance, career progression and employee relations to identify any areas of indirect discrimination and consider positive or corrective action.
- **Positive action** – widen the monitoring of performance against CCG policies to enable the identification of trends and allow for the challenge of potential barriers. This is a particularly important area for NHS South Cheshire CCG as a local employer and ensuring the workforce reflects the diversity of the local population.
- **Training** – E&D training is in place within the CCG but monitoring needs to be put in place to check the profile of attendees against worker profile.
- **Staff profile and surveys** – establish a staff profile and include E&D questions in the survey to enable an understanding of the staff relationship with organisational culture to eliminate any institutional discrimination.

At the end of December 2014 NHS South Cheshire CCG employed 2 members of staff from an ethnic minority background from the employed workforce of 69, and this equates to 2.90% of

the workforce. Analysis has shown that the Office for National Statistics (ONS) ethnic population estimate across the CCG area is 5.34% and from the analysis below it can be seen that the workforce across the CCG is not representative of the population it serves.

7. Delivering Connecting Care (our new model of care)

7.1. Building the Foundations for The Future

Our health and social care systems face significant challenges. We are living with increasingly complex care needs. This coupled with continual advancement of care options, means that each year more and more can be done for more and more of us. However, more and more money is not available and continual improvements can only be funded from being more efficient and effective. We do not claim to have every answer to this difficult problem. However, we do believe that we know where we should be heading and the main strands of change that are needed.

The NHS has generally been successful in responding to the increase demand and pressures of a growing population, an ageing population and a sicker population as well as new drugs and treatment and cuts in local councils' social care. However if the NHS is to continue as a service available to all at the point of need there are a number of challenges that need to be tackled:

- Changes in patients' health needs and personal preferences. Long terms health conditions take 70% of the health service budget, rather than illnesses that respond to a one-off cure. Many people want to be more informed and involved with their own care. Greater opportunities for better health through increased prevention and supported self-care.

- Changes in treatment, technologies and care delivery. Technology is transforming our ability to predict, diagnose and treat disease. We know there are better ways of organising care, breaking boundaries between hospital and primary care, health and social care, generalists and specialists.

- Changes in health services funding growth. NHS spending has been protected over the past five years, but the pressures are building.

New Models of Care:
We need to develop new models of care, that recognise the importance of patient goals, carers and self-care, shared decision-making, health coaching, motivational support and a move towards true partnerships with those who use services. Our new models must include a wider perspective, with an understanding of the wider determinants of health.

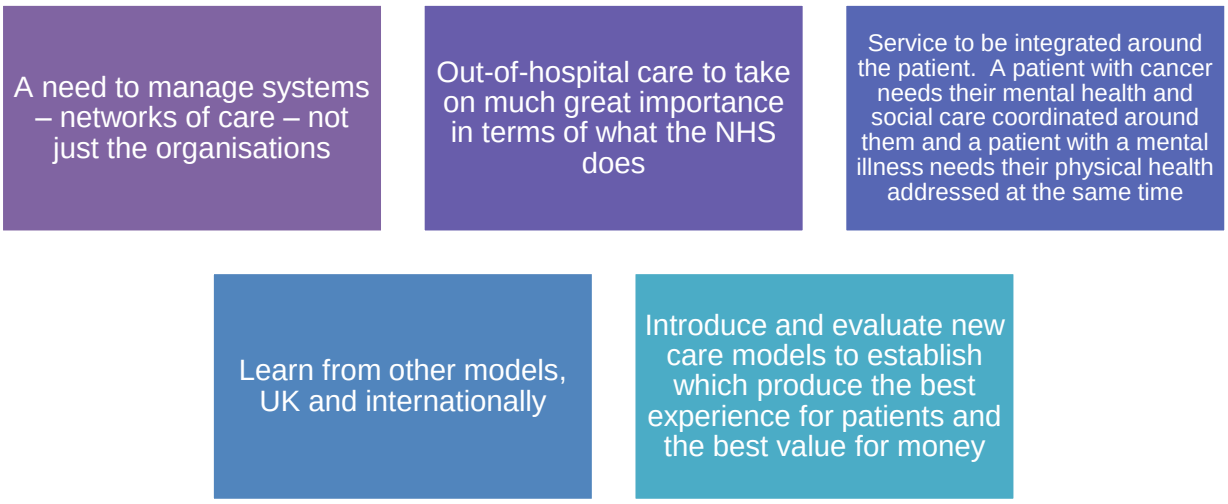
Our plans are to create structures of care that bring together professionals from different organisations and make them accountable together for a population of patients, responsible for working with those patients to deliver care but also to continually improving the system of care within which they work. We want to see them form learning organisations/teams to deliver this continual improvement in work.

These changes need new relationships between our hospitals, mental health services, social care, community services and GP practices and we need new ways to contract between them and measure their success.

The traditional divide between primary care, community services and hospitals is a barrier to a more patient-centred care and coordinated health services. The NHS *Five Year Forward View* sets out a clear vision for how traditional boundaries need to be broken down if we are to meet the changing needs and increasing demands on the health and social care service.

As long term conditions are a main priority for the NHS, our approach to caring for these patients now needs a more collaborative relationship with patients over a longer period, and not just dealing with single episodes of care, but caring for the whole person and their health and social

care needs. The direction of travel set out in the NHS Five Year Forward View sets out some key principles:



The *Five Year Forward View* sets the challenge that we must meet the needs of patients and capitalise on the opportunities presented by new technologies and treatments. Our Connecting Care Strategy in Central Cheshire sets out our ambition to achieve this.

Connecting Care: Laying the 6 Foundation Stones for Success

In NHS South Cheshire CCG we have established a Partnership Board for our **Connecting Care Programme**. This Board has representation from commissioners (CCGs, Local Authorities & NHS England), and our main providers (Mid Cheshire Hospital NHS Foundation Trust, East Cheshire NHS Trust for community services, Cheshire and Wirral Partnership NHS Foundation Trust, North West Ambulance Service and Primary Care). It has the Chief Executive, Medical Director and/or lead Executive Director from all of these organisations sitting on it. The commitment to the Connecting Care Board is strong from all partners. However there is a recognition that this commitment now needs to turn into action and delivery of change.

Published in June 2014, our **Connecting Care Strategy** articulates shared ambitions and a programme of work for the population across South Cheshire and Vale Royal. The Strategy sets out to support the people within our local communities to be empowered to take responsibility for their own health and wellbeing. They will place less demand on more costly public services through the implementation of ground-breaking models of care and support based on:

- integrated communities
- integrated case management
- integrated commissioning and

- Integrated enablers to support these new ways of working.

The Connecting Care Board has also established a 'Provider Board' which brings together multiple acute, mental health, community and primary care providers across central Cheshire. An 'Innovation Fund' was also created via an 'Alliance contract' to achieve our ambitions for the care system.

Our Connecting Care Strategy has already begun to change the way we commission and deliver health and social care; building the foundations for early adoption of a new models of care for the years ahead.

The Strategy is underpinned by 6 key integration outcomes/ Foundation Stones created by the Connecting Care Board to provide a single framework for integration and transformation, which aligned directly to the exiting NHS Constitution, health, public health, social care and 'Everyone Counts' outcomes frameworks and measures.

Each stone identifies the specific area of the Connecting Care Programme Plan and the relative plans, aspirations and measures of success that relate directly to the 6 health and social care integration outcomes. The following table illustrates our Foundation Stones and key actions to support their delivery.

	Outcome / Foundation Stone	Detailed summary	Actions
1	**Communities that promote and support healthier living**	Individuals and communities are able, motivated to and supported to look after and improve their health and wellbeing, resulting in more people being in good health or their best possible health for longer with reduced health inequalities.	Build stronger, self-reliant communities that promote and support healthier living by empowering and building resilience within individuals. Work with partners to address the multiple/wide determinants of health and well-being
2	**An empowered and engaged workforce and public**	People who work in health, social care and community support/voluntary sector support are positive about their role, are supported to improve the care and support they provide and are empowered at a local level to lead change and develop new ways of working Citizens are engaged in the shaping and development of health and care services and supported to make positive choices about their own health and wellbeing	Support service users to lead their own care and to understand and self-manage their condition Work in partnership with our citizens in the planning, development, commissioning, re-design and evaluation of care Establish integrated multi-disciplinary teams around the individual in local communities Work collaboratively to develop a joint workforce strategy and

			plans Utilise large scale change methodologies to promote positive culture change to focus on new models of care and quality/continuous improvement
3	**Personalised care that supports self-management and independence and enhances quality of life**	People with physical or mental Long Term Conditions, those with complex needs and the elderly frail are able to live as safely and independently as possible in the community. They will plan care with people who work together to achieve the outcomes important to them. Care will have a focus on prevention, self-management and independence and the individual will have control over their care and support.	Developing the skills of teams and citizens to implement whole person care to realise shared decision making, a focus on an individual's own goals and maximising health and wellbeing & quality of life Personalised care planning, care co-ordination and case management through integrated community teams Continuous evaluation with robust metrics of care and experience to facilitate continuous quality improvement
4	**Individuals will have positive experiences and outcomes of safe services**	People have positive experiences of health, social care and support services, which help to maintain and improve their own health and wellbeing People using health, social care and support services feel safe and secure, are safe-guarded from harm, have their dignity and human rights respected and are supported to plan ahead and have the freedom to manage risks the way that they wish	Build a strong focus on positive experience and safety to all aspects of care across the system and build in robust governance, shared information systems, monitoring and management systems Develop the skills of the workforce to seek, identify and address any shortcomings in quality and safety in collaboration with the public and across partners to harness opportunities for continuous improvement Create a culture of openness and transparency and develop support structures for frontline staff and the public raising concerns
5	**Carers are supported**	People who provide unpaid care for others are supported, are	A robust framework of support is offered to carers to facilitate

		consulted in decisions about the person they care for and they are able to maintain their own health and well-being and achieve quality of life	their continued role as a carer and their right to a quality of life Support carers to understand and support self-care.
6	**Effective resource use**	The most effective use is made of resources across health and social care, involving partnership working, joint commissioning, sharing of information, new contracting and funding approaches, exploiting new technologies and avoiding waste and unnecessary duplication.	Increase the amount of joint working and joint commissioning across a range of areas to avoid duplication and gain value for money Create joint systems: shared information system, system governance, integrated health and social care teams and new contracting and care models e.g. COBIC/Alliance, Accountable Care System.

Using the 6 Foundation Stones from the Connecting Care Strategy, along with the top health inequalities, the CCG has adopted the following 5 Strategic Priorities and local ambitions which will support the delivery of the Connecting Care Strategy:

CCG Strategic Priorities

- **Mental Health** – recognising that this is a significant area of health need locally with a national focus on parity of esteem
- **Transformation of Primary Care** – this will build on the transformation work that has already started in 2014-15.
- **Integration** – the delivery of Integrated Community Teams and the transformation of community services (some of which will be delivered through the Better Care Fund).
- **Urgent Care** – to bring a renewed focus on transforming the current system (some of which will be delivered through the Better Care Fund).
- **Person Centred Care** – with a focus self-care, self-management and empowering communities and individuals.
- **NHS Constitution Standards - accountable for** improving health outcomes , commissioning high quality care and best use resources

Our plans, proposed initiatives and redesign work will contribute to delivery of the Connecting Care Foundation Stones and the CCG Strategic Priorities as shown by some of our key commissioning activities for 2015/16:

Integrated Community Teams (ICTs):
This project reflects NHS South Cheshire ambition to move appropriate care from a hospital to community settings. Integrated Community Teams (ICTs) aim to facilitate a shift in focus from episodic and reactive care to continuous, long term care; from paternalistic to a person centred care model. This model aims to deliver services in a way that puts patients and service users at the centre, giving them more control.

This means that instead of patients and service users trying to navigate their way around the multitude of health and social care services, we are redesigning services to fit around their needs. We want to reduce duplication of care, prevent people having to tell their story multiple times and to minimise waste across care settings. The ICTs have been designed to achieve the model of care requirements for people with complex needs, including:

- strengthening primary care and its role in proactive long term condition management
- empowering people to live full and healthy lives, self-manage and where required supporting people and their families with improved information and technology
- increasing the investment and portfolio of services in the community to support care closer to home where safe and effective to do so
- people knowing where to get the right help at the right time
- carers supported to continue caring in partnership with other support services
- Our aim is that Integrated CommunityTeams deliver joined up care to our citizens; empowering them to be active partners in their care, improving their life expectancy and providing greater levels of integrated care. This in turn will reduce unnecessary hospital admissions and long lengths of stay in hospital.

The agreement with the Connecting Care Board is to establish 5 Integrated Community Teams across South Cheshire and Vale Royal (3 in South Cheshire and 2 in Vale Royal) from which named health and social care professionals will in-reach into the 9 Integrated Care GP clusters. This will create a localised integrated team approach linked to GP practices.

Expected outcomes for the implementation of Integrated Community Care Teams:

Patient	• Increase in the number of patients who have a positive experience of care outside of hospital, in general practice and in the community • Increase in the proportion of older people living independently at home following discharge from hospital into reablement/rehabilitation services • Increase in the number of carers who report that they have been included or consulted in discussions about the person they care for • Increase in the number of patients providing positive feedback on the quality of service and care • Increase in the number of patients with a named key worker/first point of contact • Increase in number of patients with a care plan in place to meet their needs
Clinical	• Improved health and social care related quality of life for people with long term conditions • Proportion of patients recovering to their previous level of morbidity/walking ability at 30 and 120 days
Managerial	• Reduction in emergency admissions from baseline by 15% by 2019 • Reduction in delayed transfers of care and those attributable to adult social care • Reduction in number of direct admissions to long term care from acute care • Reduction in the number of readmissions • Reduction in the length of stay in hospital • Effectiveness of reablement
Learning /Growth	• Continuous improvement cycle • Increasing effectiveness of integrated team working • Increased freedom to innovate • Improved staff experience/satisfaction/confidence

We will also be measuring the success of ICTs in terms of quantifying the improved health and social care related quality of life for people with long-term conditions and the proportion of patients recovering to their previous levels of mobility /walking ability at 30 and 120 days.

Intermediate Care – STAIRRS
In 2014 NHS South Cheshire CCG reviewed how we commission Intermediate Care services. Existing models of intermediate health care and social care reablement were found to be separate services; protected by strict access criteria. Patients described a dis-connect between services where needs are complex and a lack of coordination or single hub. Problems were found when people required a rapid response to avoid a hospital admission. Hospital discharge services were also found to be fragmented, with serial assessments for complex patients. Finally, we noted a lack of specified dementia friendly bed based services and specific dementia facilities for patients with behavioural problems.

It was found that where facilities have multiple types of beds they allow patients to move to other levels of support within the same facility as patient's care needs change. Length of stay is reduced overall to 3 weeks and allows a higher throughput of patients. In addition, this group of patients were originally thought not to have rehabilitation potential and to be largely awaiting placement in long term care but the return home rate has greatly exceeded expectations (1.5% into long term care) and it is proving to be successful at rehabilitating patients.

The findings of the review were used to create a vision for the future provision of intermediate care and reablement services to be known as 'Short Term Assessment, Intervention, Recovery and Rehabilitation Service' - STAIRRS. The STAIRRS approach will bring together these current services in a joined up way to ensure seamless health and social care at the time of greatest need to help patients who need a short, intensive period of additional help to support recovery.

Bringing together existing intermediate care, reablement and other community support services STAIRRS will shift the balance of provision from acute bed based services to community step up and home based health and social care support. The service will be delivered through a redesign of existing intermediate care, reablement and other community support services to provide timely access to assessment and intervention and reduce emergency admissions.

Development and implementation plans for STAIRRS will be in place by April 2015 with a staged implementation throughout the year.

Integrated Urgent Care
An effective integrated urgent care system is essential to achieving the CCGs strategic ambitions and connecting care foundation stone.

This commissioning intention aims to develop and implement an integrated urgent care system across health and social care that is both responsive to patient need and delivers quality care in the most suitable setting. Delivering a high quality, cost effective, seamless, responsive services both in and out of hours.

Three cross-organisational workshops have taken place during 2014-15 to develop a common understanding of the current services, the financial position, issues faced locally and the national direction for urgent care services.

The CCG has developed a suite of outcomes for service redesign in 2015/16. The Central Cheshire Connecting Care Board will be overseeing the development of these outcomes and a full business case will be developed with the aim to deliver a whole system change by April 2016.

GP Care Home Scheme
The purpose the GP Care Home Scheme is to:

- Avoiding hospital admissions

- Improving patient involvement in their care
- Delivering care in the residents' place of choice.

Following a review of the scheme in May 2014 which identified areas of good practice as well as opportunities to deliver an improved revised scheme.

At the same time the national admission avoidance Direct Enhanced Service (DES) for GP practices was introduced which incorporated elements of the CCG Care Home Scheme, specifically relating to care planning for the frail elderly.

Quality Standards in Nursing Homes

The aim of this work is to build on the robust governance and information sharing protocols, to deliver planned quality and assurance monitoring.

During 2014 we established a multidisciplinary group with CEC, working with a comprehensive data set, a Multi-Agency Risk and Safeguarding (MARS) intelligence database. This group uses information provided by all partner agencies to identify homes that are requiring support or additional monitoring.

From these initiatives the following work streams and outcomes planned for 2015-16:

- Review of the joint commissioning contracts - with clear quality outcomes identified within.
- Development of a joint monitoring audit tools for use by Health and Local Authority
- Monitoring leadership of the clinical staff in the care homes.
- Continued development of the care home network forums with opportunities to share and cascade best practice and provide information to the private providers.
- A programme of targeted interventions, training and communications in respect of identified themes.
- Ongoing development of audit tools to improve quality outcomes to promote best practice information sharing and joint working between all partners.
- Develop coordinated programme of reviews and inspections with where appropriate, CQC, Local Authority and Healthwatch.

7.2. Delivering a New Deal for Primary Care

In 2014, the NHS South Cheshire CCG outlined ambitious intentions towards delivering a programme of transformational change across Primary Care that supports the delivery of a wider programme of integration of care services. To do this, the CCG has been working alongside its member GP Practices and representative Primary Care Provider organisations to explore how we can build on the strong, high quality care primary care that is already in place.

Over the past 12 months we have developed and delivered in partnership with GP colleagues a comprehensive range of initiatives that support the CCGs vision towards:

- developing Primary Care as a prime provider for delivery of services
- supporting extended access to General Medical services
- supporting integrated care and
- advocating the development of proactive care and patient self-management.

Through our Local Quality Scheme, we have contributed to the emergence of a number of primary Care Provider organisations that bring together GP practices, set around a minimum population size of 30,000 – 50,000 patients. These provider organisations represent not only a strengthening of Primary care as a provider but provide the cornerstone for the delivery of a truly integrated health system.

We have:

- Successfully encouraged 100% of our GP practices toward formally align within a Primary Care Provider organisation
- Developed and delivered initiatives that ensure people feel supported to manage their Long Term Conditions, following an unplanned admission to hospital.
- Developed a register and a programme of intervention for those patients that are Vulnerable or Isolated. This provides health and well-being interventions to support patients and their carers to stay well, in their own home.
- Developed an enhanced programme of capturing and reviewing patients with a diagnosis of Atrial Fibrillation and ensuring that they are receiving the optimal medication in line with best practice and NICE guidelines. This has resulted in more patients receiving anticoagulant treatment to reduce their risk of stroke.
- Implemented Direct Access for Physiotherapy across Sandbach, Middlewich, Alsager, Scholar Green and Haslington.
- Identified and implemented EMIS Risk Stratification across all Practices.
- Supported the development of Primary Care Providers plans that will deliver extended primary care, including extended access from 7am – 8pm Monday to Friday and 10 – 4pm on Saturday and Sunday.
- Implemented Quality and Safety Champions in Primary Care across all localities. The Quality and Safety Champions provide clinical protected capacity within Primary Care to focus on and undertake work that will continue to embed quality and safety within all our practices, allowing us to be unique as a CCG in developing a designated champion to promote quality and safety at ground roots level.
- Placed kiosks in practices to capture real time information around patient experience and satisfaction feedback.
- Developed a detailed series of data sets and reports that enable member practices and the CCG to benchmark achievement and quality across planned care activity.
- Developed a detailed Primary Care Dashboard that enables a comprehensive understanding of practice demographics, key quality markers, disease prevalence and prescribing.

2015/16 and Beyond

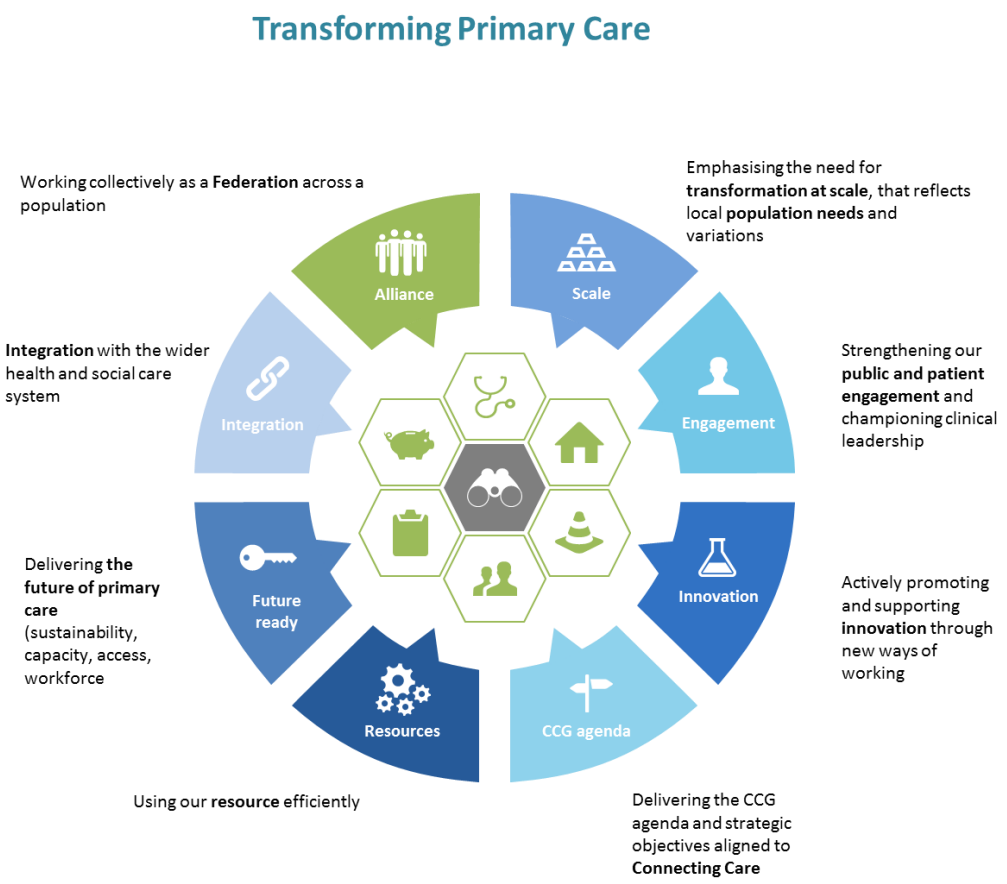
As we look forward to 2015/16 we recognise that this will be an ambitious year for Developing Primary Care. 14/15 was the test bed for the advent of far reaching and aspirational initiatives for our practices and services that focus upon delivering Primary care at scale, improved quality, delivering outcomes for the population that we serve and strengthen the collective co-ordination of general practices, across populations, and as part of the wider health system

Through the prioritisation process, we have committed our intention to delivering initiatives developed in the first year of our two year plan, which will see services such as those detailed below implemented across South Cheshire and Vale Royal.

We will deliver:

- A range of community based intervention services, such as;
    - community based catheter service
    - COPD Hotline for patients
    - Community based Minor injuries services
    - A range of consultant led GP clinics
    - Primary Care input into GP care homes
    - Community based phlebotomy services
- Larger change initiatives that will build the strength of General practice locally, such as:

- provide direct support to the practices and individual through in- practice case managers whose requirements are directly exacerbated or impacted by social factors linking in with community and voluntary sector support
- signpost' individuals into other local third sector provision
- Delivery our marketing and public awareness campaign, set around the promotion of primary care as being "Open for Business"
- ensure that each practice has processes and systems in place to enable all patients to be able to access services / advice to address their urgent needs and for practices to fully understand their access and demand needs and tools to increase capacity.
- Increase the number of on-line appointment availability across all practices
- Extended access to GP services
- Co-Commissioning of Primary Care



Outcome based Competency framework for general practice
This year, we will be implementing the first phase of our Outcomes based Competency Framework for General Practice.

This is an aspirational programme of primary care Transformation and development places emphasis and ownership on aspirational development driven by outcomes rather than process.

Not only will we seek to strengthen and mature our GP federations locally, we will seek to enable a cultural and practical shift of General practice through professional, organisational and qualitative development.

We will:

- Continue to work with influential partnerships such as AQuA and health Education England to build and promote a culture and programme of excellence for primary care quality.

- Consider and respond to the challenges and ambitions laid out within the FYFV
- Deliver a programme of Primary Care development that focuses on outcomes that are responsive to local need.
- Laid down the foundations for a continuous programme of quality improvement that will be developed over the next 3 – 5 years.

In collective agreement, we will be focusing our attention on developing competency descriptors built on outcomes across 6 key areas:

-
- Driving Clinical Quality (AF, COPD, diabetes etc)
- Addressing Access and Demand within primary care
- Building capacity within Primary Care
- Building maturity and strength across populations and federations
- Fostering organisational and cultural development within Practice
- Driving innovation in primary care

All of which will be underpinned by the following principles:

-
- Ensuring quality improvement measures are embedded
- Commitment to delivering patient centred care
- Recognising the requirement for delivering productivity
- Delivering a programme of development built upon evidence based medicine and practice.

Co-Commissioning of Primary Care

From 1st April 2015, NHS South Cheshire CCG and NHS Vale Royal CCG will be assuming greater responsibility in the commissioning of Primary Medical Care services in partnership with NHS England.

The CCG, member practices and the LMC regard the opportunity for joint commissioning of Primary Medical Care as an essential step towards expanding and strengthening general practice whilst improving services for patients.

The CCG has been working alongside its member GP Practices and representative Primary Care Provider organisations to explore how we can build on the strong, high quality care primary care that is already in place. We regard co commissioning of Primary Care an essential step towards expanding and strengthening the delivering our of Primary care services and a key mechanism that will ensure that high quality, patient centric local provision remains at the forefront of health care for the population of South Cheshire.

Delivering improved primary care

Principles will be delivered through nine changes in how primary care

Promoting consistency and collaborative working, ensuring that all patients can access services even if they are not provided by the practice they are registered with

Developing our 'provider' influence and ensure GPs have a clear understanding of their role and accountabilities

Developing **alternative solutions** to support support patients whose ill-health is caused by social factors, by utilising a range of third sector provision

Utilising IT to support our Alliance model, including promotion of self-care

Ensuring primary care is **'open for business'**, especially for urgent care needs, by utilising peer support and capacity

Developing **new models of service delivery** with collective management of patient care in priority areas (e.g., dermatology, mental health, physiotherapy, phlebotomy)

Improving the primary care of the elderly through establishment of a community geriatrician led service

Delivering **consultant outpatient sessions** locally

Ensuring robust GP practices by practices working together to improve efficiency (e.g., shared provision of non-core service, nurse bank)

Practice Nurse Membership Council

As a clinically led organisation we are keen to empower a strong nursing voice, particularly from practices nurses who have well developed relationships with patients and take a big role in supporting patients to manage their own health needs and have valuable knowledge and skills relating to impact for and approaches with patients.

Practice Nurses across South Cheshire want to ensure consistently high quality care for all patients, delivering on all of the 6C's of the nursing strategy. Therefore a Practice Nurse Membership Council was established in 2014-15, providing the opportunity for a consistent approach to achieve quality and sharing best practice within practice nursing and also to influence nursing developments and approaches within the South Cheshire area.

Achievements of work undertaken through the Practice Nurse Membership during 2014-15 are presented below:

- The formation of the Practice Nurse Membership Council was included in the Chief Nursing Officer 6Cs 'One Year On' Report at the end of 2013. This was followed with an interview for the NHS 'Putting Patients First' film in June 2014 which supported the NHS Business Strategy Plan.
- Working collaboratively with the CCG Practice Engagement Managers (PEMs), Joint Nurse Education Sessions for Practice Nurses were delivered to incorporate mandatory training along with building links and raising awareness of 3rd sector organisations.
- There has been increased activity and engagement between Practice Nurses and Patient Panel Groups (PPGs) with Nurses encouraged to attend their own PPG meetings. Patients encouraged to support the Flu campaign within their own surgery and the Quality lead Practice Nurse attended the Joint PPG Annual Meeting for the CCG.
- A second group of Pre -Registration Nursing Students have just completed their 10 week placement in Primary Care. Within South Cheshire there are currently 10 mentors, with 3 trained to Masters level to enable them to take 2nd and 3rd year Nursing students.
- One Practice was successful in their Workforce Modernisation bid to fund a HCA through Assistant Practitioner training.
- Several Nurses joined forces with teams from the CCG at the Nantwich Show to promote healthy living.
- The Practice Nurse Council developed the Vulnerable and Isolated Patient (VIP) Register through the local CQUINN scheme. This new model of care enabled nurses to remotely assess the physical, mental and social well-being of an identified vulnerable cohort of patients. (Report to follow shortly)
- The Practice Nurse Quality Lead was invited to an evening Reception with the Prime Minister at 10 Downing Street to celebrate the work of Nurses in Oct 2014
- Practice Nurses from the Nurses Council attended the 'Northwest Conference Out of Hospital Care' in November 2014 to discuss the future of Primary Care Nursing and the 5 year Forward Plan.
- The formation of the expert reference group which aims to support the connecting care board with representation from primary, community and secondary care nurses, AHPs, mental health and social care sectors.

Plans 2015-16:
Building on the foundations from their inaugural year, the Practice Nurse Council have identified the following plans for 2015-16:

- Roll out of the 6Cs Implementation Plans across Practices (at CCG Level and Practice Level
- To Support NHS Five Year Forward View
- Bespoke Leadership Course
- PNs to be 'Carer Champions' for South Cheshire by raising awareness through PLTs, VIP scheme, speaking at Carers Conference.

- Develop rolling Education programme through PLTs, HEENW,
- Workforce Project (HEENW)-developing clinical roles, fund more APs
- New Model of Care for pts with LTCs e.g House of care for pts with diabetes to encourage self-management and care planning.
- NMC Revalidation Workshops
- To increase number of nursing Students in Primary Care.
- To input into the development of Diabetes and Podiatry pathways

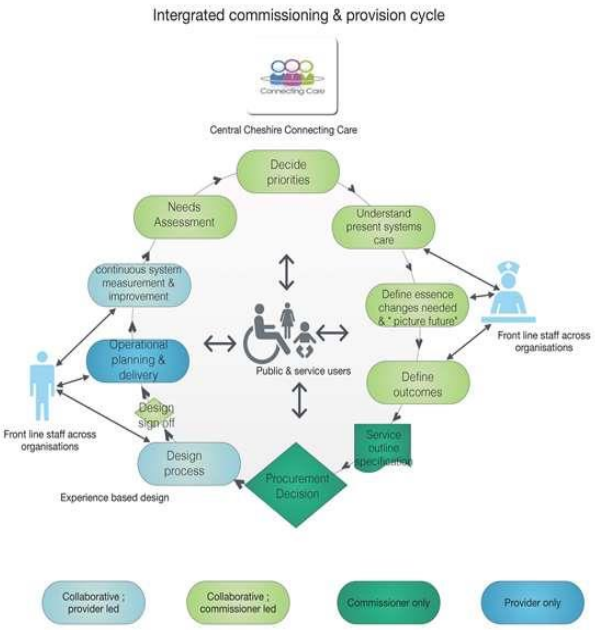
7.3. New Care Models – urgent and emergency care

2015-2016 Operational Resilience funding to address additional pressure in the health and social care system has been allocated to the CCG's base budget, rather than being allocated in late Summer early Autumn. This early notification will enable the Resilience Groups to prepare and implement robust plans in a timely manner to ensure patients continue to receive a high quality safe service during times of increased demand. NHS South Cheshire CCG has been allocated £1,080,000 and NHS Vale Royal CCG has been allocated £638,000, meaning that the whole local health and social care economy has a total of £1,718,000 to invest. The schemes supported during 2014-2015 will be evaluated in May to ensure partners clearly understand what schemes have had the largest impact for patients, whilst providing an effective and efficient service. This information will be used alongside the Resilience Groups detailed risk log to ensure schemes introduced during 2015-2016 make a significant impact on handling the increased demand and focused on the economy areas facing the highest risks.

Using our winter monies we commissioned the British Red Cross to assist our acute provider with supported discharge. The service costs approximately £9K a month to operate, which equates to £108K per year. For the first 2 months, the service set itself a target of saving 15 potential bed days, the service actually saved a potential 91 bed days, which if costed at £350/day equates to £31,850 (which could be £191,100 over an entire year). In December the service transported 80 patients home and 33 were referred to BRC Leighton Support At Home service where patients are provided with none medical support for up to 6 weeks.

7.4. Commissioning Principles – 'Ways of Working'

[DN: Joint Working Between Commissioners And Provider – include narrative for final Ops Plan]



Alliance Contract
Within 2015/16 the CCG will be continuing the use of an Alliance Contract which was developed during 2014/15. The scope of this innovative approach to contracting will be enhanced with the inclusion of the Better Care Fund (where applicable) for the local health and care economy within 2015/16. The Governance of the Alliance Contract with the Provider Board will be further strengthened with the introduction of the Commissioner Alliance Performance Management meeting which will be accountable to the Connecting Care Board.

Provider Board
The Provider Board was established in 2014/15 between partners from the local health and care economy. The remit of this group, reporting to the Connecting Care Board, was to implement Integrated Community Teams and deliver the outcomes specified within the Alliance Contract. For 2015/16 the remit of the Provider Board will be further developed with the inclusion of the Better Care Fund (applicable schemes) and included within the Alliance Contract.

Better Care Fund
One of the main strategic drivers nationally is for social and health care commissioners to work more closely together. In order to facilitate closer working the Government has identified the Better Care Fund which will be a pooled resource to facilitate joint planning, information sharing and services.

The Department for Communities and Local Government and the Department of Health has identified £3.8 billion of funds for investment in this integration. £3.4 billion is expected to come from CCG budgets; in order that the creation of the fund does not result in a financial pressure the associated investments will need to identify significant transformational change to reduce demand for social and health care. If these changes do not lead to more effective use of services this could result in a financial pressure across the health and social care system.

Plans have been agreed between NHS South Cheshire CCG and Cheshire East Council and adopted by the Health and Well Being Board. The overarching local Pioneer Project Connecting Care will provide a structure for the development of these plans.

The total better care fund to be identified by the CCG is £10.481 million.

The Plans identified include:

1. Self care and self management
    - Supporting Empowerment
    - Universal Access to low level assistive technology, occupational therapy advice and assessment
    - Assistive Technology Pilot for adults with a learning disability
    - Facilitating Early Discharge
    - Disabled Facilities Grant funded service
    - Carer's Assessment and Support

2. Integrated community services
    - Dementia Reablement
    - Community based co-ordinated care
    - Integrated Community Service Model – Connecting Care

3. Community based urgent care/rapid response
    - Implementing a Short Term Assessment Intervention recovery & Rehabilitation Service (STAIRRS)
    - Social Care Capital and Programme Enablers

8. Priorities for Operational Delivery in 2015-16

8.1. Improving Access and Outcomes

8.1.1. Meeting the NHS Constitution Standards.

At NHS South Cheshire CCG we are committed to improving outcomes: better health for the population of South Cheshire, increasing the quality of care received by all patients whilst being accountable custodians of the public purse. To achieve this, we need to deliver sustained improvements against the NHS Constitution standards, NHS Outcomes Framework and the seven sentinel indicators.

NHS South Cheshire CCG	CCG 2014/15 Target	YTD	CCG 2015/16 Performance Targets
Referral to Treatment waiting times for non-urgent consultant-led treatment			
Admitted	>= 90%	94.13%	>= 90%
Non Admitted	>= 95%	95.40%	>= 95%
Incomplete	>= 92%	95.04%	>= 92%
Diagnostic test waiting times >6 weeks	< 1%	0.51%	< 1%
A&E waits	>= 95%	94.00%	>= 95%
Cancer waits – 2 week wait			
Cancer 2 Week Wait - All cancer two week wait	>= 93%	94.92%	>= 93%
Cancer 2 Week Wait - Non-suspected cancer breast symptoms	>= 93%	94.42%	>= 93%
Cancer waits – 31 days			
Cancer 31 day first treatment	>= 96%	98.91%	>= 96%
Cancer 31 day subsequent treatments - surgery	>= 94%	100.00%	>= 94%
Cancer 31 day subsequent treatments - anti-cancer drugs	>= 98%	100.00%	>= 98%
Cancer 31 day - Subsequent treatments - radiotherapy	>= 94%	98.25%	>= 94%
Cancer waits – 62 days			
Cancer 62 day referral to first treatment -	>= 85%	89.45%	>= 85%
Cancer 62 day referral to first treatment - NHS screening referral	>= 90%	93.10%	>= 90%
Cancer 62 day referral to first treatment - consultant referral upgrade	n/a	85.37%	n/a
Category A ambulance calls			
Ambulance - Category A (Red 1) - 8 minute response	>= 75%	67.72%	>= 75%
Ambulance - Category A (Red 2) - 8 minute response	>= 75%	68.84%	>= 75%

Ambulance - Category A - 19 minute response	>= 95%	95.32%	>= 95%
NHS Constitution Support Measures			
Mixed Sex Accommodation breaches	0	0	0
Cancelled Operations - Percentage of patients not offered a binding date within 28 days of a cancelled operation. (MCHFT only)	0.00%	0.67%	0.00%
Mental Health			
Mental Health - % of patients on CPA discharged from inpatient care who are followed up within 7 days	>= 95%	95.56%	>= 95%
Referral To Treatment Waiting Times for Non-Urgent Consultant Led Treatment - waiting <=52 weeks			
Admitted	0	2	0
Non Admitted	0	0	0
Incomplete	0	0	0
A&E - Note: Plans are to be submitted by lead commissioners of Type 1 Trusts. Plan submitted should be for all attendances to A&E			
Trolley Waits in A&E - 12hr waits from Decision to Admit to Admission (MCHFT)	0	0	0
All A&E Attendances (In 2015/16 Plans for NHS South Cheshire Only as lead CCG - MCHFT)	new measure	64002	89549
Cancelled Operations - Number of Urgent Operations Cancelled for a second time (MCHFT)	0	0	0
Ambulance Handovers			
Ambulance Handover Time - delays of over 30 minutes	Reduction in delays	99.21%	Reduction in delays
Ambulance Handover Time - delays of over 1 hour	Reduction in delays	99.94%	Reduction in delays
Referrals			
GP referrals - G&A	Full year plan: 37,956	28700	38666
Other referrals - G&A	Full year plan: 17,300	12432	16302
Elective			
Inpatient - G&A	Full year plan: 4,089	2920	3739
Day cases - G&A	Full year plan: 21,572	15153	20555

Non-elective	Full year plan: 22,054	16535	19252
Out-patients			
GP referred - G&A	Full year plan: 33,957	25825	38746
All 1st Outpatients - G&A	Full year plan: 57,898	43294	58491
Subsequent Outpatient Attendances	Full year plan: 120,535	54460	127886
Infection			
MRSA	0	1	0
C Difficile	42	53	52
Mental Health			
Dementia - Diagnosis Rate	67% by end of year	57.50%	68.62%
New Mental Health access waits			
The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period. (Local Data)	No plans for 2014/15	79.00%	75%
The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.(Local Data)	No plans for 2014/15	92.20%	95%
IAPT - proportion of people who have depression/anxiety who receive psychological therapies (local data)	15% YTD	5.61%	16%
IAPT - proportion who complete treatment who are moving to recovery (local data)	50%	45.29%	50%
IAPT - proportion who complete treatment who are moving to recovery (Published)	50%	52.63%	50%

NHS OUTCOME DOMAIN

1. Prevent people from dying prematurely
2. People with Long Term Conditions (including mental illness) have the best possible quality of life
3. Patients are able to recover quickly and successfully from episodes of ill-health and injury
4. Patient have a positive experience of care
5. Patient in our care are kept safe and protected from all avoidable harm

SEVEN SENTINEL INDICATORS

i. Securing additional years of life for people with treatable mental and physical health conditions
ii. Improving the health related quality of life for people with long term conditions, including mental health conditions
iii. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital
iv. Increasing the proportion of older people living independently at home following discharge from hospital
v. Increasing the number of people having a positive experience of hospital care
vi. 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
vii. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

8.1.2. Clinical Accountability

At NHS South Cheshire CCG we believe that by having a named clinician both in primary and secondary care, with responsibility for the overall management, continuity and delivery of a patient's care will benefit patients and improve the quality of care. During 2015/16 will be continuing to seek assurance from all of our providers on the arrangements they have in place and the improvements this has brought in the quality of patient care. For our acute provider we will monitor this through the accountability structures that will be reported through the clinical review meetings. Where there is a need for escalation this will be through the appropriate governance mechanisms.

As part of the service quality review visit the name of the accountable clinician and nurse forms part of the proforma. Information is sought from both staff and patients. This will go forward into 2015/16. At Root Cause Analysis review meetings clinical accountability is part of the investigation process and if applicable is explored further as part of the investigation. All lessons learned from incidents is shared individually with responsible clinicians and also appropriate members of other health care professions. Clinical audit that have been undertaken have specifically asked the name of the accountable clinician. This will be taken forward into 2015/16.

8.2. Improving Quality & Safeguarding

8.2.1. Response to Francis, Berwick and Winterbourne View (including Transforming Care for People with Learning Disabilities)

NHS South Cheshire CCG continues to strive to improve the quality of care provided to its local population. In order for us to do this it is essential that we learn from both local and national significant events and publications such as the Francis, Berwick and Winterbourne View reports. In 2014/15 Mersey Internal Agency reported significant assurance against the key recommendations included in the Francis, Berwick and Winterbourne View Reports for the systems and process we had put in place for NHS South Cheshire CCG.

Transforming Care" is the national response to the abuse that took place Winterbourne View, an independent hospital for adults with learning disabilities. We are working closely with the local authority to implement the recommendations made in Transforming Care and the subsequent report by Sir Stephen Bubb.

One of the requirements under Transforming Care has been to carry out "Care and Treatment Reviews of all adults with learning disabilities and/or Autism who are currently resident in inpatient settings. In conjunction with service users, their families, advocates and local authority partners, the findings of these reviews will now be used to help us commission person centred support in appropriate community settings for those individuals. Our work with local authority partners will also encompass a wider use of personal budgets (through the Cheshire West and Chester Integrated Personal Commissioning Programme) and the further development of joint commissioning frameworks for Learning Disability services. These frameworks describe in detail a wide range of quality requirements that are demanded of services and are designed to ensure that provision is of a consistently high standard. In line with our organisational priorities the frameworks also reflect the fact that providers should be working towards improving their clients' physical as well as mental health.

8.2.2. Patient Safety

Specifically the quality team have commissioned root cause analysis training for Primary Care quality champions in all GP practices in South Cheshire and Vale Royal in 2015. This training will highlight the importance of incident reporting, investigation and sharing of lessons learned across all GP Practices and healthcare providers.

During 2015/16 NHS South Cheshire CCG will be taking an active role in the newly introduced **Patient Safety Collaborative** programme. Our aim is to ensure that patient safety and patient safety learning, sits at the heart of everything we do. Focused on understanding and eradicating "avoidable" harm to patients we will actively participate to identify safety priorities and develop solutions. We also encourage our providers to participate and have a GP Quality Leads attending the Academic Health Sciences Network, which links directly to the patient safety collaborative.

Our participation in the Patient Safety Collaborative has led NHS South Cheshire CCG to join the '**Sign up for Safety**' National Patient Safety Campaign during 2014/15. We have made the following 5 pledges:

1. **Put safety first.** To commit to working with healthcare providers to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally. This is achieved by monitoring patient safety measures e.g. incidents, clinical risk, complaints with all healthcare providers. Share information across Cheshire Warrington and Wirral CCG's about patient safety in order to triangulate information about healthcare providers. It is our ambition to increase the numbers of reported professional and patient concerns to 5/1000 of the population by 31st March 2017 and by 2020 100% of new pathways will be co-produced with patients and carers.
2. **Continually learn**. To make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are. Undertake service quality review visits to providers. Attendance at providers internal meetings and external monitoring visits e.g. Patient Led Assessment of the Clinical Environment (PLACE).
3. **Honesty**. To be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong. Uphold the requirements of the NHS Standard Contract with regard to the Duty of Candour. Providers are required to provide exception reports for any breaches and contractual sanctions are applied. Providers are encouraged to offer face to face meetings with complainants. Any complaints received by the CCG are managed in a robust manner with complainants offered face to face meetings.
4. **Collaborate**. To take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use. Local Authority council members are invited on quality service review visits. The work undertaken by the quality team around the 6C's has been shared with local CCG's and Local Authorities for adoption.
5. **Support**. To help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress. In 2015/16 the Quality team will continue their attendance at Root cause Analysis review meetings with providers to understand why things go wrong and to ensure any lessons learned are cascaded throughout the organisation through the action plan. Through the RCA process the CCG gathers evidence around staff support and openness with patients and carers.

Sign up to safety will be used in 2015/16 in our engagement with patients, carers, public and 3rd sector organisations The CCG has revisited the quality review visit template which incorporates the 6 C's based on the principles of Sign up to Safety. In 2015/16 as more of our healthcare providers sign up to safety then we will share our pledges. Monitoring will then commence through the quality review meetings. Action plans will be requested if appropriate.

NHS South Cheshire CCG is a member of the Advancing Quality Alliance (AQuA), as a means to improve the quality of healthcare in the North West of England. As part of our ongoing quality improvement initiatives, we support AQuA in the improvement of the quality of patient care, promotion of best practice and the reward of NHS Trusts who perform well through a system of financial incentives. These financial incentives are achieved through the Commissioning for Quality and Innovation (CQUIN) schemes for each NHS Trust and are part of the CQUIN schemes included in the NHS Standard Contract annually. During 2015/16

the “Advancing Quality Improvement Programme” will be expanded, to improve patient safety in the following clinical areas:

- Chronic Obstructive Pulmonary Disease (COPD)
- Sepsis
- Fractured neck of femur
- Diabetes
- Alcohol related liver disease
- Acute Kidney Injury

Finally, during 2015/16 through the national CQUIN scheme, NHS South Cheshire CCG will review current care pathways for acute kidney injury and sepsis and ensure that they complies with all the recommendations set out in the CQUIN guidance. The impact of the CQUIN will be reviewed quarterly throughout 2015 with final reports in April 2016.

8.2.2.1. Primary Care Initiatives

In 2014 the CCG devised a Primary Care Quality, Development and Engagement Group. This group is responsible for working to ensure the effective co-ordination of practice development, performance and education for the Practices within the CCGs. The group is responsible for identifying and taking action and making recommendations to deliver the agreed consortium objectives. The group drive the need to improve patient experience and the quality of care provided to reduce any unwarranted incidents of harm.

Each GP practice has a nominated safeguarding lead as part of their compliance with the Care Quality Commission. Our GP practices have undertaken Level 3 Safeguarding training for their clinicians. The CCG recognises that GPs are required to acknowledge and discuss significant events and complaints as part of their annual appraisals. GP “quality champions” have been appointed and are due to undertake training in March 2015 relating to root cause analysis and significant events analysis. The CCG is currently in the process of refreshing the professional incidents system via Datix to promote the necessary reporting of any clinical safety incidents. There is continued promotion of improved health care acquired infection reporting and practice based RCA via infection control nurse.

A Practice Nurse Council has been established with our Executive Nurse. Through these meetings there has been a large focus on the delivery of the 6 C’s. In addition to the 6 C’s the nurses have signed up to a seventh “C” to include culture. The Nurses have worked to develop a local infection control policy, undertaken sessions to reflect and learn from incidents and complaints that has included sharing best practice.

The CCG is keen to continue to disseminate learning across the locality newsletter and practice quality leads forums, practice medicines leads quarterly meetings.

8.2.2.2. Improving AMR and Antibiotic Prescribing in Primary and Secondary Care

NHS South Cheshire CCG continues to review and develop prescribing guidance to ensure the safety of our patients is paramount. During 2015/16 we will implement a strategy to reduce the pressure on antibiotic resistance and support providers to meet targets for incidence of Healthcare Acquired Infections including MRSA and Clostridium difficile. Developed collaboratively with the Local Antibiotic Stewardship Committee, the Strategy will deliver:

- A complete a review and update of the antibiotic prescribing guidance for our Member Practices
- A practice-based audit tool to assess the appropriateness of antibacterial prescribing
- Training and educational opportunities
- Continued work with local Antibiotic Stewardship Committees to oversee antibiotic prescribing in the local health economy

- Continued close working with Infection Control colleagues to support action planning in primary care following post-infection reviews.

8.2.2.3. Continuing Healthcare

The Continuing Healthcare Service was originally commissioning from our local Commissioning Support Unit (CSU). In February 2014 a Due Diligence Audit was undertaken to scrutinize the current service being provided to the CCGs and inform them of the best course of action to improve the situation. Following this review the CCGs withdrew from the service that was being provided and agreed to bring the service in house. This transfer was undertaken on 1st February 2015 and the relevant staff were TUPE across. The service is currently involving staff in the shaping of a new service that will be delivered locally, and efficiently in a new model based on best practice.

For patient outcomes, we intend to have an efficient system that can respond quickly to patient's needs for assessment and review. Patients will receive a patient focused service responsive to their needs. Brokerage of placements and care packages will be improved to release nursing time to spend with patients.

We will to be able to respond to the serious issues of safeguarding vulnerable patients either at home, or in a care setting, alongside the Local Authority, in a targeted and integrated manner. For patients, this should deliver a responsive service able to act quickly. We intend to integrate this service alongside out own safeguarding adults team and potentially with the local authority during 2015. We will work to remove the backlog of reviews, improving outcomes for patients so they receive the right care funded in the right way for their needs. This should also deliver savings to the CCGs to reinvest in CHC/Complex care given the rising demand from the population.

8.2.3. Seven Day Services

In 2015/16 NHS Vale Royal CCG will embrace the delivery of the seven day services initiative; acknowledging that whilst it is initially focussed on the acute inpatient pathway there are lessons we can learn in terms of our review of Urgent Care, primary care transformation and integrated community teams. We support the introduction of seven day services as we understand their potential impact on patient safety, patient experience and clinical effectiveness.

A complete seven day service plan is to be developed in partnership with our acute provider. It is hoped that this will be in place by 30th June 2015 and will be monitored through our SRG.

8.2.4. Safeguarding

NHS South Cheshire is responsible for promoting safeguarding quality and quality assurance in the services we commission. This is achieved through the contractual arrangements with our service providers. The approach of the CCG is to ensure services commissioned embed safeguarding standards in practice.

Contracts include safeguarding standards in respect of both children and adults at risk. The Commissioned Services Standards for Safeguarding Children and Adults at Risk document includes section 11 responsibilities of The Children Act 1989, and the six adult safeguarding principals linked to the 6C's of Compassionate Care.

In 2015/16 we will:

- Co-ordinate and review the delivery of all of our Provider's Safeguarding Annual Self-assessment Audits.
- Actively participate in the NHS England Quality Surveillance Group for Cheshire, Warrington and Wirral Area Team as a means of sharing any concerns with the quality and safeguarding assurance of providers, sharing best practice and opportunities for service improvement.

- Ensure services commissioned embed safeguarding standards in practice (including the statutory requirements including the section 11 responsibilities of The Children Act 1989, the six adult safeguarding principals and the 6C's of Compassionate Care). Throughout 2015/16 we will actively monitor performance against these standards.
- Review all health providers from whom we commissions services (both public and independent sector) to ensure they have comprehensive single and multi-agency policies and procedures in place to safeguard and promote the welfare of children and to protect adults at risk from abuse or the risk of abuse.
- Our safeguarding dashboard will continue to be used and develop with our providers to demonstrate the safeguards in place in our provider services.
- One of our main areas of development this year will be to align our safeguarding team with the quality team strengthening safeguarding and ensuring quality and quality assurance is core to the services it commissions.
- Continue to demonstrate we have appropriate systems in place via our policies, setting out our commitment and approach to safeguarding through our safe recruitment practices and arrangements for dealing with allegations against people working with children and adults as appropriate. Safeguarding awareness and training for all CCG staff and Governing Body members will continue to be a priority.
- Work with our colleagues in the local authority who are involved in the commissioning of public health services to ensure that effective safeguarding arrangements are in place within these services to safeguard children and young people
- Continue to lead the completion of the action plan developed in March 2014 following the Care Quality Commission Review of Health Services for Children Looked After and Safeguarding in Cheshire West and Chester across the local health systems to improve the outcomes for our children and young people. A key focus of this action plan is the work we are doing with the local authority to address the health needs of our children in care and care leavers.

The CCG will continue to support the multi-agency work of the Local Safeguarding Children Board and Safeguarding Adult Boards financially, by representation and involvement in the work of the Boards and sub groups. Our designated professionals take responsibility for undertaking serious case reviews / case management reviews / significant case reviews on behalf of health commissioners and for quality assuring the health content. We will share the learning from the reviews with our staff and consider the implications for the services we commission.

We have taken an active role in the set up arrangements for the developing multi agency Child Sexual Exploitation Team in Cheshire West and Chester in our role of working across the health system to support all aspects of safeguarding and child protection across the local health systems.

8.2.5. NHS Constitution Standards - Elective Care and Diagnostics Waiting Times Standards

The delivery of the national elective and diagnostic targets in 2015/16 will be supported through the Elective Services Review Group. The group will identify priorities for the joint development of services and whole system pathways across the local health economy. The pathway development work will be undertaken by the cross organisational Clinical Pathways Action Group and supported by partners at the System Resilience Group (SRG). This work fits with our strategic objective to ensure a whole system approach is adopted across all the services we commission.

8.2.6. NHS Constitution Standards - Emergency Care and Diagnostics Waiting Times Standards

The delivery of national Non-Elective, Emergency and diagnostic targets in 2015/16 will be supported through the Operational System resilience Group (ORG). The group has the delegated authority to identify priorities for the joint development of services and whole system pathways across the local health economy on both an ongoing basis and for the winter period and agree the

funding for these initiatives. The pathway development work will be undertaken by the ORG and supported by partners at the Strategic System Resilience Group (SRG). Again the approach supports our strategic objective to ensure a whole system approach is adopted across all the services we commission.

8.3. Parity of Esteem

NHS South Cheshire CCG are committed to the principle of delivering parity between physical and mental health and valuing mental health on the same level as physical health. Both morally and economically, there is a strong case for redressing the balance, and in recent policy documents the government has signalled its intent to improve mental health services for all ages, investing in effective treatment, highlighting the importance of early intervention and prevention, introducing a focus on crisis care and framing in law the requirement to offer choice of mental health provider.

This move towards parity is fully supported by NHS South Cheshire CCG and we are currently working on increasing resource allocations to enable the CCG to achieve the parity of esteem agenda. This information can be found in section 10. [DN: to confirm final financial position]

8.3.1. Access and Waiting Time Standards

Published in mid-October, the policy document "Achieving Better Access to Mental Health by 2020" states what action the government is taking to provide better access for mental health services from April 2015. This includes national waiting time standards in mental health services for the first time. The new waiting time standards being adopted by NHS South Cheshire CCG for 2015/16 are:

- Treatment within 6 weeks for 75% of people referred to IAPT services, with 95% of people being treated within 18 weeks

This standard is the first to replicate the standards that already exist in physical health care. The vision is that eventually, all mental health services will guarantee people access to timely, evidence based and effective treatment. In time, this will lead to more positive outcomes. The IAPT service operating in NHS South Cheshire CCG has recently been the subject of review, and undergone a number of planned improvements. This will have an impact on the ability of the service to meet the new standards.

- Service improvements that will impact both on access to the service and waiting times are:
    - Improved data quality and recording processes
    - Introduction of psycho-education groups
    - Increased use of telephone contacts for step two
    - Increased clinical capacity within the service

Initial scoping of our current performance against the waiting times suggest that the service is already exceeding the standard of 75% of people treated within 6 weeks (90%) and is narrowly missing the 18 week standard (94.6%).

- Treatment within 2 weeks for more than 50% of people experiencing a first episode of psychosis.

It is widely acknowledged that by intervening early when a person experiences an episode of psychosis this can significantly improve their recovery. The Early Intervention in Psychosis (EIP) service in South Cheshire works to the recommended evidence based principles described by NICE. This standard has been included in the specification for the service and will be monitored through the monthly contract meeting during 2015/16, ready for its introduction in April 2016. An SDIP will be included within the 2015/16 contract to inform this new standard.

Targeted investment on effective models of liaison psychiatry in acute hospitals. Availability of liaison psychiatry will inform CQC inspections in future.

Psychiatric liaison services provide mental health care to people of all ages who are being treated for physical health conditions in general hospitals. There is some evidence that certain models of liaison psychiatry can deliver clinical and cost effective care to a wide range of people who might be experiencing mental health problems. The service locally is based in MCHFT, working closely with the hospital emergency department.

A commissioning intention for 2014/15 was to review the current service, with a view to understanding the demand and scope of the service and how the present configuration compares with best practice. Based on this review, the evidence base, and the results of consultation and engagement, a business case has been developed which extends the scope of the existing hospital based service to provide a community liaison team, which will be incorporated into the primary care mental health team.

8.3.2. Mental Health Crisis Concordat

Introduced earlier this year, the Mental Health Crisis Care Concordat is a national agreement between services and agencies that sets a standard for mental health crisis care. Locally, this has been taken forward as a Cheshire wide initiative, and organisations including health, policing and local authorities have issued a public declaration to jointly deliver improved crisis care. Underpinning this public declaration, which can be found on the Mental Health Crisis Concordat website at http://www.crisiscareconcordat.org.uk/ NHS South Cheshire CCG has been working with other agencies to develop a shared Delivery Plan, to be operational by April 2015.

The delivery plan which accompanies this work is being developed jointly, and will be completed by the end of March 2015. Some of the themes coming out of the work completed to date include the following:

- Evaluating the impact and potential extension of our street triage pilots. November 2015 saw the introduction of a street triage pilot scheme across Cheshire. Street Triage offers an immediate response to calls made to Cheshire Police for situations that would benefit from the joint attendance of police and Mental Health services. The pilot is funded for a 12 month period, and a robust evaluation is being sought from a local University. Early results have been very positive, with a dramatic reduction in detentions under the mental health act and a reduction in hospital admissions and attendances.

- Supporting people experiencing mental health crisis to find the help they need − whatever the circumstances − from whichever service they turn to first.

- The need to work together to prevent crises happening whenever possible, through intervening at an early stage, and supporting individuals to manage their recovery and avoid relapse

- Recognise the needs of vulnerable people in urgent crisis, getting the right care at the right time from the right people to make sure of the best outcomes.

This declaration supports ‘parity of esteem’ between physical and mental health care in the following ways:

- Through everyone agreeing a shared ‘care pathway’ to safely support, assess and manage anyone who asks any of our services in Cheshire for help in a crisis. This will result in the best outcomes for people with suspected serious mental illness, provide advice and support for their carers, and make sure that services work together safely and effectively.

- Through agencies working together to improve individuals' experience (professionals, people who use crisis care services, and carers) and reduce the likelihood of harm to the health and wellbeing of patients, carers and professionals.
- By making sure there is a safe and effective service with clear and agreed policies and procedures in place for people in crisis, and that organisations can access the service and refer people to it in the same way as they would for physical health and social care services.

8.3.3. Child and Adolescent Mental Health Services (CAMHs)

There are national concerns about the historical provision of CAMHs and a growing imperative regarding the importance of earlier intervention with young people with mental health disorders, recognising that one in ten children aged five to 16 have a significant mental health problem (ONS Prevalence data 2004). We believe that, key to this, is a stronger focus on joint working across agencies to ensure that all commissioners share the same vision and will drive improvement.

During 2015/16 NHS South Cheshire CCG will develop a CAMHS strategy with partners to ensure commissioning plans are aligned and achieve shared improvement outcomes for children and young people.

NHS South Cheshire CCG's commissioning intentions in this area are:

- To support early intervention and prevention through a range of Universal and Tier 2 supports
- Additional investment into CAMHS services across Tier 2-3 including identification of joint commissioning initiatives- £ 200k
- Supporting joint investment plans to identify efficiencies in spend and benefits realisation across partner agencies: through economies of scale, reducing duplication and alignment of shared objectives/ outcomes for children's EHWB with related commissioner budgets (including education and public health)
- CCG commissioned CAMHS services: develop an integrated, outcome based specification with the commissioned provider
- Explore options for contracting which improve delivery of outcomes and measurement of performance in relation to patient outcomes

It is expected to achieve the above by April 2016.

8.3.4. Commissioning an effective liaison service

Community based liaison services are an integral part of modern mental health services. We believe the development of such teams allows the care of patients to be transferred from institutions to the community; leading to a reduction in suicide rates, improved patient engagement and reduction in the number of days patients stay in hospital.

During 2015/16 NHS South Cheshire CCG plans to review current Liaison Services; putting in place a community facing liaison team We believe this team will deliver care outside of a hospital setting, whilst supporting GPs to manage patients who have co-morbid physical and mental health conditions. Our work will build and maintain our commitment, clarity of purpose and shared vision for effective liaison services.

8.3.5. Dementia Diagnosis

Dementia is a clinical syndrome which affects the intellectual functions of the brain – remembering, thinking, and deciding. Dementia is a common condition, with an estimated one in three people over the age of 65 set to develop dementia before they die. The rates for dementia are forecast to increase with an ageing population.

There can be opportunities and challenges at all stages of the illness, whether in relation to prevention, early detection or at the end of life. Despite a high prevalence, rates of diagnosis have been low, and the government has set a national ambition that two thirds (67%) of the estimated number of people with dementia will have a confirmed diagnosis. A timely diagnosis is important in that it can allow support to be provided for people and their families and help to avert emergency admissions to a hospital or a care home. NHS South Cheshire CCG has been working with their GP practices to improve rates of diagnosis and ensure that people living with dementia can access the support they need. Throughout 2015/16, practices will be supported to achieve and maintain a high level of diagnosis.

8.3.6 Physical Health of People with Severe Mental Illness

Mental health conditions such as schizophrenia and bipolar disorder are associated with high medical co-morbidity; with mortality rates approximately 50% higher than in the general population. (Hennekens et al. 2005). The primary cause of death due to a physical cause is circulatory disease, diabetes and obesity. Evidence suggests excess weight gain can be 2-3 times more prevalent in people with schizophrenia than in the general population (Allison and Casey 2001). This may be due to higher levels of smoking, and lack of exercise when compared with people without mental illness, and also that antipsychotic medication can also exacerbate weight gain (Allison and Casey 2001).

In order to ensure that physical health is regarded as a priority for this group of people, a programme of annual physical health checks has traditionally been provided within primary care. The success of this intervention relies on patients being engaged with their general practice, and a CQUIN has been developed locally to follow up patients who might not have attended their general practice, but are known to mental health services, so that their physical health needs can be addressed.

This commissioning intention for 2015/16 builds on the work done during 2013/14 and involves:

- Working with providers to deliver a programme of brief interventions targeted at this vulnerable group of people.
- Liaising with general practices to improve their understanding of mental illness and in particular physical health needs.
- Delivery of lifestyle interventions targeted at people with mental ill health.

Much of the learning has come from the AQUA programme ‘Don’t just screen, intervene’. This new programme of work will take things to the next step and provide a service to ‘intervene’ to support this population group.

In addition to this, 2014/15 saw the introduction of a national mental health CQUIN which incentivised the physical health checks for those people with severe mental illness who are in patients.

8.3.7 Primary Care Mental Health Teams

The aim of this project is to develop a new primary care mental health team which will have a focus on improved dementia care and mental health liaison in the community. The aim of an integrated team would be to provide high quality care that results in improved health and wellbeing and a better experience for adults with complex care needs. This will be achieved by joining up mental health and physical health services to focus on individuals in their own homes and community, and reduce the need for emergency care during 2015/16.

The team will provide the additional skills and knowledge necessary to manage patients living with dementia, and patients who have a mental health condition as well as a physical health problem. It is envisaged that the team will work closely with GP practices and link with the developing integrated neighbourhood team model.

8.3.8 Learning Disabilities - Challenging Behaviour

Development of high quality, community based provision, (as an alternative to a hospital placement) for people with a learning disability whose behaviour challenges is a priority as set out in the Winterbourne Concordat.

The work programme which underpins the national " Transforming Care Programme' and the 'Winterbourne Concordat' has set out the principle that "a hospital is not a home" and has put forward a number of recommendations for the development of community based services to support people with challenging behaviours. As a signatory to this Concordat, NHS South Cheshire CCG is committed to work with partners to agree a joint strategic plan to commission high quality health, housing and support services for people of all ages with challenging behaviours throughout 2015/16.

8.3.9 Dementia Services for people at End of Life

The CCG is running a two year pilot commissioning a dementia end of life service to enhance the quality of experiences from patients, carers and family members. Over the past year there has been the development of an operational model and service specifications to enable an operational service to be implemented across the localities. The agreed outcomes were established in May 2014 to enable the service to be evaluated at the end of the pilot. Education and training programmes are taking place throughout February to progress the team into a fully functioning operational service. An evaluation of the service will take place in December 2016.

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8.4. Other CCG Operational Priorities

8.4.1. Cancer Pathways

As part of our CCG priorities to reduce the premature mortality of our local population we are reviewing our cancer pathways. This will include ensuring the highest quality of care that meet the NICE Improving Outcome Guidance and national performance standards. This review will include moving care closer to home. In 2014/15 the specialised commissioning team reviewed gynaelogical and urology cancer patient pathways to ensure that our local cancer pathways are of the highest quality and meet NICE Improving Outcome Guidance and national performance standards. In addition to this there was a complete pathway review undertaken due to health inequality and population health need reports and commissioning for value recommendations for our lung and upper GI pathways.

As part of Mid Cheshire Hospital Foundation Trust and University Hospital of North Midlands "Stronger Together" Programme there is commissioner commitment to review all cancer pathways that currently do not flow to the University Hospital of North Midlands. This will be led by the specialised commissioning unit and follow a commissioning led process being patient centred, clinically led and outcome focused considering also capable provider and competition rules.

The cancer pathway reviews will continue into 2015/16. The new Gynaelogical and Urology cancer pathways will be reviewed and outcomes monitored by specialised commissioning and the Greater Manchester Cancer Commissioner Group. Following the review any actions will be co-

ordinated into a formal action plan for the CCG to monitor. The CCG will continue to review the of the whole lung cancer pathway with a focus on survivorship. This will align cancer care reviews, after treatment summaries and holistic needs assessment with a focus on self are / self-management.

The CCG plan to recruit a Macmillan Project Manager who will be responsible for reviewing the upper GI cancer pathway. This will include reviewing statistical information alongside patient experience. The first year of this will focus on early diagnosis, diagnostic pathways and Primary Care partnerships.

The CCG will continue to review cancer waiting times and performance against the NICE Improving Outcomes guidance.

8.4.2. Chemotherapy Reform

As part of our drive to reduce the number of premature deaths across our locality cancer and the early diagnosis of cancer is imperative to this. It is hoped that by diagnosing cancer early this will improve outcomes of people going through treatment for cancer and thus being one of our reasons for undertaking the Chemotherapy reform to provide cancer care closer to home resulting in a greater patient experience. Within this two year project the CCG plans to transfer of solid tumour protocol driven chemotherapy delivery from Christie's and North Staffs to Leighton Hospital; it will purchase and set up of electronic prescribing of chemotherapy at Leighton Hospital and an acute Oncology team will be accessed from the emergency department and extended into primary care. Within the first year of the project the following was achieved:

In February 2014 the breast chemotherapy service was moved from Christies to Leighton Hospital. In April 2014 the CCG secured Macmillan funding to support the development of an acute oncology service to be provided in the community. Following this service specifications and operational policies have been developed for the community service. A contract variation is being managed between the CCG and MCHfT to allow the recruitment and operational functions of the acute oncology service to go forward. The recruitment of staff into posts commenced in February 2015.

It is now the CCGs intention to identify further tumour groups where chemotherapy can be moved from the Christie to Leighton Hospital and implement any changes by 31st March 2016. As part of the community acute oncology service part of the project there will be a review of outcomes and patient experience under taken. In addition to this the next aim will be a reduction in average length of stay to 6 days following an Acute Oncology admission.

8.4.3. Diagnose Cancer Early

The CCG will continue with its programme to diagnose cancer early in its local population over the next year there will be several "Be Clear on Cancer" campaigns that will include Information being promoted through GP practices, pharmacies, via involvement groups, and internally via staff groups. We will also use our external facing websites to promote these campaigns and the "Be Clear on Cancer" website: http://campaigns.dh.gov.uk/category/beclearoncancer/

The CCG is committed to engaging with the community to develop "community champions" to target awareness to early signs and symptoms of cancer with support from Accelerate Coordinate Evaluate (ACE) project and Public Health Transformation Fund.

The CCG will be reviewing the Upper GI pathway to look at promoting how to detect upper GI cancers early. Following that review the CCG will ensure that there are quality diagnostic pathways in place to support this. There will also be the development of targeted direct access for patients to chest x-rays. Our aim is to have this in place by July 2015. Finally there will be a breast screening redesign to meet our quality assurance guidance for screening for the population size. This will be completed by March 2016.

8.4.4. Respiratory

There will be a large focus on respiratory within the CCG over the next couple of years. With numbers increasing relating to emergency department attendances and admissions this has been identified as a significant health inequality across our locality. It is our intention to build up on the existing services currently in place to improve care and empower patients to self-care within their level of competence and motivation to manage respiratory conditions and so minimise any adverse effect on quality of life. The review during 2015-16 of the respiratory services will include ensuring compliance with NICE quality standards for COPD and Asthma; review the resources currently in place and develop a bronchiectasis service in the community to reduce the number hospital spells and the length of stay in an acute setting for patients with bronchiectasis this will have a focus on delivering care close to home for patients. In addition to this review the CCG will work with the general practices within our locality to reduce variation between practices and CCGs for respiratory admissions and will improve the consistency of spirometry provision within general practice.

8.4.5. NHS111

NHS 111 is a national initiative available to the public to call if they need medical help fast but are not in a life-threatening situation. The easy-to-remember, free to call number is being introduced across England to help reduce the pressure on emergency departments and the 999 service. The service will be available 24 hours a day, 365 days a week, the service is for people who aren't sure if they need to go to the emergency department, don't have a GP to call or generally need reassurance and advice. This is currently available across our locality on a limited basis. During 2014/15 work has been undertaken to develop robust service specifications to enable the CCG to hold the relevant provider to account once this is fully operational. The next steps will be to award the contract to a successful provider who will then roll out the service. It is expected that this will be fully operational by 31st October 2015.

8.4.6. Pain Management Service

The current community pain management service was one that NHS South Cheshire inherited from Central and Eastern Cheshire Primary Care Trust (PCT). In December 2013, it was agreed at the Ageing Well Programme Board that an in-year project to revise and update the service specification for the current community pain management service was required. During 2014-15 several engagement events were undertaken with our local stakeholders. A tender process was undertaken and the contract awarded to the successful provider. In 2015/16 the new contract arrangements will be implemented and a review of the new service will be take place in early 2016.

8.4.7. Children's Nursing Review

NHS South Cheshire CCG undertook the Children's Nursing Review to ensure that appropriate nursing input is delivered within our community settings to meet the individual needs of children and their families. The review also included ensuring that commissioned resource in children's nursing is sufficient and deployed effectively to meet the needs of individuals and their families and that where appropriate the review would identify opportunities for redesign and productivity.

Within 2014/15 the Starting Well team lead this piece of work reviewing and ensuring that:

- Multi-agency childrens' reference groups have informed the process for commissioning school nursing
- Local Authority led engagement and consultation on re-commissioning school nursing
- Cross organisational strategic commissioning approach to the development of children's health services (Public health, NHSE)
- Reviewed special school nursing activity in terms of baseline provision
- Identification of special school nursing funding arrangements and transfer arrangements to CCGs in 2015

This work will now continue into 2015/16 with the following taking place:

- Input into the preparation of plans with current provider to ensure continuity of clinical nursing supports to children in identified special schools by June 2015
- Lead the engagement with children, young people and families; also schools and stakeholders regarding provision of clinical nursing support to children by June 2015
- Work with Cheshire East Council finalise specifications for 0-19 service including CCG commissioned clinical nursing elements by June 2015
- Development of commissioning plans and specifications by the end of September 2015
- Review financial envelope for existing provision and identify any funding gaps/ risks or efficiencies to be gained though redesign by the end of September 2015
- Draft specifications and outcomes relating to children's nursing services by the end of December 2015
- Clarify the commissioning intentions of the CCG for children's nursing including contract notice if required by the end of March 2016

8.4.8. Special Educational Needs and Disabilities (SEND)

There is a particular need for improvement, working in partnership across different services, in supporting children and young people with special educational needs or disabilities. NHS England's objective is to ensure that they have access to the services identified in their agreed care plan, and that parents of children who could benefit have the option of a personal budget based on a single (coordinated) assessment across health, social care and education. Children and young people who have a Special Education Need and/or Disability make up a significant proportion of the childhood population, with up to 20% of school age children and young people having SEN. The Children and Families Act 2014; Special Educational Needs and Disabilities (SEND) reforms and legislation came into effect on the 1st September 2014. In order to fulfil its legal duties the CCG has worked closely with the Local Authority who has the lead responsibility for development and implementation. Working with the Local authority and co-ordinating the input of local health providers the CCG has:

- Contributed to the development of an agreed multiagency process for an Education Health and Care (EHC) assessment and completion of an EHC Plan with the Local Authority
- Provided relevant information for inclusion in the Local Offer for both LAs
- Produced a SEND Strategy and Work Plan with Cheshire East LA
- Produced a SEND Joint Commissioning Strategy with Cheshire East LA
- Established a Multi- agency managers group to continue the delivery and embedding of the SEND reforms
- Are establishing a Joint Commissioning Strategy with Cheshire West and Chester
- Identified the process for delivering Personal Health Budgets for Children and Young People linked to SEND personal budgets
- Based on a new business case have secured one year's funding for a Designated Clinical Officer role for the CCG
- Used findings from the implementation of the SEND reforms to inform commissioning work for the next year

The work that has been undertaken relating to this project in 2014/15 will continue into 2015/16 and will help to identify other gaps in services that will need reviewing. The main actions will focus on:

- Through the Designated Clinical Officer role gain a better understanding of the number of children and young people receiving Education Health Care assessments and plans and from these identify the levels of health provision required and ensure appropriate local provision is in place. This will be done through quarterly reporting through the Designated Clinical Officer operational group to give trend analysis and final data collation in March 2016

- Identify gaps in local provision and link this with developing a robust Joint Commissioning Plan with the Local Authority
- Complete a business case to secure recurrent funding for the Designated Clinical Officer role as this is a legal requirement for CCGs to have a permanent Designated Clinical Officer by the end of December 2015.
- Develop transition pathways and processes with the Local Authority and adult commissioners to ensure services for young adults with SEND; this will be done on an ongoing basis.
- Ensure that Personal Budgets for Children and Young People are embedded in the Personal Health Budget strategy that is adopted across the CCG.

9. Enabling Change

9.1. Harnessing the Information Revolution and Transparency

In line with our NHS South Cheshire CCG ICT Strategy, numerous projects have been undertaken to enhance the use of ICT across the local health economy. We have supported the development of Telehealth as a means of empowering patients to monitor and manage their own health conditions as well as reporting any high risk issues back to general practice that in turn would enable interventions to happen at the right time. There is a pilot currently taking place that will finish in February 2015, following this there will be a review undertaken as part of a tendering process to look a models of care against value for money that can be rolled out to the Community Matrons and patients.

During 2014/15 NHS South Cheshire CCG supported the piloting of a risk stratification tool to enable the pro-active case management of patients classed as vulnerable or at risk of an unplanned admission. Following pilots with NHS South Cheshire Member Practices, the CCG is now looking to expand the use of the EMIS risk stratification tool to enable General Practice to identify their top 2% of *"at risk"* patients. During 2015-16 we believe this will enable GPs to find at risk patients before they have a hospital admission, enabling GPs to classify their risk factors and plan appropriate care. All member practices will have EMIS capability by April 2015 and will be able to access health and social care data.

We recognise sharing patient information across the health and social care economy will improve treatment and patient experience. During 2014/15 NHS South Cheshire CCG has increased the number of ICT systems that are interoperable across the local health economy and will continue to develop this further in 2015/16. All the GP practices are now using unique patient NHS numbers on EMIS web software that can be used across healthcare providers. During 2015/16 further work will be undertaken to increase the usage of EMIS web within our main acute provider.

This is a national mandate for the implementation of electronic prescriptions to be sent from GP practices directly to a pharmacy of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for both patients and healthcare staff. NHS South Cheshire and NHS South Cheshire CCGs have deployed EPS to over 90% of GP Practices so far, this is expected to be over 95% by June 2015.

During 2015/16 NHS South Cheshire CCG will continue the work to enable online access to medical records and online appointments. The first wave programme will enable patients to book online GP appointments and to order repeat prescriptions. In addition to this, we also plan to ensure patients will be able to view an on line summary care record of their medical history by April 2015.

NHS South Cheshire CCG aspires to implement an Integrated Digital Care Record across Cheshire and have been working with our Pioneer partners to map service requirements. Work is now being undertaken to understand the financial elements of this project. A business case will be developed for consideration by our Clinical Commissioning Executive in March 2015. Recommendations from the Clinical Commissioning Executive will then go to the CCG Governing Body for any final decisions.

By March 2016 NHS South Cheshire CCG is required to achieve at least 80% electronic referrals between GPs and other services. NHS South Cheshire CCG is currently awaiting HSCIC release of E-Bookings to bring enhancements and improvements to the current service. During 2015/16 we will pilot electronic GP referrals with our GP practices to enable us to decide how this will be rolled out across the local health economy.

We have been working with our acute providers to implement electronic discharges. Both Mid Cheshire Hospital Foundation Trust and the University Hospital of North Midlands rolled out

services in October 2014. The CCG is now looking to expand to integrate with other acute providers and tertiary centres across Cheshire during 2015-16.

The CCG applied to be a “pathfinder” organisation for the roll out of care.data. Unfortunately the CCG were unsuccessful on this occasion. NHS England are currently evaluating materials and processes with the public that will continue until the end of March 2015. The CCG are currently in discussions regarding how this can be rolled out across our locality towards December 2015.

9.2. A Modern Health and Care Workforce

NHS South Cheshire CCG is committed to deliver new models of care in the future and for the NHS to be sustainable and provide quality joined-up care. As such, we are committed to the delivery of our ‘Connecting Care Strategy’ with our social, community and mental health providers. This Strategy also describes how we will equip our staff and managers with the skills and leadership ability to work effectively in theses prescribed new models of care. In particular these areas of the strategy will focus on the development of a leadership academy. [DN: AW]

At NHS South Cheshire CCG we believe the delivery of high quality health care is underpinned by the development of a workforce that has the right numbers, skills, values and behaviours. To achieve this goal, we recognise we have a role to play in the identification of what these ‘right’ numbers, skills, values and behaviors are, and then influence our local LETB to support their delivery. During 2015/16 we will explore our planned service transformation initiatives; developing workforce proposals reflect the needs of our Connecting Care Strategy and the challenge of changing and growing health needs.

9.3. Staff Satisfaction

NHS South Cheshire CCG works with all its providers around understanding the factors that affect staff satisfaction. Annually, each provider undertakes a national staff satisfaction survey. The results and actions are reviewed and monitored by the Quality review meetings with all healthcare providers.

However at each meeting with the providers there is information shared specifically around factors that affect staff satisfaction. This work was commenced in 2014/15 and will be carried on in 2015/16.

Areas that may affect staff satisfaction	Information gained from	Measure improvements
Staffing levels	Nurse staffing levels are published on NHS Choices through the safe staffing website	Where staffing levels are low in specific clinical areas then assurance will be sought through the quality review meetings with each provider. Action plans requested and monitored. Evidence at service quality visits about the impact of low staffing levels or skill mix.
Sickness levels	Requested from providers at Quality review meetings	Where sickness levels are high in specific clinical areas then assurance will be sought through the quality review meetings with each provider. Action plans requested and monitored. Evidence at service quality visits about the impact of high sickness levels
Recruitment and retention	Vacancies in each health	Where vacancies are high in

	care provider requested	specific clinical areas then assurance will be sought through the quality review meetings with each provider. Action plans requested and monitored. Evidence at service quality visits about the impact of high vacancy rates
Competencies/ development opportunities	Mandatory training figures Other development opportunities e.g. AQuA programmes, specific competencies for roles	Training figures requested through the quality review meeting with each provider. Action plans requested and monitored. Evidence at service quality visits about the impact of difficulties in attendance at mandatory training
Open and honest culture – safety	Providers are high reporters of incidents Evidence of a 'no blame' culture and shared organisational learning from incidents/complaints Duty of candour reporting	Open and transparent report received each month at the quality review meeting with acute provider. Other providers are just setting up systems to participate in open and honest care programme Review of National Reporting and Learning System each quarter when figures published to benchmark providers around reporting culture Application of contractual requirements around the Duty of Candour. Evidence on every root cause analysis document detailing involvement of patients and carers Evidence of 'open and honest' culture sought at service quality review visits
Staff are valued and listened to	Evidence of listening events by providers Outcomes from staff suggestions	Evidence sought at service quality review visits
Engagement of staff through CQUIN to participate in service developments with patients	Evidence that staff are involved in CQUIN schemes around service developments and are fully engaged with the process	Evidence sought through service quality review visits

All information received into NHS South Cheshire CCG is triangulated. Therefore using the information detailed above with complaints about staff, incidents, patient opinion websites such as NHS Choices, findings from Healthwatch clinical visits in all healthcare settings forms a picture of the motivation and satisfaction of staff.

Using data from the annual national staff survey and all other hard and soft intelligence from all our healthcare providers is used to benchmark our healthcare providers both locally and nationally.

During 2014/15 NHS South Cheshire CCG has anticipated the new requirement for nursing and midwifery revalidation in December 2015. We have been discussing this as part of the Quality Meetings that hold with our providers throughout the year to ensure the nursing and midwifery staff is fully supported through this process. For Practice Nurses and staff within the CCG who are required to hold a nursing registration, we have liaised with the Royal College of Nursing to

hold sessions via the Practice Nurse Membership Council/Assembly around re-validation and portfolio development. During 2015 we will also deliver further sessions as part of the GP Practice Protected Learning Time events and provider-led development sessions. Further work is planned with the Practice Nurse Council\Assembly to ensure best practice and support is provided to all practice nurses employed across the CCG locality regarding their revalidation throughout 2015-16.

9.4. Accelerating Useful Innovation

NHS South Cheshire CCG is committed to supporting innovation throughout the NHS; as a means of not only delivering improvements in the quality and value of care delivered but also transforming the way services are delivered. During 2015/16 we will promote innovation in health care delivery by:

Reducing Variation and Strengthening Compliance; supporting rapid and consistent implementation of National Institute of Clinical Excellence (NICE) Technology Appraisals (TAs) by including clauses in all our contracts that require all providers commissioned by the CCG to comply with NICE Technology Appraisals. This includes them to publish their formularies so that anyone can see which medicines and technologies are being made available locally. The CCG is working to improve implementation of NICE TAs and use of the scorecard will be part of the role for the additional resource.

What we do is work with our local acute trusts and the Area Prescribing Committees to review implementation of NICE guidance. The Medicines Management Team review all the list of NICE TAs against our local Health Economy Formulary at least twice a year to ensure there is nothing missing from anything in the routine process. During 2015-16 our new medicines group will look to continue horizon scanning for forthcoming medicines.

The CCG's new medicines subgroup looks at horizon scanning for forthcoming medicines and the Area Prescribing Committee looks at changes to use for established agents. Much of this feeds into service and guideline development. Our high cost drugs team use Blueteq templates to provide assurance that ex-PBR medicines used by Trusts are prescribed within guidance.

Delivering Innovation: NHS South Cheshire CGG is committed to building strong relationships with the scientific and academic communities, to develop solutions to current health care problems. We have a named GP who attends the Academic Health Science Networks (AHSNs) as a means of NHS South Cheshire CGG influencing, clinical research, informatics, innovation, training and education and healthcare delivery.

NHS South Cheshire CCG has been awarded 'Research Capability Funding' from the National Institute for Health Research. These monies are being used to assist the CCG to act flexibly and strategically to maintain research capacity and capability. NHS South Cheshire CCG have committed this funding to involvement in the North West Coast 'Collaboration for Leadership in Applied Health Research and Care' (NWC CLAHRC), which brings universities, local authorities, NHS organisations and the public together, to support the translation of research findings into health service improvements and changes that will reduce health inequalities and improve population health. The four programme themes of the NW CLAHRC are:

- Delivering Personalised Health and Care
- Improving Mental Health
- Public Health; and
- Managing Complex Needs

Our involvement has mainly been focused on scoping the current work, processes and networks, with the view to thinking about what this means for the CCG commissioning processes and generating innovative ideas for the CCG's next steps.

Developing Our People: We recognise that training and development is crucial to promote innovation and change within South Cheshire. We believe that leadership for Innovation must be become core business for the CCG; we want to promote an enduring shift in attitudes towards experimentation and innovation amongst clinicians and managers at all levels in the NHS. [DN: AW]

CQUIN Payments: The CCG has previously undertaken several initiatives as part of the *Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS1* that was implemented in 2013. Originally the CCG put in an action plan for a CQUIN as part of the pre-qualification requirement in 2013/14. It was agreed in 2014/15 that this wouldn't be a formal CQUIN however it was agreed that an action pan and progress reports would be required going forward. The CCG is now waiting for the 2015/16 guidance to be released to see what the requirements will be for 2015/16.

10. Driving Efficiency & Delivering Value

10.1. A More Productive and Efficient NHS

Planning Assumptions

The plan developed by the CCG is governed by a number of planning assumptions issued by NHS England.

Consequently in 2015/16 we will be using inflation and efficiency targets as identified in the Forward View into Action: planning for 2015/16. The inflation uplift is assumed to be at 3% with an efficiency requirement of 3.8% giving a net deflator of 1.9%.

Commissioning Assumptions	
Demographic Growth	Locally determined based on population projections and historic data
Prescribing Inflation	4%growth in demand
Continuing Health care	Full impact of in year growth plus 4%
Business Rules	1% surplus 1% non-recurrent 0.5% contingency

These assumptions are derived or adopted to allow the CCG to produce financial plans which reflect the on-going commissioning of services in South Cheshire to ensure that finances are in place to support additional demand or to support service redesign

The finances of the CCG will support the above assumptions where it is financially possible to do so.

The CCG has activity plans with its main acute provider which takes into account national peer averages and other benchmarking tools such as commissioning for value. The CCG has an on-going improvement and review programme for all its services embedded within contract requirements.

Finance and Activity plans are based on locally agreed figures between the local acute provider and the CCG. The plans are derived from current and future demand projections and are clinically based.

10.2. Joint Working Between Commissioners And Providers

10.2.1. Better Care Fund

There is a cross local authority and CCG finance subgroup which reports into the governance of the BCF locally, and includes, Cheshire West and Chester Council, Cheshire East Council, NHS East Cheshire CCG, NHS Western Cheshire CCG , NHS Vale Royal CCG and NHS South

Cheshire CCG. The joint working group has designed the local Section 75 agreements including the rules in respect of financial management, monitoring and financial risk.

There is clear financial linkage with the delivery of 3.5%. A risk sharing arrangement is to be agreed between all the parties to ensure implementation delivers the required outcomes whilst maintaining system stability. This is a key plank for contract agreement. The CCG operates a collaborative Contracting Group where all providers and health and social care commissioners work together to arrive at contract settlements which provide overall benefit and do not penalise any party during the transformation of services. The list of plans is included in section 7.4.

10.2.2. Provider Board

The Provider Board is an innovative approach to partnership in South Cheshire. Discussion locally have led to the establishment of a Provider Board which brings together all local providers including social, acute, primary and community care to develop plans to encourage greater integration of care. The Provider Board is the main vehicle for the delivery of Integrated Community Teams.

10.2.3. Alliance Contract

Within 2015/16 the CCG will be continuing the use of an Alliance Contract which was developed during 2014/15. The scope of this innovative approach to contracting will be enhanced with the inclusion of the Better Care Fund (where applicable) for the local health and care economy within the 2015/16 contract. The Governance of the Alliance Contract with the Provider Board will be further strengthened with the introduction of the Commissioner Alliance Performance Management meeting which will be accountable to the Connecting Care Board.

10.2.4. Operational Planning Outcomes Framework for 2015-16

A summary of the CCGs Operational Planning Outcomes Framework for 2015-16 is provided in Appendix 2

10.3. Delivering Value – Financial Summary

The financial plans are prepared based on assumptions and rules set out by NHS England. Additional information on local trends and the impact of local commissioning intentions are also included in the plan to giving a view of the financial health of the CCG. The financial plan is aimed at producing a sustainable, high performing organisation commissioning care for its population.

10.3.1. Revenue Resource Limit

The CCG is funded based on the size of their population and its demographic make-up. The details of the South Cheshire population are included in section 2.

NHS South Cheshire CCG allocation is shown in the table below:-

Programme Allocation	14/15 £'000's	15/16 £'000's
Allocation	191,446	198,616
Growth	6,036	10,992
Subtotal	197,482	209,608
Population	177,339	178,251

% growth	3.15%	4.99%
Revenue allocation Per head of Population	1.114	1.176
Target revenue allocation per head of Population	1.187	1.222
Distance from target	0.073	0.046
% distance from target	-6.19%	-3.76%

It can be seen that the revenue funding per head has increased by £62 per head of population for 2015/16 and the CCG moves closer to target by 2.43%.

10.3.2. Better Care Fund

One of the main strategic drivers nationally is for social and health care commissioners to work more closely together. In order to facilitate closer working the Government has identified the Better Care Fund which will be a pooled resource to facilitate joint planning, information sharing and services.

The funding will formally sit with the commissioner who has been allotted the allocation which is included in the BCF. This is in line with the Bevan Brittan s75 guidance as issued by NHS England. The governance arrangements have been embedded within the BCF plan and the s75 agreement. The BCF implementation and delivery will be overseen by the Health and Wellbeing Board. Each BCF project has a lead organisation, management and monitoring structure assigned. The value of the Better Care Fund is £10.625m

10.3.3. Financial Plan 2015/16

The Summary Financial plan remains in draft and will be agreed at the Formal Governing body on 1st April 2015.

The initial budget setting process has identified a number of challenges, including unidentified QIPP of £3,835,000 which will need to be resolved before the final budget is agreed; this includes ensuring the robustness of QIPP schemes and the timeliness of commissioning intention implementation. Further discussions will be held at our clinically led Clinical Commissioning Executive in March 2015.

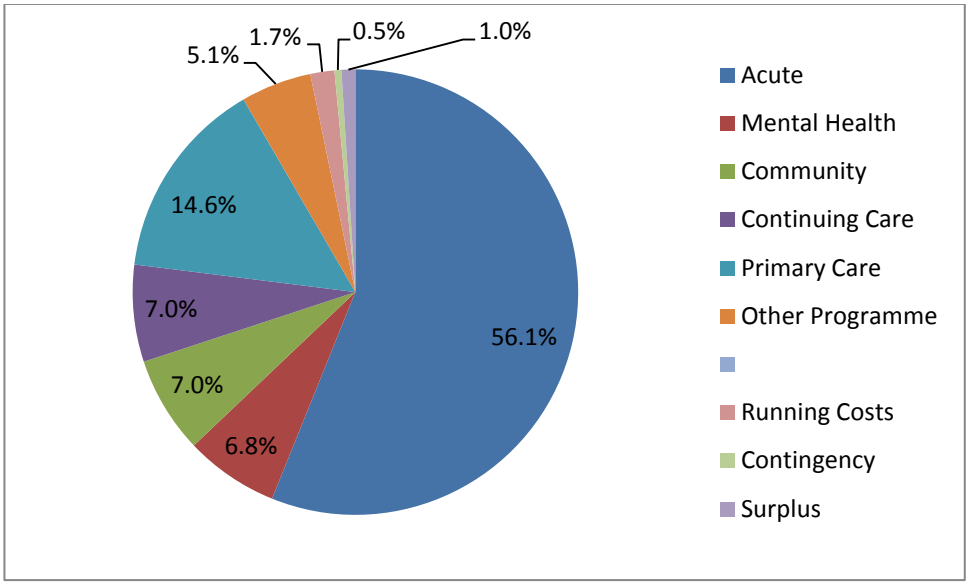
The initial expenditure plan is shown below:-

Income and Expenditure	2014/15 £'000's		2015/16 £'000's
Acute	123,455		122,093
Mental Health	14,000		14,803
Community	14,940		15,299
Continuing Care	13,314		15,319
Primary Care	31,151		31,871
Other Programme	7,420		11,155
Total Programme Costs			

	204,280		210,540
Running Costs	3,900		3,800
Contingency	-		1,090
Total Costs	208,180		215,430
Surplus	1,118		2,180
Total Revenue Resource	209,298		217,610

The allocation of expenditure is shown diagrammatically below:-

NHS South Cheshire CCG - Split of 2015-16 Budget



10.3.4. Key Budget Areas

Provider Services (Acute, Ambulance, Community and Mental Health Services)

The CCG has made assumptions as per the guidance from NHS England with the deflator value at 1.9%. The quality and innovation payment (CQUIN) remains a non-recurrent allocation of 2.5% as in 2014/15.

There is on-going pressure in the acute sector in particular in respect of Urgent Care whilst elective demand is also rising.

The main challenges in 2015/16 are:

- the on-going drive to improve the effectiveness of the Urgent Care Services leading to a reduction in demand, and;
- Maintaining the 18 week target and other constitutional requirements whilst keeping financial control on the elective services costs.
- The implementation of the Integrated Community Teams across Health and Social Care.
- Ensuring the investment in Parity of Esteem for Mental Health is delivered

In 2015/16 the CCG has continued with its approach of collaborative contracting between our main acute, community, primary care, local authority and mental health providers using either alliance or lead contractor models.

The model to be developed will use the approach of a joint resource to drive innovation funding collaborative working across the health economy.

The table below shows those provider contracts over £5m.

Provider	£'000's
Mid Cheshire Hospitals NHS FT	91,454
University Hospital of North Midlands NHS Trust	8,913
North West Ambulance Service NHS Trust	6,175
East Cheshire NHS Trust	16,409
Cheshire And Wirral Partnership NHS FT	13,791
Other Contracts (less than £5m)	9,798
Total	146,540
Non NHS Providers	5,655
Total NHS & Non NHS Providers	152,195

10.3.5. Prescribing

Primary care providers within NHS South Cheshire CCG have always maintained a focus on efficient and effective prescribing; the details of the medicines management actions to control expenditure can be seen in Appendix 3 [DN: to follow] The inflation recommended for prescribing has been maintained at 4%.

10.3.6. Continuing Health Care (CHC) and Funded Nursing Care (FNC)

There is pressure on these budgets locally due to the demographic changes and the increasingly aged population. The CCG has funded all new packages in 2014/15 at a full year effect with an additional growth of 4% due to the increased demand and uncertainty in this area.

10.3.7. Primary Care – Co Commissioning

The CCG has opted for joint commissioning with NHS England and envisage an increasing responsibility over the next financial year in relation to this commissioning area.

10.3.8. Running Cost Allowance

The CCG has planned to reduce its expenditure in this area by 10% in 2015/16 in line with national guidance.

10.3.9. Quality Innovation Productivity and Prevention (QIPP) 14/15-2018/19

It has been recognised that the NHS savings required in the four years from 2015/16 to 2018/19 will be an additional £30 billion i.e. a total NHS savings requirement of £50 billion over a period of 8 year.

The identification of QIPP for 2015/16 by type can be seen in the table below:-

QIPP Scheme Type	£'000's
Transactional Productivity and Contractual Efficiency Savings	438
Transformational Service Re-design and Pathway Changes	3,132
Unidentified QIPP	3,835
Total	7,405

Locally the initial CCG requirement in respect of the £20 billion has been achieved. The additional financial challenge has been identified above.

The most significant projects delivering change and productivity are:-

- Transitional Care Beds impact Urgent Care
- Extended Practice Teams impact Urgent Care
- Redesign Urgent Care 24/7 impact Urgent Care
- Better Care Fund impact Urgent Care – reduction of 3.5% in activity

10.3.10. Key Financial Priorities for 2014/15 to 2018/19

The CCG has a number of statutory financial and national requirements the key items are identified:-

- To maintain a balanced position and deliver the 1% surplus as required by the NHS England;
- To deliver our QIPP targets whilst ensuring that we are delivering improved care to patients;
- To invest the commissioning budget to maximise value for money;
- To ensure the financial resources are applied to support the CCG commissioning Strategy;
- To utilise the Better Care Fund in 2015/16 locally on health and care to drive closer integration and improve outcomes for patients and service users and carers;
- To remain within the CCG running cost allowance of £22.5 per head of population;
- To set aside 1% of recurrent resource for non-recurrent expenditure in 2015/16 to focus on transformational schemes, in particular Integrated Neighbourhood teams

10.3.11. Key Financial Risks:

- increased pressures in elective and non-elective care, continuing health care, funded nursing care and learning disabilities services leading to contract over performance
- ensuring the drive to closer integration can be achieved within existing allocations and change recognised through provider contracts in particular the reduction in activity by 3.5%
- ensuring 1% in 2015/16 is identified for non-recurrent expenditure to enable change;

- ensuring the financial risks associated with the introduction of Personal Health Budgets and Integrated Personal Care Budgets are managed, particularly in respect of safeguarding;
- the productivity requirements are achieved to deliver the CCG element of the £30 billion national productivity challenge
- Identification of an additional investment in Mental Health services to deliver parity of esteem.
- Additional Charges in respect of NHS Property Services
- Additional Costs related to any required transfer of services from the North West CSU.
- Resilience Funding has decreased from 2014/15 by £1m to a value of £1.080m for 2015/16, this may lead to issues with the commissioning of additional winter services in 2015/16.

10.4. Quality Premium Measures 2014-15 Update

The 'quality premium' is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

The quality premium paid to CCGs in 2015/16 – to reflect the quality of the health services commissioned by them in 2014/15 – will be based on six measures that cover a combination of national and local priorities. These are:

- reducing potential years of lives lost through causes considered amenable to healthcare and addressing locally agreed priorities for reducing premature mortality (15 per cent of quality premium);

- improving access to psychological therapies (15% of quality premium);

- reducing avoidable emergency admissions (25 % of quality premium);

- addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in 2014/15 and showing improvement in a locally selected patient experience indicator (15 % of quality premium);

- improving the reporting of medication-related safety incidents based on a locally selected measure (15 % of quality premium);

- a further local measure that should be based on local priorities such as those identified in joint health and wellbeing strategies (15% of quality premium).

For 2014-15 the CCG chose to focus its local quality premium on continuing their programme of work to appropriately manage patients with Atrial Fibrillation whilst promoting therapeutic optimisation in accordance with best practice.

The CCG plan was to increase the number of patients who are appropriate anti-coagulated who have been identified most at risk of catastrophic stroke in line with second quartile national average.

The planned milestones for the project were :

- Provide general practice with education events relating to AF – completed (protected learning time events in NHS South Cheshire CCG)
- Provide practices with lists of patients to review (completed)
- GPs to review lists and commence / adjust anticoagulation based on stroke risk and bleeding risk assessment – in progress, practices funded to provide some protected time via the Quality and Safety Champion

- Review the service specification for the anticoagulation clinic to increase capacity overall, update the service specification to include regular feedback to practices relating to sub-optimal control of INR, improve access to domiciliary testing and incorporate a pathway for self-testing / self-monitoring in line with NICE Clinical Guideline 180 [published June 2014] and NICE DG14 [published Sep 2014] .

The indicator is based on improving performance on the QOF indicator AF07, defined as follows:

AF07 = In those patients with Atrial Fibrillation whose latest record of a CHADS2 score is greater than 1, the percentage of patients who are currently treated with anti-coagulation drug therapy

The target is to increase from the 2012/13 achievement level of 79.9% to at or above the second highest quartile in England, (i.e. 86.17%)

The CCG held a PLT event in September and issued some data and an action plan to practices, to facilitate reviews of people:

- Who are currently taking warfarin but who have not achieved appropriate Time in Therapeutic Range (list provided by the anticoagulation clinic)
- Who have been identified as having AF but who are not taking an anticoagulant (list provided by the MMT).

The CCG has also made available funding for 1 or 2 session of GP time to undertake or co-ordinate the reviews in practice, using the Quality and Safety Champion sessions.

A 6 month position of delivery against the Quality Premium is presented below :
[DN: to be included in the final submission of the Operational Plan].

10.5. Quality Premium 2015-16

The CCG is awaiting national guidance on the quality premium for 2015-16.
[DN: However discussions are currently taking place within the CCG to review possible options for a local Quality Premium for 2015-16 and will be finalised in time for the final submission of the Operational Plan].

10.6. Procurement of Healthcare

We have developed and implemented a local policy on the Procurement of Healthcare services. This policy follows the implementation of the NHS (Procurement, Patient Choice and Competition) (No2) Regulations which were implemented under section 75 of the Health and Social Care Act 2013 on 01 April 2013. The Policy also takes into consideration the substantive guidance published by the Regulator – Monitor in May and December of 2013 and the Public Services (Social Value) Act 2012.

The aims of our approach are specifically to promote:

- **Choice**: ensuring a range of providers for our population to choose from
- **Competition**: encourage a degree of competition within the health system, with the aim of continuously improving quality of service and innovation
- **Consistency**: ensuring clinical safety, equity of access and quality of outcomes for our patients

Implementing our approach will ensure that through the utilisation of best practice procurement processes we are able to:

(i) Demonstrate value for money for all expenditure of public money,
(ii) Adhere to relevant legislation governing the award of contracts by public bodies,

(iii) Comply with our own Standing Financial Instructions/Standing Financial Orders (SFI's/SFO's)

We have adopted a proactive stance towards securing services that meet the needs of the local patient population and competitive procurement will be a key part of this in the coming years; as will the option for greater integration within the existing health economy. To support consistency in the decision making process regarding the use of competitive procurement, a key part of our approach will be to adopt a decision making matrix which will support a clear and unbiased decision.

We will adopt a fair, open and transparent approach, publishing procurement opportunities and decisions related to the contracting of services.

To facilitate the procurement process, the CCG will utilise the professional procurement team at the North West Commissioning Support unit to provide an overarching procurement support service. During 2015/16, the CCG will procure an alternative provider of Healthcare Procurement Support. Utilising one of the nationally accredited organisations on the Lead Provider Framework, or through establishing a new 'shared service' will ensure that the CCG remains compliant with the procurement regulations and obtains maximum benefit from the procurement process.

We are reviewing contracting and commissioning activity as contracts expire; areas currently subject to a competitive procurement process include: Community Pain Management, Outcome Based Commissioning support and a 'co-commissioning' review. Additional areas under consideration include: a 'case-loading' community midwifery service, a Learning Disability placement 'framework agreement' and Dementia Information and Support services. An annual work-plan of activity will be developed each year so there is full oversight of the competitive procurement activity at CCG level.

In addition to the proactive approach to the procurement of healthcare services, we will encourage the adoption of the 'Better Procurement, Better Value, Better Care' guidance which was published in 2013. As well as adopting the principles in the procurement of all internal goods and services, we aim to include a mandate around the adoption of the same principles into all standard contracts held with local NHS Providers, ensuring that the overarching health economy takes responsibility for improving procurement efficiency for the benefit of patient care.

10.7. Risk Management

The CCG has in place processes and procedures to assure our Governing Body, Membership and the public we serve that we are carrying out the commissioning of healthcare in the best interests of our patient population. One of the mechanisms we use to do this is an effective assurance framework, supported by robust risk management processes.

In line with national requirements for all NHS bodies the Governing Body developed an assurance framework outlining the key risks to us achieving our strategic objectives. This will be refreshed for the coming year to take into account new areas of shared working such as the better care fund and primary care co-commissioning. This assurance framework is also used to inform the CCG's Annual Governance Statement.

Supporting this overall strategic assurance framework are the CCG's risk management systems. An overall corporate risk register is fed into by programme and team registers and is reviewed by the Governance & Audit Committee, with a highlight report going to the Governing Body. Risks are reported through a variety of sources and the risk owners are supported by the Performance & Risk Manager to actively manage the risks, providing monthly updates on progress against the action plans put in place.

Plans are being developed to further integrate risk management into day-to-day working, looking at incorporating our systems within a programme management approach, being able to cross-reference with our complaints and incident reporting systems.

10.8. Programme/ Project Management Office (PMO) Approach

NHS South Cheshire CCG is committed to developing and implementing a PMO approach in order to facilitate the effective and efficient delivery of our Strategic and Operational Plans.

The PMO approach will work with staff to develop the methodologies, processes and tools in order to prioritise, implement and evaluate agreed programmes and projects of work. The approach will ensure conformance to agreed processes for decision making, resource allocation, governance and risk management and performance monitoring.

Benefits from utilising the PMO approach will include programmes and projects being aligned with corporate strategies and objectives/ outcomes; improved communication and planning and integration of work across the CCG; reduction in duplication of work or ineffective work; improved governance and performance reporting processes to measure impact and outcomes; improved resource utilisation and skills development and transfer.

The initial stages of our implementation of a PMO approach are focusing on workforce engagement and development, developing executive management support and development of PMO methodology and tools.

10.9. Contract/Performance Management

We manage provider/contractor performance based upon business performance principles of:

- Clear targets and accountabilities;
- Performance Tracking;
- Effective review meeting structures;
- Good Performance Conversations; and
- Consequence of breach.

The principles highlighted above are the mechanism for which the CCG identify any failing service. Taking the main Provider as an example, Mid Cheshire Hospitals NHS Foundation Trust, to highlight how a failing service will be identified.

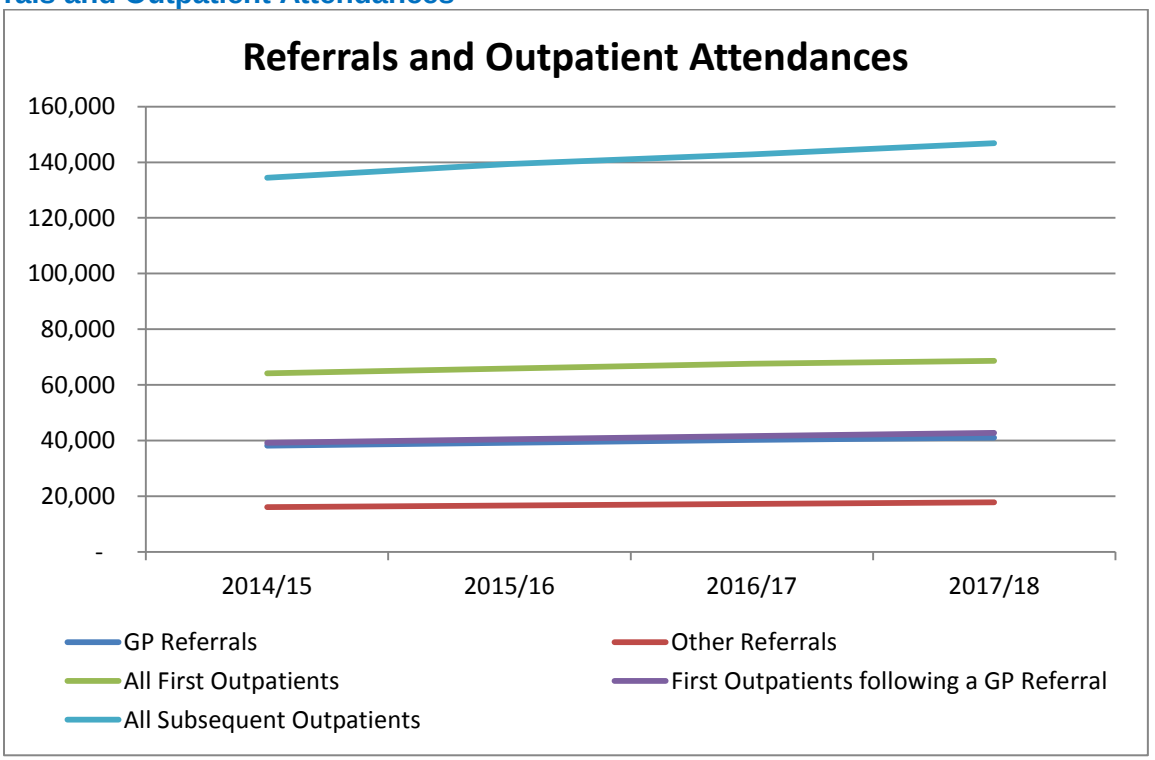
The CCG has established a clear and accountable Governance Structure for identifying failing services within the Trust. There are two main sub committees of the main contract performance review meeting with the frequency of these being monthly. These are the Finance and Performance Review Group and the Quality and Safety Committee with core membership including senior staff from both organisations. All performance issues are initially discussed via these two groups and where there are items that cannot be agreed/disputes these are then escalated to the main contract performance review meeting.

To identify performance issues within the Trust e.g. a failing service, key metrics are discussed from the Trusts performance report and where there are issues the CCG request action plans for remedial action. The consequence of any non-compliance results in escalation to the main performance meeting, sanctions and/or a formal contract query in line with the NHS Standard Contract. This is a defined process and the ultimate sanction for non-compliance/consequence of breach is withholding of monies to the Trust.

Appendices

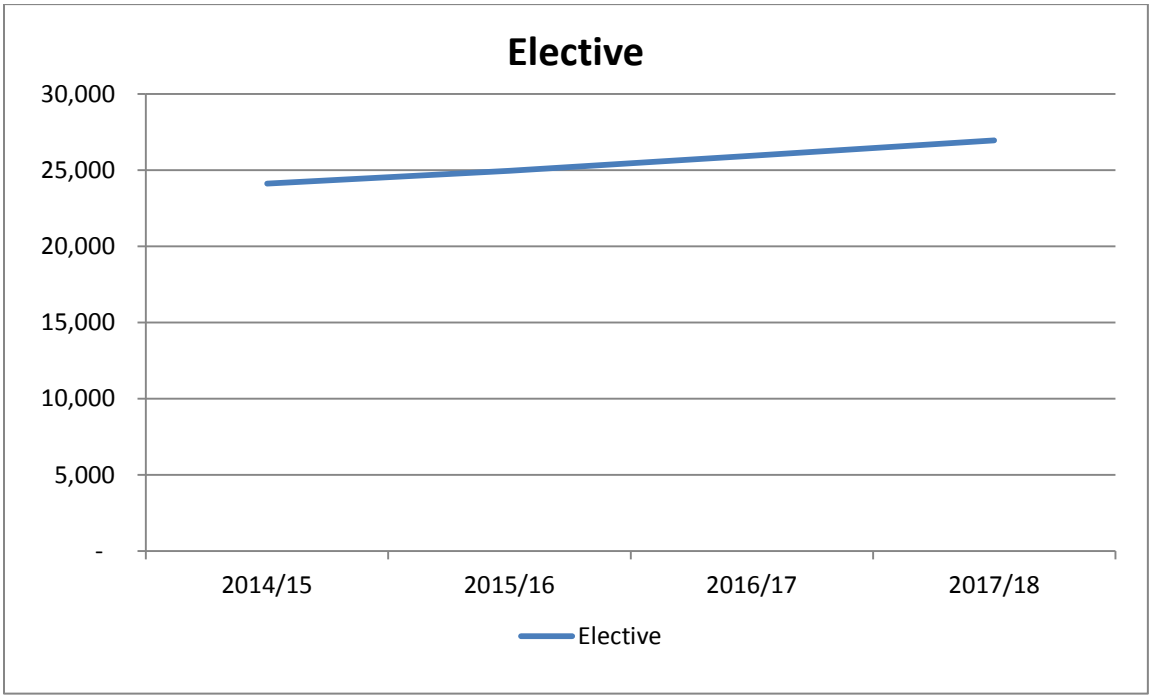
Appendix 1 - Activity Trajectories

Referrals and Outpatient Attendances



The CCG has experienced an increase in GP referrals over the last year and it is anticipated that this may grow due to the change in demography and the increasing pressure in primary care. The local trust operates at peer level for first to follow up ratios.

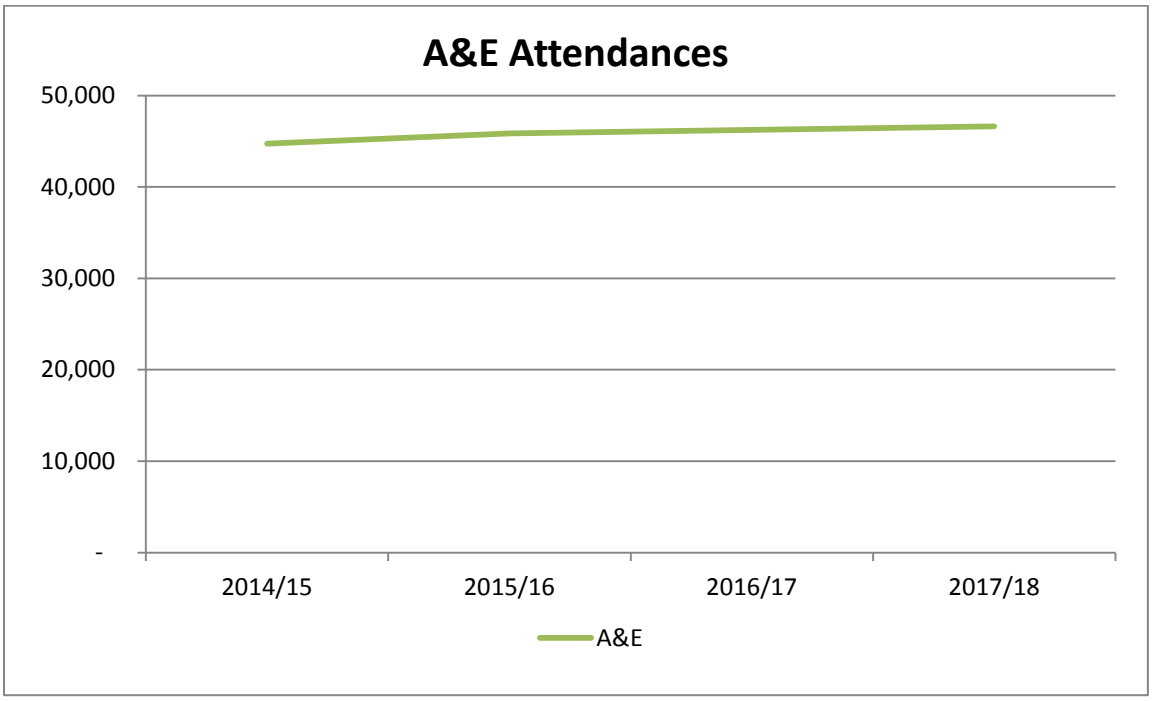
Elective Care



The CCG and local main provider are increasing the ratio of day-case to elective procedures to improve efficiency. The provider has recently implemented a new theatre suite and has a dedicated

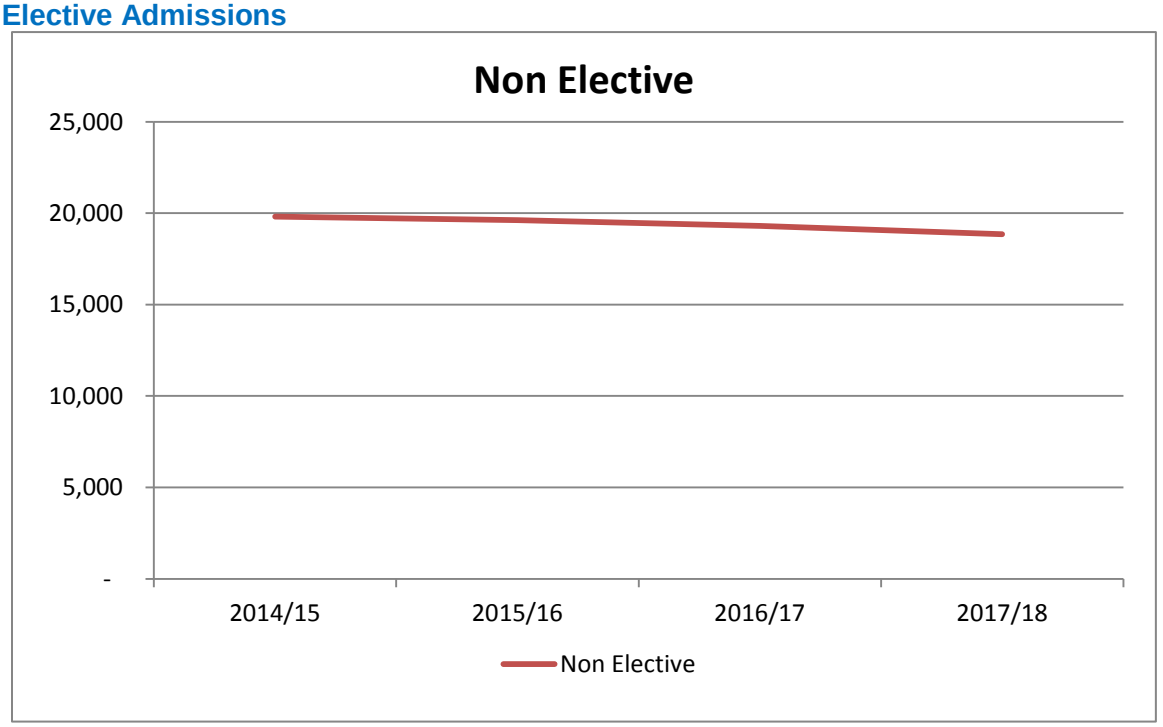
day-case unit. The CCG and trust are reviewing locally the commissioning for Value pack to improve effectiveness. The impact of this has not been taken into account above but it is anticipated that this will have a significant effect in a number of specialties e.g. gastroenterology.

A&E attendances



A&E attendances have increased slightly during 2014/15 and have been predicted to continue at the current level. A number of initiatives have been carried out at the local provider to achieve this level of stability additional schemes will be put in place over the planning period to ensure that the level remains stable.

Non Elective Admissions



The Connecting Care strategy focusses on decreasing non elective activity. The main drivers of a reduction in NEL admissions are Integrated Community Teams and additional beds in community to prevent admission and ensure earlier discharge.

Appendix 2 -2015-16 Operational Planning Outcomes Framework – Summary

North West
Commissioning Support Unit

NHS South Cheshire CCG 2015/16 Operational Planning Outcomes Framework Summary Report V3.0

23/02/2015

Changes to previous submission:

E.A.S.1 - Dementia Prevelance – now provided by NHS England as a static 2247/month.
E.A.S.5 - C Diff Objectives – now set by NHS England
E.H.1-A.1 & A.2 –IAPT Waiting Times - Revised projections completed after receiving historical actuals from CWP.
E.D.1 – 3 – Primary Care Quality Surveys – plans to be agreed and signed off for this round of submissions.

NHS CONSTITUTION MEASURES

	Data Validation Tests - will prevent upload (Please review the data in the template and amend as appropriate)					Data Warnings (highlights in amber unsual figures) (Review data in the template and either amend or select Yes to approve the warning in column Q)							
	Complete data entered	Is format correct? Text/Number	Within character limit?	Is data a whole number?	Measure < 100%	Is the difference between consectutive months larger than the following:		Is the submitted data below the following national standards?		Does not equal following national objective		Check data?	If row labelled as red. Is data checked and approved? (Yes/No)
RTT - Admitted - E.B.1						10%		90%				Validation passed	
RTT - Non - Admitted - E.B.2						10%		95%				Validation passed	
RTT - Incomplete - E.B.3						10%		92%				Validation passed	
Diagnostics - E.B.4						10%		1%				Validation passed	
Cancer Waiting Times - 2 week wait - E.B.6						10%		93%				Validation passed	
Cancer Waiting Times - 2 week (breast symptoms) - E.B.7						10%		93%				Validation passed	
Cancer Waiting Times - 31 Day First Treatment - E.B.8						10%		96%				Validation passed	
Cancer Waiting Times - 31 Day Surgery - E.B.9						10%		94%				Validation passed	
Cancer Waiting Times = 31 Day Drugs - E.B.10						10%		98%				Validation passed	
Cancer Waiting Times - 31 Day Radiotherapy - E.B.11						10%		94%				Validation passed	
Cancer Waiting Times - 62 Day GP Referral - E.B.12						10%		85%				Validation passed	
Cancer Waiting Times - 62 Day Upgrade - E.B.14						10%						Validation passed	
Cancer Waiting Times - 62 Day Screening - E.B.13						10%		90%				Validation passed	
Ambulance Performance - E.B.15.i						10%		75%		Not lead commissioner		Validation passed	
Ambulance Performance - E.B.15.ii						10%		75%		Not lead commissioner		Validation passed	
Ambulance Performance - E.B.16						10%		95%		Not lead commissioner		Validation passed	
A&E Performance Provider 1						10%		95%				Validation passed	
A&E Performance Provider 2						10%		95%		Not lead commissioner		Validation passed	
A&E Performance Provider 3						10%		95%		Not lead commissioner		Validation passed	
C.Difficile - E.A.S.5						10				C.Difficile objective set for each CCG:		Validation passed	
Dementia - E.A.S.1						10%		66.70%				Validation passed	
IAPT Access - E.A.3						5%		3.75%				Validation passed	
IAPT Recovery - E.A.S.2						20%		50%				Validation passed	
Mental Health Access - 18 Weeks - E.H.2 - A2						10%		95%				Validation passed	
Mental Health Access - 6 Weeks - E.H.1 - A1						10%		75%				Validation passed	
Satisfaction at a GP Practice - E.D.1						Is E.D.1 between 100 and 500?						Validation passed	
Satisfaction at a Surgery - E.D.2												Validation passed	
Satisfaction with access to primary care - E.D.3												Validation passed	

Referral To Treatment waiting times for non-urgent consultant-led treatment.

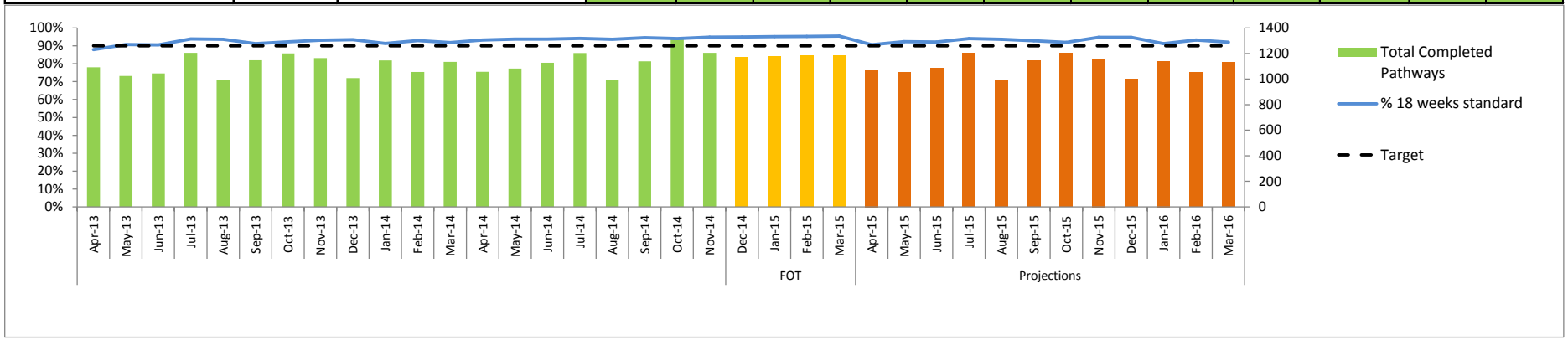
E.B.1 - The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period, on an adjusted basis.

Monitoring Data Source - Consultant-led RTT Waiting Times data collection (National Statistics)

Target - Performance will be judged against the following waiting time standards:-

Admitted operational standard of 90% – the percentage of admitted pathways (on an adjusted basis) within 18 weeks should equal or exceed 90%

E.B.1			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
RTT - The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period, on an adjusted basis	2013-14	Completed pathways < 18 weeks	961	930	945	1131	928	1047	1108	1085	942	1047	982	1042
		Total Completed Pathways	1093	1025	1044	1205	991	1148	1201	1165	1008	1146	1056	1135
		%	87.9%	90.7%	90.5%	93.9%	93.6%	91.2%	92.3%	93.1%	93.5%	91.4%	93.0%	91.8%
	2014-15	Completed pathways < 18 weeks	986	1015	1057	1134	930	1077	-	-	-	-	-	-
		Total Completed Pathways	1057	1082	1127	1204	993	1139	-	-	-	-	-	-
		%	93.3%	93.8%	93.8%	94.2%	93.7%	94.6%	-	-	-	-	-	-
	2015/16 Plan	Completed pathways < 18 weeks	973.5	972.5	1001	1132.5	929	1062	1104	1100	950	1040	979	1040
		Total Completed Pathways	1075	1053.5	1085.5	1204.5	992	1143.5	1201	1160	1002	1140	1050	1130
		%	90.6%	92.3%	92.2%	94.0%	93.6%	92.9%	91.9%	94.8%	94.8%	91.2%	93.2%	92.0%



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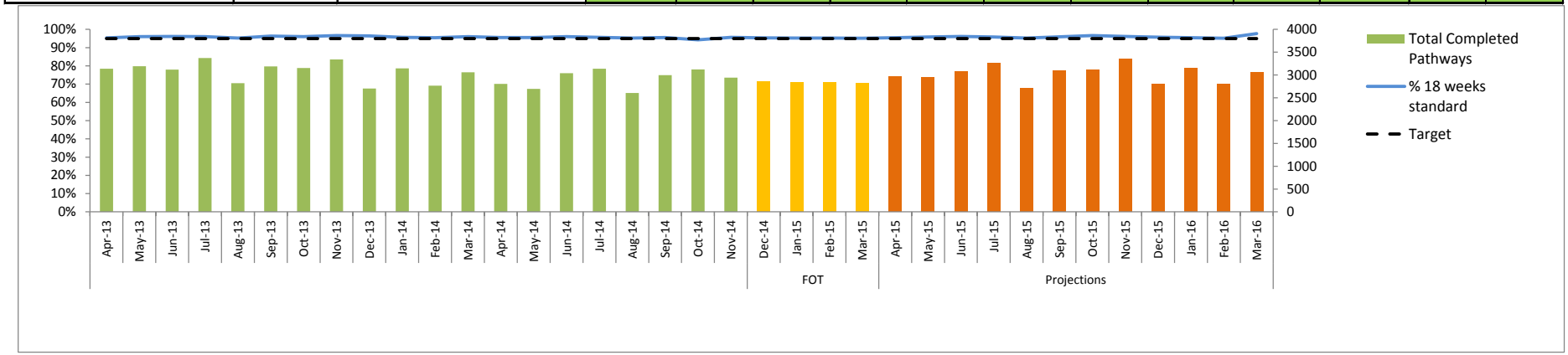
E.B.2: The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period.

Monitoring Data Source - Consultant-led RTT Waiting Times data collection (National Statistics)

Target - Non-admitted operational standard of 95% – the percentage of non-admitted pathways within 18 weeks should equal or exceed 95%

E.B.2			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
RTT - The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period.	2013-14	Completed pathways < 18 weeks	2990	3067	2998	3237	2687	3070	3028	3229	2608	3006	2642	2936
		Total Completed Pathways	3136	3193	3117	3372	2822	3187	3154	3343	2705	3144	2767	3058
		%	**95.3%**	**96.1%**	**96.2%**	**96.0%**	**95.2%**	**96.3%**	**96.0%**	**96.6%**	**96.4%**	**95.6%**	**95.5%**	**96.0%**
	2014-15	Completed pathways < 18 weeks	2680	2577	2919	3002	2483	2864	-	-	-	-	-	-
		Total Completed Pathways	2804	2696	3039	3138	2607	2996	-	-	-	-	-	-
		%	**95.6%**	**95.6%**	**96.1%**	**95.7%**	**95.2%**	**95.6%**	-	-	-	-	-	-
	2015/16 Plan	Completed pathways < 18 weeks	2835	2822	2958.5	3119.5	2585	2967	3010	3220	2681	3011	2670	2990
		Total Completed Pathways	2970	2944.5	3078	3255	2714.5	3091.5	3115	3350	2801	3154	2805	3060
		%	**95.5%**	**95.8%**	**96.1%**	**95.8%**	**95.2%**	**96.0%**	**96.6%**	**96.1%**	**95.7%**	**95.5%**	**95.2%**	**97.7%**



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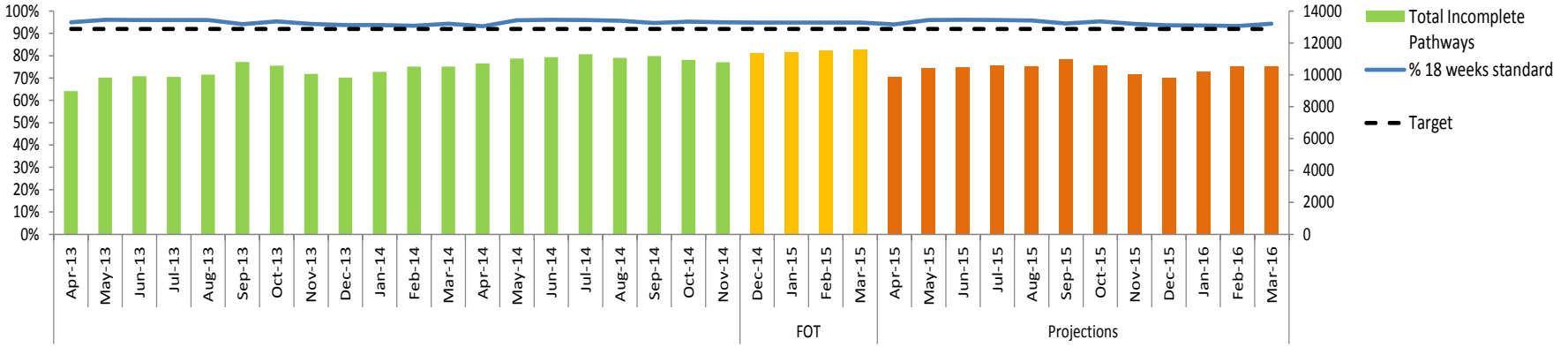
E.B.3: The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.

Monitoring Data Source - Consultant-led RTT Waiting Times data collection (National Statistics)

Target -Incomplete operational standard of 92% – the percentage of incomplete pathways within 18 weeks should equal or exceed 92%

E.B.3			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
RTT - The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.	2013-14	Incomplete Pathways < 18 weeks	8533	9445	9519	9472	9613	10171	10081	9478	9216	9546	9817	9911
		Total Incomplete Pathways	8985	9831	9916	9867	10016	10809	10570	10060	9833	10190	10516	10513
		%	**95.0%**	**96.1%**	**96.0%**	**96.0%**	**96.0%**	**94.1%**	**95.4%**	**94.2%**	**93.7%**	**93.7%**	**93.4%**	**94.3%**
	2014-15	Incomplete Pathways < 18 weeks	9993	10569	10665	10839	10572	10574	-	-	-	-	-	-
		Total Incomplete Pathways	10723	11022	11100	11292	11057	11173	-	-	-	-	-	-
		%	**93.2%**	**95.9%**	**96.1%**	**96.0%**	**95.6%**	**94.6%**	-	-	-	-	-	-
	2015/16 Plan	Incomplete Pathways < 18 weeks	9263	10007	10092	10155.5	10092.5	10372.5	10079	9470	9211	9540	9820	9920
		Total Incomplete Pathways	9854	10426.5	10508	10579.5	10536.5	10991	10570	10050	9845	10200	10520	10520
		%	**94.0%**	**96.0%**	**96.0%**	**96.0%**	**95.8%**	**94.4%**	**95.4%**	**94.2%**	**93.6%**	**93.5%**	**93.3%**	**94.3%**



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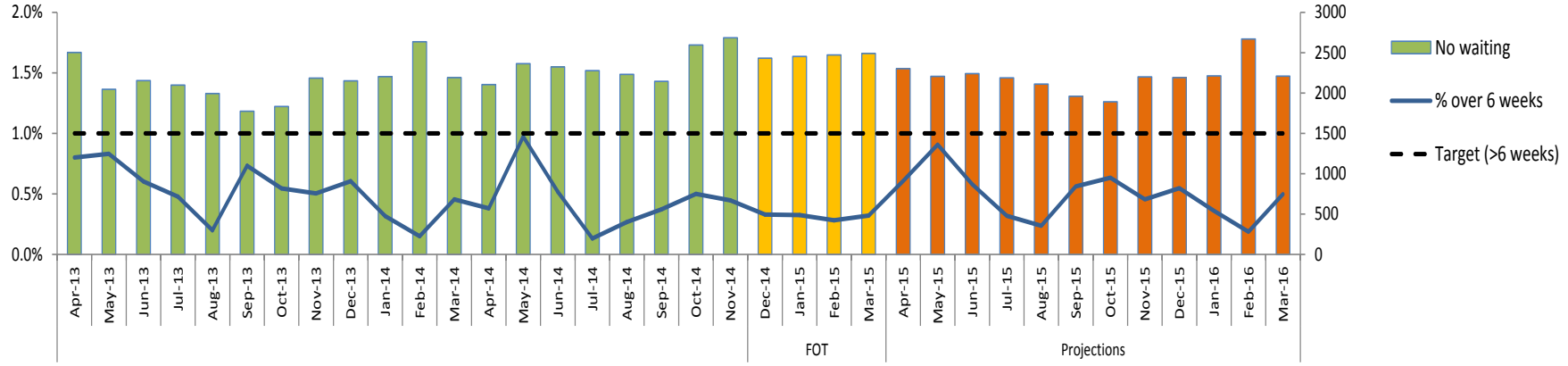
E.B.4: Diagnostic Test Waiting Times - The percentage of patients waiting 6 weeks or more for a diagnostic test.

Monitoring Data Source: Monthly diagnostics data collection - DM01

Target - Diagnostic operational standard of less than 1% – the percentage of patients waiting six weeks or more for a diagnostic test should be less than 1%.

E.B.4			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
Diagnostics Test Waiting Times	2013-14	Number waiting > 6 weeks	20	17	13	10	4	13	10	11	13	7	4	10
		Total Number waiting	2501	2047	2155	2097	1994	1775	1832	2184	2150	2202	2636	2192
		%	**0.8%**	**0.8%**	**0.6%**	**0.5%**	**0.2%**	**0.7%**	**0.5%**	**0.5%**	**0.6%**	**0.3%**	**0.2%**	**0.5%**
	2014-15	Number waiting > 6 weeks	8	23	12	3	6	8	-	-	-	-	-	-
		Total Number waiting	2104	2364	2323	2277	2231	2145	-	-	-	-	-	-
		%	**0.4%**	**1.0%**	**0.5%**	**0.1%**	**0.3%**	**0.4%**	-	-	-	-	-	-
	2015/16 Plan	Number waiting > 6 weeks	14	20	12.5	6.5	5	10.5	12	10	12	8	5	11
		Total Number waiting	2302.5	2205.5	2239	2187	2112	1960	1890	2200	2190	2212	2670	2210
		%	**0.6%**	**0.9%**	**0.6%**	**0.3%**	**0.2%**	**0.5%**	**0.6%**	**0.5%**	**0.5%**	**0.4%**	**0.2%**	**0.5%**



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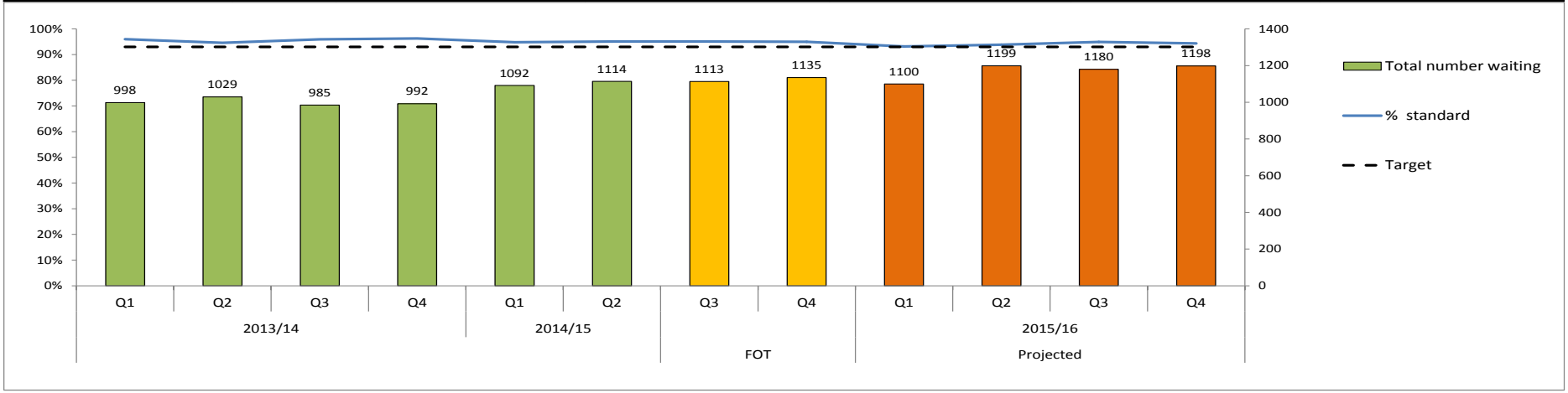
E.B. 6-7: Cancer two week waits

E.B.6: All cancer two week wait - Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer

Monitoring Data Source: Data are sourced from the CWT-Db on a monthly and quarterly basis.

Target - Performance is to be sustained at or above the operational standard of 93%.

E.B.6			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer- All Cancer two week wait	2013-14	Number waiting < 2 weeks	958	973	945	955
		Total number waiting	998	1029	985	992
		%	**96.0%**	**94.6%**	**95.9%**	**96.3%**
	2014-15	Number waiting < 2 weeks	1035	1059	-	-
		Total number waiting	1092	1114	-	-
		%	**94.8%**	**95.1%**	**-**	**-**
	2015/16 Plan	Number waiting < 2 weeks	1025	1125	1120	1130
		Total number waiting	1100	1199	1180	1199
		%	**93.2%**	**93.8%**	**94.9%**	**94.2%**



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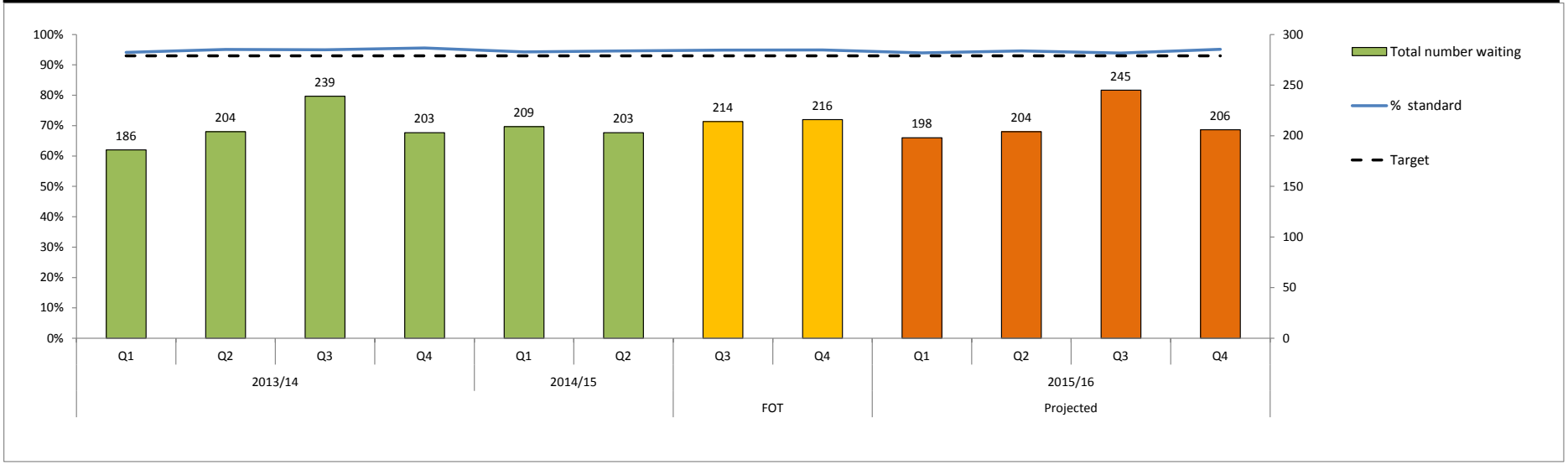
E.B.7: Two week wait for breast symptoms (where cancer was not initially suspected).

Monitoring Data Source: Data are sourced from the CWT-Db on a monthly and quarterly basis.

Target - Performance is to be sustained at or above the operational standard of 93%.

E.B.7			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - Two week wait for breast symptoms (where cancer not initially suspected)	2013-14	Number waiting < 2 weeks	175	194	227	194
		Total number waiting	186	204	239	203
		%	**94.1%**	**95.1%**	**95.0%**	**95.6%**
	2014-15	Number waiting < 2 weeks	197	192	-	-
		Total number waiting	209	203	-	-
		%	**94.3%**	**94.6%**	**-**	**-**
	2015/16 Plan	Number waiting < 2 weeks	186	193	230	196
		Total number waiting	198	204	245	206
		%	**93.9%**	**94.6%**	**93.9%**	**95.1%**



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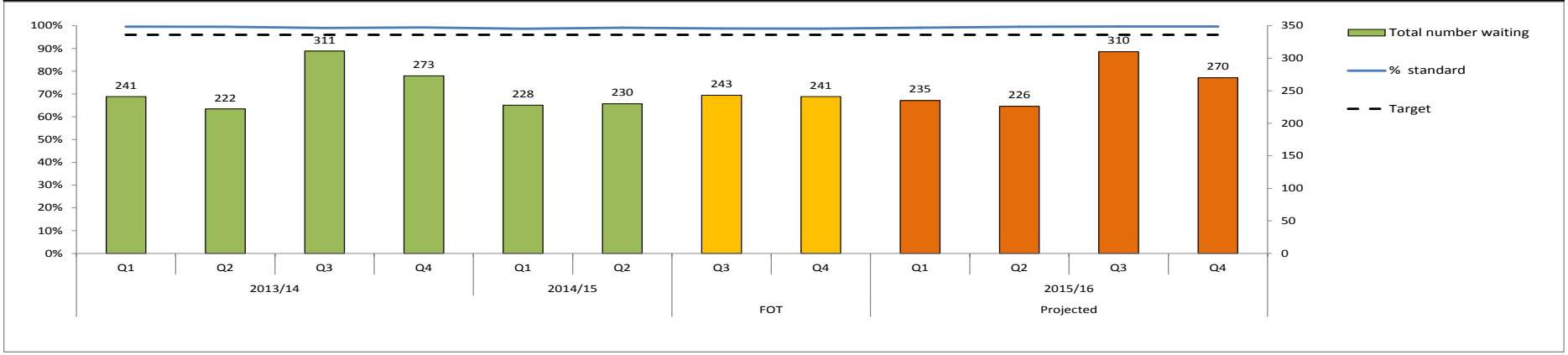
E.B.8-11: Cancer 31 day waits

E.B.8: Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat')

Monitoring Data Source: Data are sourced from the CWT-Db on a monthly and quarterly basis

Target - Performance is to be sustained at or above the operational standard of 96%.

E.B.8			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - Percentage of patients receiving first definitive treatment within 31 days of a cancer diagnosis.	2013-14	Number waiting < 31 days	240	221	308	271
		Total number waiting	241	222	311	273
		%	**99.6%**	**99.5%**	**99.0%**	**99.3%**
	2014-15	Number waiting < 31 days	225	228	-	-
		Total number waiting	228	230	-	-
		%	**98.7%**	**99.1%**	**-**	**-**
	2015/16 Plan	Number waiting < 31 days	233	225	309	269
		Total number waiting	235	226	310	270
		%	**99.1%**	**99.6%**	**99.7%**	**99.6%**



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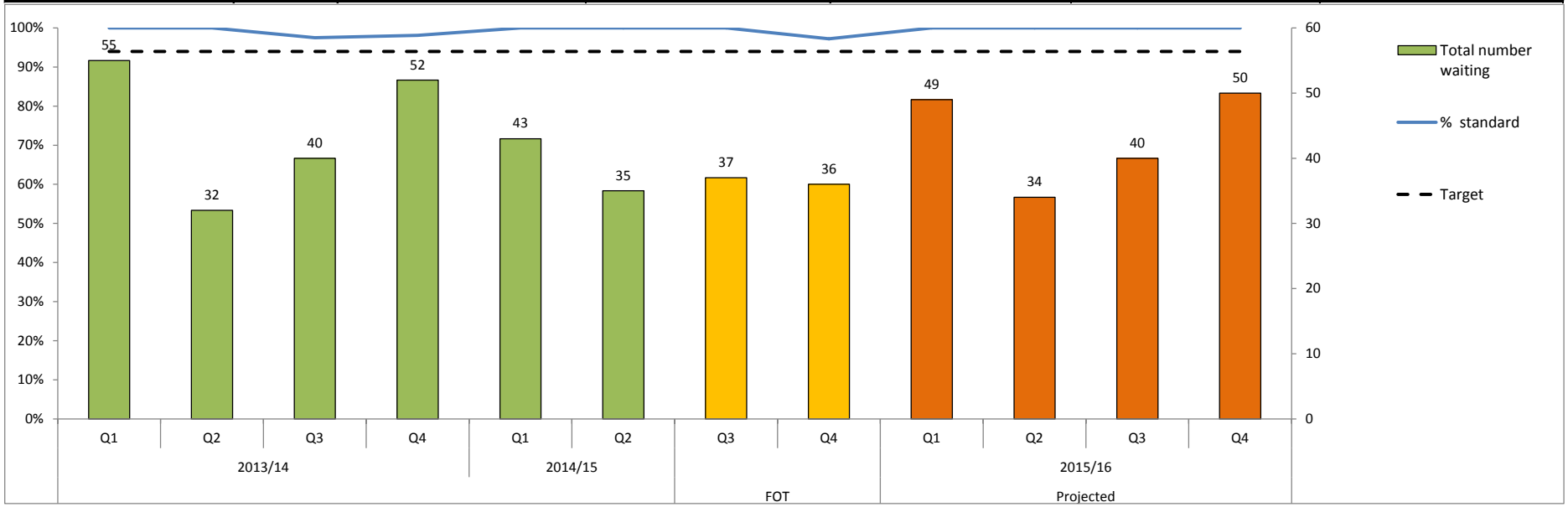
E.B.9: 31-day standard for subsequent cancer treatments-surgery

Monitoring Data Source: Data are sourced from the CWT-Db on a monthly and quarterly basis

Target - Performance is to be sustained at or above the operational standard of 94%

E.B.9			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - 31 Day standard for subsequent cancer treatments - surgery	2013-14	Number waiting < 31 days	55	32	39	51
		Total number waiting	55	32	40	52
		%	100.0%	100.0%	97.5%	98.1%
	2014-15	Number waiting < 31 days	43	35	-	-
		Total number waiting	43	35	-	-
		%	100.0%	100.0%	-	-
	2015/16 Plan	Number waiting < 31 days	49	34	40	50
		Total number waiting	49	34	40	50
		%	100.0%	100.0%	100.0%	100.0%



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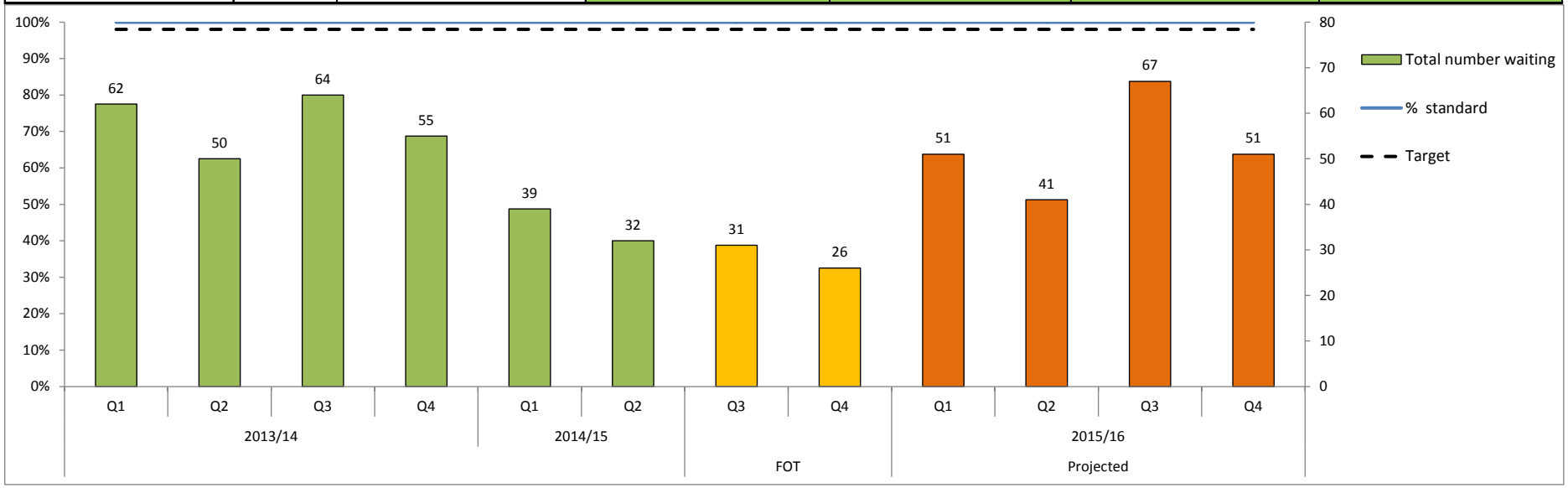
E.B.10: 31-day standard for subsequent cancer treatments - anti cancer drug regimens

Monitoring Data Source: Data are sourced from the CWT-Db on a monthly and quarterly basis

Target - Performance is to be sustained at or above the operational standard of 98%.

E.B.10			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - 31 Day standard for subsequent cancer treatments - anti cancer drug regimens	2013-14	Number waiting < 31 days	62	50	64	55
		Total number waiting	62	50	64	55
		%	100.0%	100.0%	100.0%	100.0%
	2014-15	Number waiting < 31 days	39	32	-	-
		Total number waiting	39	32	-	-
		%	100.0%	100.0%	-	-
	2015/16 Plan	Number waiting < 31 days	51	41	67	51
		Total number waiting	51	41	67	51
		%	100.0%	100.0%	100.0%	100.0%



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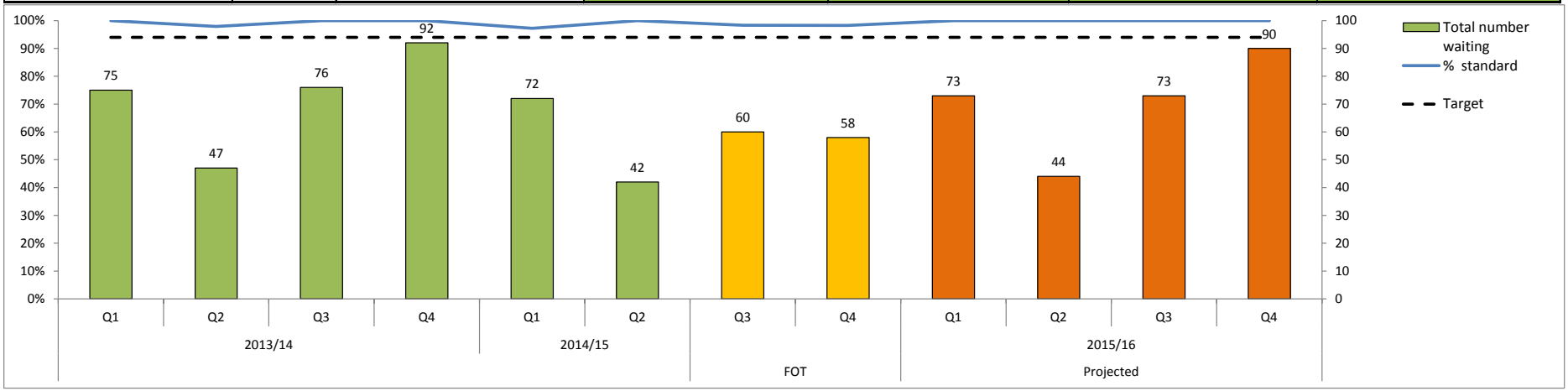
E.B.11: 31-day standard for subsequent cancer treatments – radiotherapy

Monitoring Data Source: Data are sourced from the CWT-Db on a monthly and quarterly basis

Target - Performance is to be sustained at or above the operational standard of 94%.

E.B.11			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - 31 Day standard for subsequent cancer treatments - radiotherapy	2013-14	Number waiting < 31 days	75	46	76	92
		Total number waiting	75	47	76	92
		%	100.0%	97.9%	100.0%	100.0%
	2014-15	Number waiting < 31 days	70	42	-	-
		Total number waiting	72	42	-	-
		%	97.2%	100.0%	-	-
	2015/16 Plan	Number waiting < 31 days	73	44	73	90
		Total number waiting	73	44	73	90
		%	100.0%	100.0%	100.0%	100.0%



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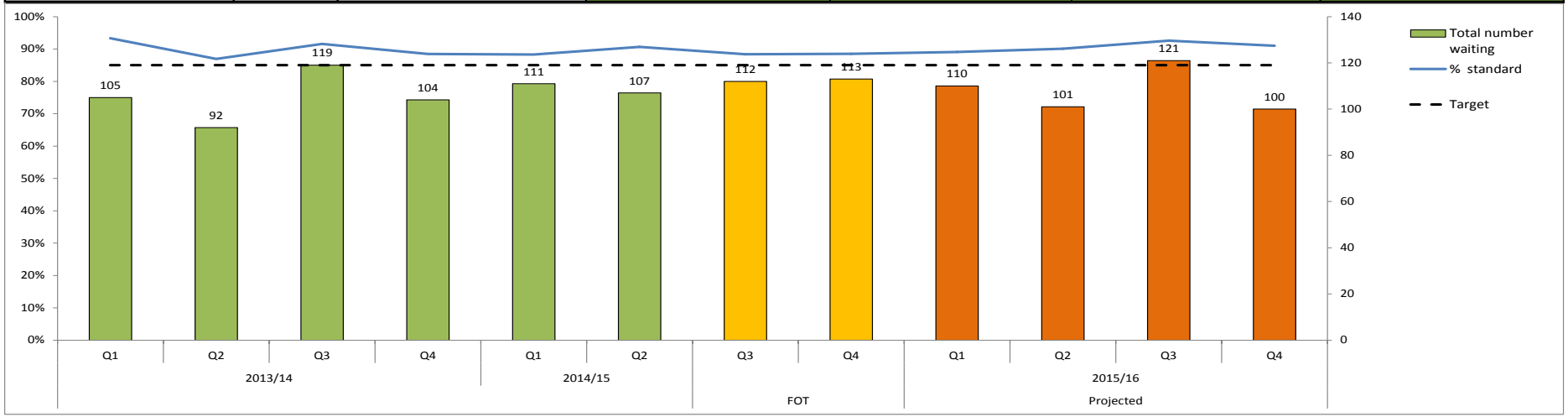
E.B.12-14: Cancer 62 day waits

E.B.12: All cancer two month urgent referral to first treatment wait

Monitoring Data Source: Data are sourced from the CWT-Db on a monthly and quarterly basis

Target - Performance is to be sustained at or above the published operational standard of 85%.

E.B.12			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - All cancer 62 day urgent referral to first treatment wait	2013-14	Number waiting < 62 days	98	80	109	92
		Total number waiting	105	92	119	104
		%	**93.3%**	**87.0%**	**91.6%**	**88.5%**
	2014-15	Number waiting < 62 days	98	97	-	-
		Total number waiting	111	107	-	-
		%	**88.3%**	**90.7%**	**-**	**-**
	2015/16 Plan	Number waiting < 62 days	98	91	112	91
		Total number waiting	110	101	121	100
		%	**89.1%**	**90.1%**	**92.6%**	**91.0%**



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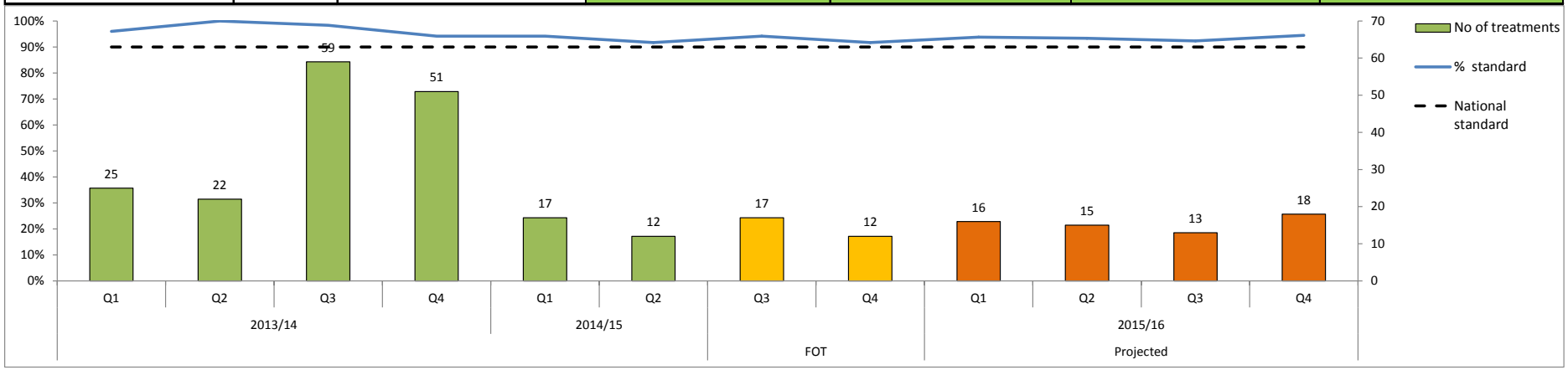
E.B.13: 62-day wait for first treatment following referral from an NHS cancer screening service

Monitoring Data Source: Data are sourced from the CWT-Db on a monthly and quarterly basis

Target - Performance is to be sustained at or above the published operational standard of 90%.

E.B.13			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - 62 day wait for first treatment following referral from an NHS cancer screening service	2013-14	Number waiting < 62 days	24	22	58	48
		Total number waiting	25	22	59	51
		%	**96.0%**	**100.0%**	**98.3%**	**94.1%**
	2014-15	Number waiting < 62 days	16	11	-	-
		Total number waiting	17	12	-	-
		%	**94.1%**	**91.7%**	**-**	**-**
	2015/16 Plan	Number waiting < 62 days	15	14	12	17
		Total number waiting	16	15	12	17
		%	**93.8%**	**93.3%**	**100.0%**	**100.0%**



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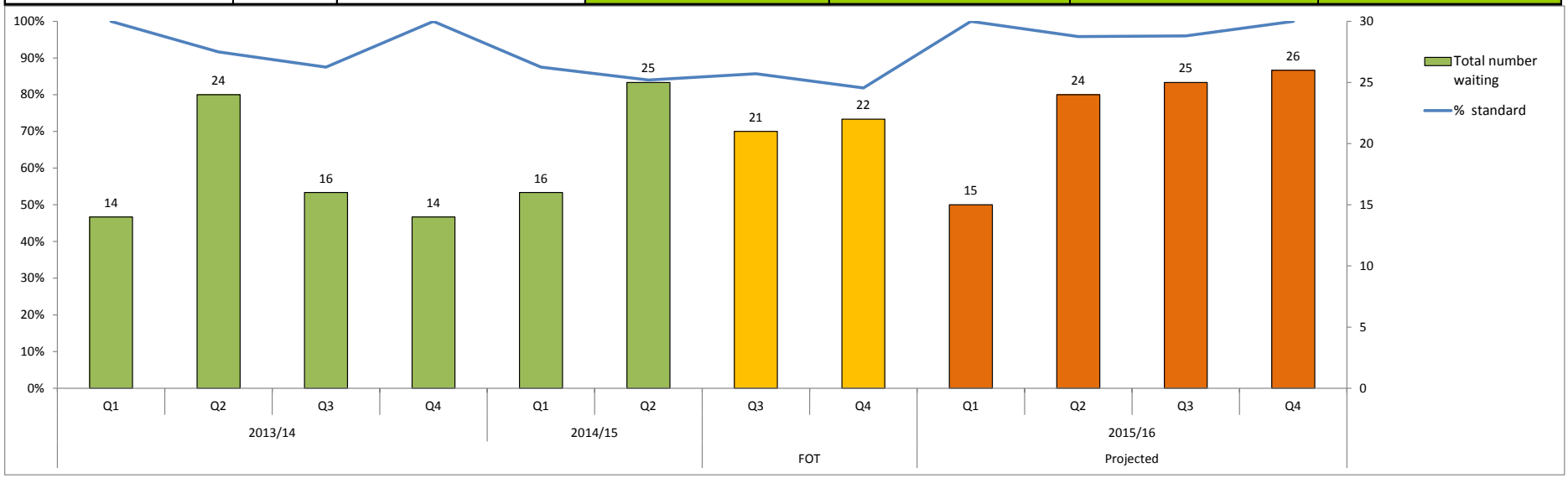
E.B.14: 62-Day wait for first treatment for cancer following a consultant's decision to upgrade the patient's priority

Monitoring Data Source: Data are sourced from the CWT-Db on a monthly and quarterly basis

Target - There is no current operational standard, therefore will not be centrally assessed against a set threshold. These performance data will however be monitored and published as national statistics.

E.B.14			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - 62 day wait for first treatmnet for cancer following a consultant's decision to upgrade the patients priority	2013-14	Number waiting < 62 days	14	22	14	14
		Total number waiting	14	24	16	14
		%	**100.0%**	**91.7%**	**87.5%**	**100.0%**
	2014-15	Number waiting < 62 days	14	21	-	-
		Total number waiting	16	25	-	-
		%	**87.5%**	**84.0%**	**-**	**-**
	2015/16 Plan	Number waiting < 62 days	15	23	24	26
		Total number waiting	15	24	25	26
		%	**100.0%**	**95.8%**	**96.0%**	**100.0%**



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E.B.5: A&E Waiting Times –Total time in the A&E department

1. Total number of A&E attendances.
2. Number of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge.
3. Percentage of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge.

Monitoring Data Source: Weekly sitrep data (WSitAE)

Target - Standard is 95% of patients seen within 4 hours

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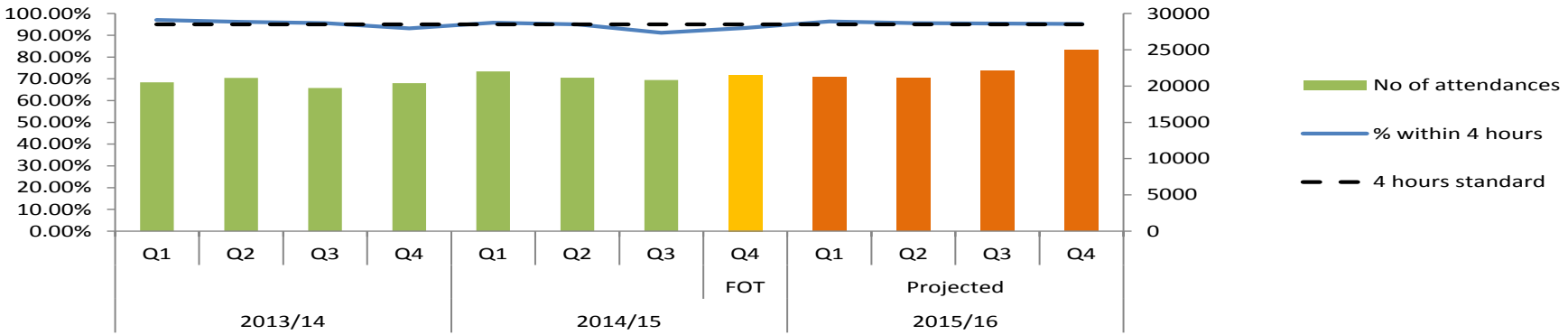
		Quarter 1	Quarter 2	Quarter 3	Quarter 4
2013-14	Number waiting > 4 hours	611	803	869	1386
	Total Attendances	20525	21124	19747	20409
	% < 4 hours	**97.0%**	**96.2%**	**95.6%**	**93.2%**
2014-15	Number waiting > 4 hours	939	1061	-	-
	Total Attendances	22026	21137	-	-
	% < 4 hours	**95.7%**	**95.0%**	-	-
2015/16 Plan	Number waiting > 4 hours	775	932	1015	1190
	Total Attendances	21276	21131	22141	25001
	% < 4 hours	**96.4%**	**95.6%**	**95.4%**	**95.2%**



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E.A.S.5: Healthcare acquired infections (HCAI) measure (Clostridium Difficile Infections)

The number of C. difficile infections reported, in people aged 2 and over, per CCG.

Monitoring Data Source: Public Health England HCAI DCS, CCG OIS

Target - Annual CDI objectives for each CCG published by NHS England and all CCGs should establish and report against monthly trajectories for CDI cases in order to ensure continued reduction.

E.A.S.5		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	Total	
HCAI measure (C.Difficile infections)	2013-14	0	1	2	2	3	7	4	6	1	2	2	1	31	
	2014-15	6	6	3	13	7	5	-	-	-	-	-	-	40	2015-16 Objective
	2015-16 Plan	5	5	5	5	4	4	4	4	4	4	4	4	52	52

E.A.S.1: Estimated diagnosis rate for people with dementia

Diagnosis rate for people with dementia, expressed as a percentage of the estimated prevalence

Monitoring Data Sources:

- Quality and Outcomes Framework
- Health and Social Care Information Centre
- Dementia UK report 2007
- Office for National Statistics Population Statistics

Target - Improving the ability of people living with dementia to cope with symptoms, access to treatment, care and support. The planning guidance states that an increase in the dementia diagnosis rate to 66.7 percent should be achieved by March 2015, and sustained through 2015/16.

Dementia - Estimated diagnosis rate	2015-16 Plan	Number of People diagnosed (65+)	1499	1500	1510	1508	1510	1511	1513	1515	1518	1516	1519	1520
		Estimated dementia prevalence (65+ Only (CFAS II))	2247	2247	2247	2247	2247	2247	2247	2247	2247	2247	2247	2247
		%	66.71%	66.76%	67.20%	67.11%	67.20%	67.25%	67.33%	67.42%	67.56%	67.47%	67.60%	67.65%

FOT

Values	2011/12	2012/13	2013/14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Number of People diagnosed	966	1024	1155	1208	1208	1230	1229	1215	1218	1260	1274	1301	1410	1440	1501
Estimated number with dementia	2120	2155	2214	2212	2212	2212	2240	2240	2234	2263	2264	2263	2276	2284	2291
Dementia Diagnosis Rate	45.56%	47.52%	52.17%	54.62%	54.62%	55.61%	54.86%	54.24%	54.52%	55.67%	56.27%	57.49%	61.95%	63.05%	65.52%
Ambition				67.00%	67.00%	67.00%	67.00%	67.00%	67.00%	67.00%	67.00%	67.00%	67.00%	67.00%	67.00%

E.A.S.2: IAPT Recovery Rate

The primary purpose of this indicator is to measure the maintenance of recovery rates in psychological services achieved at the end of 2014/15 via the national Improving Access to Psychological Therapies (IAPT) programme for people with depression and/or anxiety disorders. The effectiveness of local IAPT services is measured using this indicator and E.A.3 which is focused on access to services as a proportion of local prevalence.

E.A.S.2 measures the proportion of people who complete treatment who are moving to recovery.

Monitoring Data Source: IAPT Minimum Data Set, HSCIC

Target - Maintenance of at least the recovery rates achieved at the end of 2014/15. Ongoing improvement is anticipated where a rate of less than 50% was achieved.

E.A.S.2			Quarter 1	Quarter 2	Quarter 3	Quarter 4
IAPT Recovery Rate	2013-14	The number of people who have completed treatement having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved 'caseness' and at final session did not)	-	47	90	95
		The number of people who finish treatement having attended at least two treatment contacts and coded as discharged) minus (The number of people who finish treatment not at clinical caseness at initial assessment)	-	144	258	335
		%		32.6%	34.9%	28.4%
	2014-15	The number of people who have completed treatement having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved 'caseness' and at final session did not)	120	-	-	-
		The number of people who finish treatement having attended at least two treatment contacts and coded as discharged) minus (The number of people who finish treatment not at clinical caseness at initial assessment)	375	-	-	-
		%	32.0%	-	-	-
	2015-16 Previous plan (from year 2 of 14/15 to 18/19 planning round)	The number of people who finish treatement having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved 'caseness' and at final session did not)	579			
		The number of people who finish treatement having attended at least two treatment contacts and coded as discharged) minus (The number of people who finish treatment not at clinical caseness at initial assessment)	1135			
		%	51.0%			
	2015-16 Plan	The number of people who finish treatement having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved 'caseness' and at final session did not)	193	58	143	163
		The number of people who finish treatement having attended at least two treatment contacts and coded as discharged) minus (The number of people who finish treatment not at clinical caseness at initial assessment)	385	115	286	326
		%	**50.1%**	**50.4%**	**50.0%**	**50.0%**

E.A.3: IAPT Roll-Out

The primary purpose of this indicator is to measure the maintenance of access rates to psychological therapy services achieved at the end of 2014/15 via the national Improving Access to Psychological Therapies (IAPT) programme for people with depression and/or anxiety disorders. The effectiveness of local IAPT services is measured using this indicator and E.A.S.2 which is focused on recovery of patients completing a course of treatment in IAPT services.

E.A.3 measures the proportion of people that enter treatment against the level of need in the general population (the level of prevalence addressed or 'captured' by referral routes).

Monitoring Data Source: IAPT Minimum Data Set, HSCIC

Target - Maintenance of at least the access rates achieved at the end of 2014/15 is anticipated. NHS England will expect CCGs to commission services with this in mind and for the recovery rate to be a minimum of 50%.

In detail the expectation is that CCGs achieve 15% IAPT Access by the end of 2014/15 and maintain this throughout 2015/16. Assessment will be based on a quarterly "run rate" requirement, in each quarter of 2015/16, of at least 3.75% of local prevalence entering services.

E.A.3			Quarter 1	Quarter 2	Quarter 3	Quarter 4
IAPT Access - Roll Out	2013-14	The number of people who receive psychological therapies	Incomplete Data	600	552	565
		The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).	17670	17670	17670	17670
		% per quarter (e.g. 3.75%)		3.40%	3.12%	3.20%
	2014-15	The number of people who receive psychological therapies	480	-	-	-
		The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).	17670	-	-	-
		% per quarter (e.g. 3.75%)	2.72%	-	-	-
	2015-16 Previous plan (from year 2 of 14/15 to 18/19 planning round)	The number of people who receive psychological therapies	2827			
		The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).	17670			
		% annual	16.00%			
	2015-16 Plan	The number of people who receive psychological therapies	663	663	663	663
		The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).	17670	17670	17670	17670
		% per quarter (e.g. 3.75%)	**3.75%**	**3.75%**	**3.75%**	**3.75%**

E.H.1-3: IAPT Waiting Times

The primary purpose of these indicators is to measure waiting times from referral to treatment in improved access to psychological therapies (IAPT) for people with depression and/or anxiety disorders.
For planning purposes the indicator is focused on measuring waits to treatment for those finishing a course of treatment i.e. two or more treatment sessions and coded as discharged, but also requires local monitoring of all referral to treatment starts.

E.H.1_A1: The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.

E.H.2_A2: The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.

E.H.1 - A1			Quarter 1	Quarter 2	Quarter 3	Quarter 4
The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.	2015-16 Plan	The number of ended referrals that finish a course of treatment in the reporting period who received their first treatment appointment within 6 weeks of referral	350	361	252	340
		The number of ended referrals that finish a course of treatment in the reporting period.[1]	460	440	320	400
		%	**76.1%**	**82.0%**	**78.8%**	**85.0%**

E.H.2 - A2			Quarter 1	Quarter 2	Quarter 3	Quarter 4
The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.	2015-16 Plan	The number of ended referrals that finish a course of treatment in the reporting period who received their first treatment appointment within 18 weeks of referral	420	410	280	380
		The number of ended referrals who finish a course of treatment in the reporting period.[1]	460	440	320	400
		%	**91.3%**	**93.2%**	**87.5%**	**95.0%**

Primary Care (E.D.1, E.D.2 and E.D.3)

E.D.1: Satisfaction with the Quality of Consultation at a GP Practice

Satisfaction with the quality of consultation at the GP practice.

Data Definition: The aggregated percentage of patients who gave positive answers to five selected questions in the GP survey about the quality of appointments at the GP practice.

Value: A score based on the sum of the percentage values of sub-indicators a, b, c, d and e (Score out of 500).

Monitoring Data Source: - GP Patient Survey results Question 21 and 22

What success looks like - Annual improvement

CCGs applying for full delegated commissioning responsibility or joint commissioning arrangements are asked to submit E.D.1, E.D.2 and E.D.3. CCGs applying for joint commissioning will need to liaise with their area team to agree the responses.

E.D.1			**Satisfaction with the quality of consultation at GP practices** **This is a score out of 500**
The aggregated percentage of patients who gave positive answers to five selected questions in the GP survey about the quality of appointments at the GP practice		**2015/16**	**449**

E.D.2: Satisfaction with the Overall Care received at the Surgery

Patient satisfaction: Satisfaction with the overall care received at the surgery.

Data Definition: The percentage of patients who gave positive answers to the GP survey question 'Overall, how would you describe your experience of your GP surgery?'

Monitoring Data Source: GP Patient Survey results Q28

What success looks like - Annual improvement

CCGs applying for full delegated commissioning responsibility or joint commissioning arrangements are asked to submit E.D.1, E.D.2 and E.D.3. CCGs applying for joint commissioning will need to liaise with their area team to agree the responses.

E.D.2			Satisfaction with the overall care received at the surgery
The percentage of patients who gave positive answers to the GP survey question 'Overall, how would you describe your experience of your GP surgery?'	2015/16	Numerator - The number of patients who answered 'very good' or 'fairly good' to the question, 'Overall, how would you describe your experience of your GP surgery?'	2467
		Denominator - The number of patients responding to the question 'Overall, how would you describe your experience of your GP surgery?'	2885
		%	85.5%

E.D.3: Satisfaction with Accessing Primary Care

Patient satisfaction: Satisfaction with accessing primary care

Data Definition: The percentage of patients who gave positive answers to the GP survey question 'Overall, how would you describe your experience of making an appointment?

Monitoring Data Source: GP Patient Survey results Q18

E.D.3			Satisifcation with access to primary care
The percentage of patients who gave positive answers to the GP survey question 'Overall, how would you describe your experience of making an appointment?'	2015/16	Numerator - The number of patients answering ''Very good' or 'Fairly Good' to the question 'Overall, how would you describe your experience of making an appointment?'	2099
		Denominator - The number of patients responding to the question 'Overall, how would you describe your experience of making an appointment?	2862
		%	73.3%

Update 23/2 – No requirements to complete for 27th Feb Submission

Appendix 3 - Prescribing and Medicines Optimisation Plan 2015-16

[DN: to be inserted with final Ops Plan]

Glossary of Terms

A Call to Action This is an NHS England document and programme of action focused on the challenge to staff, the public and politicians to help the NHS meet future demands and tackle the funding gap through honest and realistic debate.

Better Care Fund (BCF) A single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities.

Care.data An information system which will make increased use of information from medical records with the intention of improving health services. The system is being delivered by the Health and Social Care Information Centre (HSCIC) and NHS England on behalf of the NHS.

Commissioning for Quality and Innovation (CQUIN) The system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.

Everyone Counts: Planning for Patients 2013/14 outlines the priorities, incentives and levers that were used to improve services from April 2013, the first year of the new NHS, where improvement was driven by clinical commissioners.

Friends and Family Test The Friends and Family Test (FFT) aims to provide a simple headline metric which, when combined with follow-up questions, can drive a culture change of continuous recognition of good practice and potential improvements in the quality of the care received by NHS patients and service users.

CCG Outcomes Indicator Set (CCG OIS) The CCG Outcomes Indicator Set is part of the NHS England's systematic approach to promoting quality improvement. Its aim is to support clinical commissioning groups and health and wellbeing partners in improving health outcomes by providing comparative information on the quality of health services commissioned by CCGs and the associated health outcomes – and to support transparency and accountability by making this information available to patients and the public.

Compassion in Practice Compassion in Practice is the three year vision and strategy for nursing, midwifery and care staff drawn up by NHS England and the Department of Health.

NHS Outcomes Framework The NHS Outcomes Framework sets out the outcomes and corresponding indicators used to hold NHS England to account for improvements in health outcomes.

Quality Premium The Quality Premium rewards CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

Unit of Planning A number of CCGs who have joined together with relevant Area Teams, providers, Local Authorities and Health and Wellbeing Boards to create a footprint of a size large enough to enable effective strategic planning.