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|  | **Agenda Item 6** |

Gloucestershire Clinical Commissioning Group

(Shadow Board)

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| **Meeting Date** | **2nd April 2013** |
| **Title** | **Annual Operating Plan: 2013/14** |
| **Executive Summary** | This paper provides an outline of the key components of the Gloucestershire Clinical Commissioning Group (GCCG) 2013/14 Annual Operating Plan. This has been developed in the context of the national guidance ‘Everyone Counts: Planning for patients 2013/14’ published by the NHS Commissioning Board.  The paper outlines the 2013/14 annual operating plan, commissioning intentions including the identified local quality premiums alongside the enabling strategies to support delivery. |
| **Key Issues** | The plan identifies the following key areas:   * Commissioning Intentions covering the key elements of transformational change and an overview of national targets to be delivered * Enabling strategies required to support delivery. * Key risks to delivery for the CCG in 2013/14 * Financial plan assumptions. |
| **Risk Issues:**  **Original Risk**  **Residual Risk** | Delivery of the plan by 31st March 2014  **Risk: 3x3: 9**  **Addressed by:**  Action plans in place, CCG structure near full recruitment, major contracts will be signed by 31st March 2013.  **Current rating: 3x3 : 9** |
| **Financial Impact** | The CCG is planning to deliver a surplus in line with national requirements. There is a challenging savings target within the plan which has associated risks. |
| **Legal Issues(including NHS Constitution)** | GCCG will meet its legal commitments contained within the NHS Constitution and other national guidance. |
| **Impact on Equality and Diversity** | The finalised plan will include an assessment on equality and diversity. |
| **Impact on Health Inequalities** | An overview of the demographic and health inequalities challenges is included within the annual operating plan. |
| **Impact on Sustainable Development** | The finalised plan will include any detail on sustainable development impact |
| **Patient and Public Involvement** | Elements of the plan are based on the ‘Your Health Your Care’ strategy which was subject to public engagement. Individual service transformation will subject to engagement as appropriate through development. |
| **Recommendation** | The Board is approve the AOP and note the next steps:   * detailed performance management framework under development * plan components, including the prevention strategy, urgent care plans and detailed locality plans, to be refined by governing body members during April. * Final plan including public facing document to be signed off by the Board in May 2013 |
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**Agenda Item 6**

Gloucestershire Clinical Commissioning Group

**Annual Operating Plan: 2013/14**

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| **1.0**  1.1  1.2 | **Introduction**  There is a national requirement for the Clinical Commissioning Group to produce an Annual Operating Plan (AOP) for 2013/14, which outlines its key programmes of work, how national standards will be met and the financial impact of plans. This is in the context of the national guidance ‘Everyone Counts: Planning for patients 2013/14’ published by the NHS Commissioning Board.  This paper outlines the key components for the integrated annual operating plan, detailing the service transformation and commissioning priorities for 2013/14, supported by the strategic vision, basis for change, ensuring national standards are met and the financial impact. The mechanisms to support delivery are outlined. |
| **2.0** | **The Vision for Gloucestershire Clinical Commissioning Group**  Gloucestershire Clinical Commissioning Group (GCCG) will be a clinically led, membership driven organisation with a focus on joined up care. Using clinical experience to ensure high quality, safe, efficient services alongside an innovative and dynamic approach to change. The Annual Operating Plan will identify the actions to be taken in 2013/14 as means to deliver this vision; alongside a commitment to effective communication, engagement and transparency across the breadth of the commissioning agenda.  Working with partner organisations from across the health and social care community GCCG has signed up to the strategic principles and priority areas outlined within the Health and Well Being Strategy, ‘Your Health Your Care’ (YHYC) and Children and Young People’s Plan.  As laid out in YHYC the vision for the Gloucestershire Community is to have:   * Joined up care for the people of Gloucestershire. * People empowered to take more control over their own care. * Mainstream services that are accessible by all vulnerable people wherever they may live. * Enhanced outcomes for the population. * Improved use of resources.   As part of the Annual Operating Plan development the vision for GCCG will be reviewed and finalised in the published plan in May 2013.  The Annual Operating Plan defines the progress to be made in 2013/14 towards delivering this vision; both across the breadth of the CCG and at a local level; through the engagement of member practices and their localities. |
| **3.0**  3.1  3.2  3.3 | **Supporting Our Population**  As outlined in the Health and Well Being Strategy, Gloucestershire is one of the healthiest counties in England. Overall health outcomes are better than the English national average with death rates from all causes falling over the last 10 years. However there are a two significant challenges GCCG face over the coming years:  Changing Demographics  The proportion of older people in Gloucestershire is already above the national average and this trend is expected to continue; with our older population growing at a faster rate than most of the rest of the country. According to the latest Office for National Statistics (ONS) projections, the number of people aged 65 and over in Gloucestershire will increase by about 70% (or 78,300) between 2010 and 2035 and will account for nearly one third of the total population. The number of people aged 90 and over is growing at an even faster rate and will double in just the next 15 years. Moreover, national statistics show that people aged 90 and over require double the amount of care than a typical 70 year old. In contrast, the numbers of young people and people of working age are likely to remain similar or even slightly decrease (see figure 1).  Figure 1 – Projected percentage change in population demographics by age bracket between 2010 and 2035.  Source: JSNA (ONS)  Health Inequalities  Health inequalities arise from differences in the social and economic conditions in which people are born and live. The burden of ill health falls disproportionately on individuals, families and communities in Gloucestershire that have lower incomes and lower educational levels. The people that are most likely to have the very worst health and wellbeing outcomes in our county include those living in the most deprived geographical areas and people who may be vulnerable to experiencing inequalities.  Whilst the life expectancy of the county overall continues to increase, the health of the less well-off is improving more slowly than the rest of the population and the gap in life expectancy between the most and least deprived areas in Gloucestershire is not narrowing. Looking at life expectancy by district we can see differences within the county with Gloucester residents living fewer years than any other district. In Gloucester City on average men live to 78.0 years compared to 80.7 years in the Cotswolds, a difference of 2.7 years. Women in Gloucester live 82.4 years compared to 84.4 years in Cheltenham, a difference of 2 years. The life expectancy of Gloucester City residents is below the England average for both men and women.  Using Information from the Joint Strategic Needs Assessment (JSNA) GCCG identify priorities for focus; either as a countywide approach or due to locality variation.  An example of the application of this is obesity. 24.7% of adults in Gloucestershire are obese (approximately 110,000 people) and consequently at increased risk of a range of serious health conditions including diabetes, cancer, cardiovascular disease and osteoarthritis. The proportion of adults who are classified as obese shows variation between the GCCG localities (figure 2).    Figure 2 – Proportion of adults aged 16+ who are obese, 2006-08 (Source: iJSNA)  Performance Challenges  A reported to the Board in March 2013; performance in NHS Gloucestershire is very good with 80% of the indicators (covering national and key local targets on plan and rated green year to date). These indicators cover a range of themes including Unscheduled Care, Planned Care, Primary and Community care, Public Health, Mental Health and Learning Disabilities and Quality.  Action Plans were in place in 2012/13 to focus on delivering the required performance by the 2012/13 year end. As reported previously, all targets are forecast to be a green rating by the end of 2012/13 with the exception of the two targets relating to Healthcare Inquired Infections (specifically MRSA and C-Diff). Both of these indicators are particularly challenging, with low target levels to achieve, and therefore will be an area of focus for GCCG into 2013/14; alongside ensuring delivery of the requirements in 2013/14. Due to the increased pressure in unscheduled care in 2012/13, the system of urgent care is currently under review to ensure systems are more robust and delivery is sustained in 2013/14. |
| **4.0**  4.1  4.2  4.3  4.4 | **GCCG Priorities**  This section outlines what we plan to achieve in 2013/14; focusing on the detail on commissioning intentions and priorities to be implemented in the coming financial year. A summary of the GCCG Plan on a Page is included in Appendix A.  Expected End State  As part of the development of YHYC and the GCCG annual operating plan, the expected key deliverables by the end of 2013/14 are defined as:   * Focus on quality, safety and experience. * Improved patient and public engagement. * A focus on prevention will form part of the commissioning focus in GCCG, with a strong Health and Wellbeing Approach. * The consolidated, quantified 5 year plan for YHYC will be in place, including understanding the impact on providers. * Integrated CCG and Locality plans are in place and delivering. * The Clinical Programme Approach is embedded across the health and social care community, under the clinical leadership of GCCG. * Integrated Community Teams delivering joined up health and social care. * A reduction in emergency admissions from the expected profile. * Continued improvement in performance, including the quality premiums, NHS outcomes framework and compliance with the NHS Constitution. * Partnership working across all commissioners. * Ensuring best use of assets.   Continued Performance  GCCG is committed to ensuring the continued improvement and sustainability of the national and locally identified performance indicators. As part of this effective performance management, the utilisation of CQUIN schedules and integrated approach to the delivery of key priorities is fundamental to in year success.  GCCG will ensure robust reporting is in place (as described in section in 5.2.4); including focus on CQUIN gateways and the pre-qualification criteria for quality premiums.  Commissioning Intentions  The commissioning intentions for GCCG have been developed by commissioning leads from across the organisation; supported by clinical leadership and endorsed within GCCG discussions. The development of the intentions has taken account of:   * Your Health Your Care (YHYC). * The NHS Mandate (published 13th November). * Everyone Counts: planning for patients 2013/14: NHS Commissioning Board (published December 2012). * Joint Strategic Needs Assessments. * Local Intelligence, including public health, performance, quality, benchmarking, activity and financial analysis.   The commissioning intentions have been discussed with the main providers for GCCG; and are enclosed in Appendix B for information. These commissioning intentions are underpinned by the YHYC Strategy; which has been subject to clinical engagement alongside patient and public involvement across the main themes.  Local Quality Premiums (QP’s)  In line with the planning guidance GCCG have identified three local priorities, to drive improvements in quality and improve health inequalities. The areas chosen are:   * COPD admissions. * Care Homes. * Weight Management.   The areas supported are focussed towards driving improvement in quality of care received, building preventative strategy to the forefront of commissioning changes and reducing locality variation. The delivery of the QP indicators will be a key priority within the service re-design work programme. A full briefing of the areas chosen is attached as Appendix C. |
| **5.0**  5.1.1  5.1.2  5.1.3  5.1.4  5.1.5  **5.2**  5.2.1  5.2.2  5.2.3  5.2.4 | **Enabling Strategies**  In order to support delivery of the priorities as laid out in the operating plan a number of enabling strategies will need to be put in place. The key components are outlined below:  Clinical Programme Approach  GCCG are committed to clinically led commissioning, informed and developed through integrated working with colleagues from across the health and social community. Clinical Programme Groups, for the priority specialty areas, are established, currently developing and implementing short and long term work programmes. The focus is end to end pathway re-design, ensuring focus on preventative care, integrated patient centred pathways and independent living. Each group is chaired by a clinical GCCG representative, supported by clinical and allied health professionals, with input from patient and public representation. The approach aims to drive clinical changes to commissioning, informed by best practice, opportunity for change and innovative thinking.  The Clinical Programme Groups work under the umbrella of YHYC; an integrated strategy endorsed by the health and social care community.  Communication and Engagement  GCCG is committed to ensure the views of patients and the public inform the development of service change proposals and their evaluation. Setting the foundation for this was the public engagement jointly on the Health and Well Being and YHYC strategies. As part of this process views were sought on the direction of travel the community is working towards; with programme areas subject to engagement in relation to the detailed changes proposed.  The established Reference Group will continue to facilitate early discussions with Healthwatch and HCCOSC representatives. This Reference Group will receive information about proposed service changes at the earliest stage in their development, allowing members of the Reference Group the opportunity to comment and influence them ahead of formal presentation to scheduled HCCOSC meetings. In addition, the Reference Group will provide an early steer on the likely perceived ‘significance’ of any proposed changes in relation to statutory public consultation requirements relating to ‘significant variation’. Alongside the reference group a variety of different communication and engagement tools and techniques will be deployed, such as focus groups, targeting hard to reach groups, questionnaires, drop in discussions and communication briefings.  The key focus for GCCG will be to ensure a systematic approach to engagement, which is informative and relevant.  GCCG also recognise the importance of communicating and engaging a range of stakeholders, in particular with a focus on clinicians including GP member practices. GCCG will prioritise developing a member driven organisation in 2013/14; ensuring primary care has a voice in the priorities, developments and changes undertaken within Gloucestershire. In Gloucestershire there is an established clinical priorities forum where the clinical discussions in respect of the required system changes take place. There are primary community and secondary care clinicians sitting on this board, who have been identified as the clinical leaders for the health economy.  Organisational Development  As 2013/14 is the first year for GCCG, formally in operation from 1st April 2013, a focus will be placed on developing the organisation both from a perspective of the internal organisation alongside the relationship with external partners. Key areas of focus include:   * Developing GCCG internally; ensuring staff work towards a focus of clinical leadership in a member practice driven organisation. The organisational development plan will focus on the skill set across GCCG; ensuring capability and capacity is in place to deliver the commissioning and service transformation agenda. * Communication and Engagement within GCCG, across directly employed staff and member practices, will be developed to ensure everyone is integrated into the work plan of the organisation. The use of IM&T, such as the development of the intranet, will ensure this is approached in an efficient and effective way. * The relationship with key partners will continue to strengthen, building on the good progress made whilst GCCG has been operating in shadow form. The Clinical Programme Approach, joint infrastructure governing YHYC and the Health and Well Being Board provide key mechanisms to facilitate and develop clinical and business discussions. * The successful implementation of Central South Commissioning Support Unit (CS CSU) will ensure robust commissioning and contracting mechanisms are in place. GCCG have developed and are continuing to refine clear specifications for support services; promoting the joint working between CS CSU and GCCG staff for a seamless delivery of a commissioning service.   Contractual Frameworks  The use of the NHS Standard Contract, including incentives and levers, will be applied to ensure the contractual frameworks support the GCCG priorities for delivery. Within the contract agreements with our main providers the Service Development Improvement Plan (SDIP) schedule outlines the agreed QIPP programme for the financial year, including financial risk share agreements, supported by the CQUIN schedule for quality enhancements. The contractual agreements for 2013/14 will be in place by 31st March 2013.  Informatics  The use of technology and information will be core to GCCG to ensure an innovative approach to the commissioning agenda. A GCCG IM&T strategy is currently being developed. The strategy will focus on four key areas:   * Commissioning enablement * Shared records * Patient / citizen empowerment * Enabling infrastructure   The planning guidance focuses on the use of data and IM&T to inform service re-design at both a strategic and operational level; which will be evident in 2013/14 in GCCG; including areas such as the investment in the new community and child health system, Telehealth, risk stratification and development of the JSNA.  **Ensuring Delivery**  GCCG will ensure a robust governance system is in place to support delivery of the priorities as laid out in the annual operating plan.  Alignment to strategy  The priorities identified within the annual operating plan ensure alignment with the strategic principles agreed across the health and social care community; incorporating the national requirements to be delivered. This approach ensures sign up from key partners; alongside an effective governance framework involving clinical partners in support of delivery. Strategy alignment continues to recognise the annual operating plan defines a number of bespoke actions to be delivered as part of a wider programme of work; encouraging evolvement, development and enhancement to the way services are commissioned by GCCG moving forwards.  Programme Management  Through the establishment of a robust programme and performance management structure the service transformation agenda (most notably the QIPP programme) is subject to rigorous governance and control. GCCG has an organisational approach to programme and project management; underpinned by processes, tools and techniques to ensure a controlled approach to change management. Integrated with financial planning and management, QIPP performance reporting is undertaken by a web based reporting system ensuring accountability and ownership of each change programme. Project risks and issues are reported through this system; and aligned to the corporate risk reporting as appropriate.  GCCG will ensure all work priorities are integrated into a comprehensive plan.  Delivery of the expected changes and outcomes is fundamental to the enhancement of patient care. Benefits realisation across a range of indicators including patient outcomes and experience, clinical feedback, quality, safety, patient activities and financial elements are key to the evaluation and development of the service re-design programme.  Risk Management  A corporate risk register is in place; collating organisational, programme and directorate risks. Managerial and clinical leadership to the management of risks (as appropriate) is in place; with routine updates in place. The risk register will be taken to each meeting Integrated Governance Committee for review. Significant risks will be taken to the Board.  In relation to the annual operating plan specifically the following risks and mitigating actions should be noted:   |  |  | | --- | --- | | Risk | Action | | Growth higher than anticipated | Demographic growth and incidence rate has been calculated and local knowledge incorporated into planning assumptions. Clinical discussion to take place in early March to sign off. | | Prescribing growth greater than expected levels | Robust Medicines Management QIPP plan and Joint Formulary in place. Engagement with clinicians is on-going and some contingency has been built into the plan. | | Level of transformational QIPP is not realised | Established PMO processes are in place. QIPP plan falls out of YHYC assisting stake holder sign up. Accountability and risk share arrangements to be included in contracts by 31/3/13. | | In year cost pressures impact on affordability | Robust planning and modelling assumptions utilised to develop the financial plan including feedback from commissioner leads and integration with developed commissioning intentions. Systems and processes being established for in year management. | | Challenges to deliver required performance targets | Robust performance management in place. Action plans to be in place for areas requiring improvement. | | Engagement of member practices | Engagement with member practices and localities has commenced. Development of locality plans by end of Q1. | | Impact of organisational transition | Transition planning in place regarding organisational change. Service Specification with Commissioning Support Unit in place. GCCG leadership through transition phase in place. | | Resolution of funding flows following commissioning new commissioning responsibilities between commissioning organisations may not lead to an overall cost neutral impact | The finance and information teams are working closely with colleagues in other organisations to ensure that the impact of proposed changes are understood and the overriding principle that funds flow changes should be cost neutral is maintained | | Individual organisation work plans divert resources from joint initiatives | Joint working arrangements in place. Alignment of organisational plans, as far as possible, is fundamental. |   Performance Management  GCCG is developing a robust integrated performance framework to monitor and manage progress against the key indicators and objectives for the organisation. The performance framework aims to:   * Reflect the key priorities for GCCG across the entire organisational business. * Ensure effective reporting and monitoring mechanisms are in place. * Ensure clinical and managerial leadership for the standards against which they are the accountable for delivery. * Ensure action is taken, where necessary, to address under performance.   Performance against the Annual Operating Plan will be monitored monthly, although data on some performance targets will only be available on a quarterly basis. Performance against all areas will be reported to GCCG through an integrated finance and performance report. Areas of risk and under-performance will be highlighted; with remedial actions identified. Clinical leadership against each priority is in place, and will be established in support of remedial actions as and when required. The performance measures contained within the Everyone Counts: Planning for Patients 2013/14 document against which CCG performance will be monitored are given in appendix D. This covers those outcome framework measures that contribute towards the attainment of the Quality premium, the Expected Rights and Pledges from the 2013/14 NHS Constitution and additional measure mandated by the National Commissioning Board.  Also included are the trajectories for the two key priorities i.e. improved access to psychological therapies and increasing the dementia diagnosis rate. |
| **6.0**  6.1  6.2  **7.0** | **Finance Plan**  The CCG will face a challenging year in 2013/14 as there is a significant amount of transformational change that needs to be effected in order to ensure that services are re designed to meet the demographic changes. The CCG’s financial risk rating is medium risk for 2013/14 reflecting the service changes that must occur in order to ensure a continued delivery of financial targets and a recurrently balanced position for the medium term. The emphasis in 2013/14 must be one of strong governance, financial control and input and ownership by member practices and localities enabling these changes to be made in an effective manner.  The 2013/14 financial plan has been developed alongside the commissioning plans. Developments and savings plans within the commissioning intentions and contracts are reflected within the financial plan. The plan reflects only those services for which the CCG is responsible.  The CCG financial plan includes the following:   * A surplus equivalent to 1% of recurrent programme resources for 2013/14 * Uncommitted headroom funds equivalent to 2% of recurrent resources, £13m, to pump prime service change * Contingency reserves as nationally prescribed equivalent to 0.5% of recurrent resources to manage in year risks * Contingency reserve in additional to the nationally prescribed reserve of £3.5m   QIPP  The finance plan includes a savings target that GCCG intend to deliver via both transformational and transactional QIPP schemes to ensure financial balance.  The transformational QIPP programme has been identified as part of “Your Health, Your Care” with the associated impacts being mapped across 2012/13 to 2016/17, based on service redesign across 2012/13 and 2013/14.  Outside of the transformational QIPP schemes shown within “Your Health, Your Care” a range of transactional QIPP schemes will be developed which cover contract strategies with in county major service providers, joint funding arrangements and non-clinical arrangements.  Financial Risks  The following risks will influence the delivery of the financial plan:   * Demographic growth exceeds the levels forecast in the “Your Health, Your Care” Strategy. * Prescribing growth exceeds planned growth levels. * Mandatory cost pressures are higher than the funded position. * Level of transformational and transactional QIPP savings do not achieve planned levels or have the impact forecast. * In year cost pressures exceed planning assumptions and cannot be managed down to affordable levels. * Levels of over-performance within service level agreements that cannot be mitigated via QIPP schemes or contingent reserves. * Funding flow changes between organisations to reflect the changes in commissioning responsibilities may not be cost neutral   Full details of the financial plan are contained within the budget setting paper.  **Recommendation**  The Board is approve the AOP and note the next steps:   * Detailed performance management framework under development * Plan components, including the prevention strategy, urgent care plans and detailed locality plans, to be refined by governing body members during April. * Final plan including public facing document to be signed off by the Board in May 2013 |



**Appendix B**

**NHS Gloucestershire Clinical Commissioning Group**

**Commissioning Intentions 2013/14**

There are a number of documents which feed into the commissioning intentions for 2013/14, including:

* Your Health Your Care
* The NHS Mandate (published 13th November)
* Everyone Counts: planning for patients 2013/14: NHS Commissioning Board (published December 2012)

Alongside this the commissioning intentions have taken into account local intelligence, including the Joint Strategic Needs Assessment (JSNA) to form the priorities for 2013/14

1. **Your Health Your Care**

‘Your Health Your Care’ (YHYC) has been developed in conjunction with our main Health and Social care partner organisations within the Gloucestershire community; and identifies the strategic priorities for the next 5 years (commencing in 2012/13). Using the strategic priorities; areas of focus for GCCG to develop in 2013/14 have been identified. Each of these will be pulled together into a Strategic Implementation plan and built into contracts through the Service Development and Improvement Plan Schedule.

The following provides an overview of the priority areas which flow from Your Health Your Care and are a part of the Commissioning Intentions for 2013/14.

* 1. **Cross Cutting Service Models**
* The delivery of Integrated Community Teams within all Gloucestershire localities; including developing the Living Well, Case Management and Telehealth programmes to improve quality of care and productivity.
* A focus on services for the Frail elderly; including development of the Frail elderly Pathway, introducing Older People Advice and Liaison and continued implementation of the dementia strategy.
* Development of robust responsive community services to: prevent hospital admissions, access to timely reablement services to maximise and maintain independence

The unscheduled care programme is a cross cutting theme and the governance structure links very closely to the clinical programme approach for Long Term Conditions (LTC). Our intentions, therefore, are described in terms of initiatives that drive:

* Maximising outcomes for those with specific long term conditions, including those with multiple conditions and/or frailty as a result of older age
* Key delivery mechanisms that underpin support to those with these LTC but also their urgent care needs e.g. integrated care teams in the community.
* System management to drive integrated and accessible urgent 24/7 care
* Provider development to ensure services are available and delivered efficiently at the right time in the right place
  1. **Clinical Programmes**

With a focus on the Clinical Programme Approach to commissioning a number of priority areas have been identified for 2013/14:

* Musculoskeletal Services. The clinical programme continues to develop a longer term strategy for the commissioning of Integrated Musculoskeletal services across the patient pathway. In 2013/14 areas of focus to work towards this ambition will be on equity of access across the existing interface service provision, development of the patient outcome approach to evaluation and implementation of the clinical pathways developed with a range of stakeholders during 2012/13.
* Ophthalmology. Review of pathways to identify where care closer to home can be provided, supporting the management of eye conditions.
* Dermatology. In 2013/14 the service re-design portfolio will focus on developing and implementing an equitable intermediate tier across all localities in Gloucestershire.
* Diabetes – In 2013/14 the Clinical Programme Group will continue to build upon the development of Specialist Diabetes services and primary care engagement to date. The next stage is to focus on the development of integrated care across the patient pathway.
* Respiratory. Further develop the integrated community model to incorporate oxygen assessment; alongside further development of pathway work.
* Mental Health. Work plan in place comprising the development of integrated care pathways and teams, recovery focussed care and psychiatric liaison across the community.
  1. **Part of Care Journey**

Whilst the focus of GCCG is an integrated clinical approach to service transformation there are a number of large programmes impacting on part of the care journey.

* Improving urgent care access. In 2013/14 GCCG will embed the implementation of NHS 111 and the re-commissioned Out of Hours service following the procurement exercise. Primary care variation will be a focus for development, informed by the findings from the Primary care Foundation audit.
* Demand Management. GP Peer Review and Advice & Guidance will continue to be implemented into 2013/14.
* Diagnostic Access. In 2013/14 the AQP procurement for Direct Access to diagnostic tests will go live.
* Re-ablement will be agreed and implemented across health and social care.
  1. **System Wide Change**

Areas developed across the system to support the commissioning agenda of GCCG; with a focus on medicines management and efficient utilisation of services and assets.

1. **Clinical Programme Group priorities (above and beyond YHYC)**

Whilst YHYC details the major change programmes against the clinical programmes, additional commissioning objectives are summarised below.

**2.1 Cancer**

* Ensure all patients have access to the best possible treatment, achieve earlier diagnosis of cancer, to increase the scope of successful treatment and increase survival rates.
* Build in capacity to meet the requirements of screening programmes.
* In 2013/14 a focus will be placed upon:
* Chemotherapy
* Waiting times performance
* Reporting staging information
* Breast services – 23 hour pathway
* Colorectal services
* Dermatology Community provision
* Patient Experience

**2.2 Mental Health** (as YHYC), plus:

* Development of MH PbR tariff – reflecting in care pathways and service specifications, address health inequalities with a focus on medically unexplained symptoms, recovery inpatient services.
* In line with Autism Act and national strategy requirements to provide ASC assessment/diagnostics.
* Achieve a reduction in suicide rates, both within statutory and voluntary providers, looking at enhanced training of staff, risk assessment and management, and review of service provision.
* Development of bereavement support across providers and sectors.
* A programme of mental wellbeing promotion in the general population and in ‘high-risk’ groups that also reduces the risk of developing mental health problems.
* Enhance access to psychological therapies for Children and Young People

**2.3 Children and Maternity.**

Our commissioning objectives for women, fathers, babies and families are to ensure that they have access to:

* Births that are as normal as possible based on assessment of individual need.
* Ensure services are viable and sustainable, and take into account the impact of service provision in neighbouring ‘counties’.
* Antenatal and postnatal services provided away from general hospital sites, with a multiagency approach where indicated, in community locations and environments.
* Antenatal and postnatal care that contribute to reducing key health inequalities and outcomes, such as infant mortality, by working to improve breastfeeding rates and working with other agencies to reduce smoking cessation and obesity especially for vulnerable groups.
* Services that promote confident parenting and secure attachments through providing an integrated approach to supporting parents with Public Health Nursing, Mental Health and children centre services.
* Choices regarding where they can have their baby, which will include home birth and midwife-led birthing unit amongst the options available, based on an appropriate assessment of their need and risk.
* Continuity of care provided by a well-trained and suitably qualified maternity workforce; adopting a team approach incorporating clerical and care assistants; using caseload approaches to care; and care pathways.
* Mental health services: targeted support for children and young people at particular risk of developing mental health problems, such as looked after children.
* Enhance delivery on maternal mental health pathway; ensuring NICE compliance.

**2.4 Learning Disabilities**

* Increased Numbers of people receiving a health check and Health Action Plan.
* Refocus specialist inpatient services to support care at home.
* Review of community services to people with learning disabilities to include element specifically focused on needs of people with learning disabilities who present challenging behaviours.
* To identify key health areas for LD population that demonstrates equality of outcome with general population.

1. **2013/14 everyone counts: planning for patients**

The following key areas are identified nationally as priority areas for CCG’s to develop and / or deliver through 2013/14:

**3.1 NHS Services, Seven days a week**

Working together to identify services which are only provided Monday to Friday, identifying those that would benefit patients by being available 7 days a week and agreeing priority areas to progress and implementation plans

Priority areas are:

* Diagnostics.
* Urgent and emergency care pathways (across acute and community care), including psychiatric liaison in hospital setting.

**3.2 Transparency and Choice**

Gloucestershire CCG will require providers to publish data sets on the quality of services on their web sites based on definitions in the Health Quality Improvement Partnership website.

**3.3 Listening to Patients and increasing their participation**

* Real time patient and carer feedback reviewed and fed into CQRG on a quarterly basis.
* Introduction of the friends and family test: acute inpatients and A & E from 1st April 2013 and Maternity services from 1st October 2013. Outputs will form part of contractual discussions and negotiations for 2014/15. consider how this type of survey can be used within a mental health setting, trial a version to gain feedback on services from patients (link to the patient experience escalator).
* Improving uptake of Telehealth services across Gloucestershire.

**3.4 Better data, driving improved outcomes**

* Use of the NHS number as the primary identifier for all patients in contact with NHS services
* High levels of quality and data completeness in SUS data, where concerns are identified contract sanctions will be applied
* Working with commissioners to identify and measure outcomes resulting from clinical interventions. This will be taken forward through clinical programme boards.

**3.5 Higher standards, safer care**

* Through the Clinical Quality Review Group review the recommendations within the Francis report, produce an assurance report and action plan which will address any areas of concern. Reflect on the Winterbourne review report ensuing all key areas are reviewed. Action plans will be monitored and reported through to the CCG Board.
* Implementation of Compassion in Practice across all staff groups

**3.6 Emergency Preparedness**

Ensure providers demonstrate that they can meet the requirements of Emergency Preparedness and Resilience as defined within the new national standard contract in the service conditions number 30.

**3.7 Protecting Patents Continuity of Care**

The 2012/13 contract defines those services which are mandatory for the provider as part of their authorisation. We will review those in partnership during 2013/14 to identify those services which will meet the new ‘Commissioner Requested Services’ (details to be published by Monitor).

**3.8 Health Care Acquired Infections**

* There will be a zero tolerance approach to MRSA infections
* Continuing to reduce the incidence of C Diff, meeting the target as defined by the NHS Commissioning Board.

**3.9 Meeting the NHS Constitution**

Gloucestershire Commissioning Group expects that all providers deliver against the NHS Constitution, and will use contract sanctions where targets are not delivered.

18 week RTT targets will be delivered, specifics related to this are

* Zero tolerance of over 52 week waits.
* Providers will respond to patients who request treatment at an alternative provider where the 18 week RTT may be missed.
* PTLs will be shared with the CCG performance team and where concerns are identified these will be discussed through the Contract Performance Meeting and if and when required joint PTL monitoring meetings will be instigated.
* All patient letters in reference to a first outpatient appointment will include information on a right to treatment within a maximum waiting time and what action the patient can take if they are concerned they are or will wait longer than 18 weeks.
* Providers will implement an in year guidance on 18 week RTT and keeping patients informed.

Minimum wait times in A & E Departments:

* Zero tolerance of over 12 hour trolley waits.
* All ambulance hand overs to take place within 15 minutes of arrival.

Cancelled operations:

* All patients who have operations cancelled on or after the day of admission for non-clinical reasons will be offered another binding date within 28 days, or the patients treatment will be funded by the provider at the time and hospital of the patients choice.
* Zero tolerance of urgent operations being cancelled for a second time.
  1. **Mental Health Outcomes**

Begin to develop outcome measures for mental health services

Complete the full roll out of the access to psychological therapies programme by 2014/15, with a recovery rate of 50%. In 2013/14 the CCG are commissioning to achieve an access rate of 13% increasing to 15% by 2014/15.

**3.11 Quality checks**

Providers will share their Cost Improvement Plans with the Clinical Commisioning Group and will provide evidence that the plans have been signed off by their Medical and Nursing Directors as having been assured as clinically safe.

Providers will demonstrate how they intend to implement the ‘comply or explain’ regime.

Providers will be part of the Academic Health Science Networks.

**3.12 CQUIN**

Pre-qualification Criteria

As per the guidance issued by the NHS Commisioning Board pre-qualification criteria will be applied. The details of the schemes and criteria will be refined once further NHSCB guidance has been released. Criteria are:

* A trajectory for increasing planned use of Telehealth/Telecare technologies.
* Intra-operative fluid management: trajectories developed consistent with National Technology Assessment Centre guidance.
* Plans in place to exploit the value of commercial intellectual property (standalone or with the AHSN).
* A trajectory to reduce inappropriate face to face contacts.
* Plans in place to ensure that for every person admitted to hospital where there is a diagnosis of dementia, their carer is signposted to relevant advice and receives information to support them.

National CQUINS will be applied and will be worth 0.5% of the CQUIN value

Local CQUINs will be developed in relation to key local priorities.

1. **Partnership working**

The development of partnership working with other commissioners will be a focus for GCCG into 2013/14; to ensure a collaborative, joined up approach.

**Appendix C:**

**NHS Gloucestershire Clinical Commissioning Group.**

**Quality Premium Selections 2013/14.**

**Quality Premium One: COPD Admissions**

Chronic Obstructive Pulmonary Disease (COPD) is the fifth biggest cause of death in the UK, the second most common cause of emergency admission to hospital, one of the most costly in-patient conditions treated by the NHS and a major cause of morbidity within Primary Care.  With effective services, therapies and treatment, exacerbations of COPD can be shortened, so reducing the need for hospital admission and improving the outcomes and quality of life for patients.

COPD accounts for approximately 10% of hospital medical admissions (equating to over 90,000 annually) in the United Kingdom. The number of admissions has increased by 50% in the last decade and accounts for one million bed days per annum. Inpatient mortality was 7.4% in the 2003 Royal College of Physicians Audit and 90 day mortality was 15.3%. 31% of patients were re-admitted to hospital within 30 days. On average patients spend 8.7 days in hospital.

There is good evidence to demonstrate that the provision of high-quality, integrated respiratory care can:

* Improve support and relieve symptoms for patients with respiratory disease
* Support hospital discharge
* Help reduce inappropriate hospital admission

As part of our priority areas a Respiratory Clinical Programme Group is established, with a focus on integrated care including pulmonary rehabilitation and oxygen assessment. The KPI commits to reduce admissions by 10% overall from a forecast outturn of 2012/13.

The basis of identifying COPD admissions as a quality premium is the locality inequality. From the data the CCG has reviewed there are higher rates of emergency admissions for COPD from Cheltenham (9.2 per 1,000 over 65 population), Gloucester (9.4 per 1,000) and Forest (10.3% per 1,000) localities, the intention is to target these localities through the development of locality plans, with the intention of bringing them down to the Gloucestershire average in the first instance (7.7 per 1,000).



**Quality Premium Two: Care Homes**

Evidence shows that Residents in Care Homes have multiple complex medical needs. Residents have higher needs than other patients for essential medical cover because their medical needs are complex and changeable. They are also usually unable to attend the primary care centre requiring visits to the home, often necessitating frequent and multiple prescribing interventions. Over 50% of residents have dementia or other mental health needs as the primary clinical need or in addition to complex physical disabilities. There is some evidence locally that patients are admitted to acute care for conditions that, with support for the General Practitioner (GP), could be managed in the home. Examples of reasons for admission include Urinary Tract Infection, respiratory infection, Congestive Heart Failure and Cellulitis. The range, type, quality and consistency of overall care vary widely between the individual homes, leading to potential inequalities for this section of the population.

There are currently 269 care homes within Gloucestershire, and the intention is to provide an enhanced level of health service into the homes to deliver pro-active health care based on regular routine visits providing high quality care in the Care Home setting. This will prevent inappropriate admissions to Acute Care, improving management of medical and long term conditions, ensuring that end of life care is co-ordinated, and that all decisions and preferences made by the patients are communicated between organisations that may take care of that patient. Current unscheduled care admissions from care homes are circa 2,100 per annum, and the intention is to reduce this number through this scheme.

In year 1 we will collect a range of a baseline data to be able to demonstrate the effectiveness and impact of the new service on this vulnerable section of the population. The plan is to ensure we have a minimum of 50% of care homes covered by the new enhanced level of service for year 1.

**Quality Premium Three: Weight Management**

24.7% of adults in Gloucestershire are obese (approximately 110,000 people) and consequently at increased risk of a range of serious health conditions including diabetes, cancer, cardiovascular disease and osteoarthritis. The estimated cost to NHS Gloucestershire of treating the consequences of obesity was estimated at £149.1 million in 2010 (NICE, 2007).

Obesity is strongly linked with deprivation and local data shows that those living in the most deprived quintile are at an increased risk compared to the least deprived. Other groups at increased risk of becoming obese include adults with mental health problems, those with physical and learning disabilities and people from certain BME groups.

A recent cost effectiveness review of weight management interventions for adults concluded that there is evidence that multicomponent interventions (addressing eating and physical activity habits using evidence based behaviour change techniques) are likely to be cost-effective. Furthermore, targeting high-risk individuals e.g. those with impaired glucose tolerance, early osteoarthritis, raised cardiovascular risk, is likely to result in lower costs per QALY (HTA Programme, 2011).

While there are some limited primary care and community-based weight management interventions available in parts of Gloucestershire, there are significant gaps in evidence-based provision and in some areas of need there is no service.

The following action will be taken to provide weight management support for adults, at increased health risk, wherever they live in Gloucestershire:

1. To build on existing weight management provision to develop and commission a comprehensive, community-based weight management service in each locality, adopting a menu-based approach, and supporting the development of self-care skills
2. To embed weight management interventions in all relevant clinical pathways thereby reducing avoidable ill-health and premature mortality, and associated health and social care costs.

In order to reduce premature mortality within the population, the CCG will need to address the physical health needs of people with mental health conditions and learning disabilities. These groups will form a significant proportion of the target population for this initiative.

Other priority groups will be:

* People with, or at increased risk of developing, a long term condition including diabetes, cardiovascular disease, respiratory disease and osteoarthritis
* Pregnant women with BMI > 30 and BMI > 35).

KPI: Number and proportion of eligible people who are offered, and who take up, a weight management referral.

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| **Appendix D:**  **NHS Gloucestershire Clinical Commissioning Group.**  **2013/14 Performance |Commitments**  **PERFORMANCE MEASURES CONTAINED WITHIN THE EVERYONE COUNTS: PLANNING FOR PATIENTS 2013/14 DOCUMENT** | | | |
|  |  |  |  |
| **NHS Outcome Framework measures forming part of the Quality Premium.** | | |  |
|  |  |  |  |
| **Preventing people from dying prematurely** | **Measurement type** | **In Quality premium** | **Threshold for quality premium payment** |
| Potential years of life lost (PYLL) from causes considered amenable to healthcare | Annually | Yes | At least 3.2% reduction between 2013/14 |
| **Enhancing quality of life for people with long term conditions** |  | | |
| Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) | In-year and Annually | Yes | Zero or reduction between 2013/14 and 14/15 |
| Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s | In-year and Annually | Yes | Zero or reduction between 2013/14 and 14/15 |
| **Helping people to recover from episodes of ill health or following injury** |  | | |
| Emergency admissions for acute conditions that should not usually require hospital admission | In-year and Annually | Yes | Zero or reduction between 2013/14 and 14/15 |
| Emergency admissions for children with lower respiratory tract infections (LRTI) | In-year and Annually | Yes | Zero or reduction between 2013/14 and 14/15 |
| **Ensuring that people have a positive experience of care** |  | | |
| Friends and Family test | In-year and Annually | Yes | 1. Roll out of Friends and family test as per agreed national timetable 2. An improvement in the average FFT score for acute inpatient care and A&E services between Q1 2013/14 and Q1 2014/15 for the acute hospitals that serve a CCG's population. |
|  |  |  |  |
| **Treating and caring for people in a safe environment and protecting them from avoidable harm** | | | **Threshold** |
| Incidence of healthcare associated infection: MRSA | | | |
| Health Community | In-year and Annually | Yes | 0 |
| Incidence of healthcare associated infection: Clostridium difficile | | | |
| Health Community | In-year and Annually | Yes | 162 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Expected rights and pledges from the NHS Constitution 2013/14** | |  |  |
|  |  |  |  |
| **Referral To Treatment waiting times for non-urgent consultant-led treatment** | | | **Operating Standard** |
| Admitted patients to start treatment within a maximum of 18 weeks from referral | | | 90% |
| Non-admitted patients to start treatment within a maximum of 18 weeks from referral | | | 95% |
| Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral | | | 92% |
| **Diagnostic waiting times** | | |  |
| Patients waiting for a diagnostic test should have been waiting no more than 6 weeks from referral | | | 99% |
| **A&E waits** | | |  |
| Patients should be admitted, transferred or discharged within 4hours of their arrival at an A&E department | | | 95% |
| **Cancer waits – 2week wait** | | |  |
| Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP | | | 93% |
| Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) | | | 93% |
| **Cancer waits – 31 days** | | |  |
| Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers | | | 96% |
| Maximum 31-day wait for subsequent treatment where that treatment is surgery | | | 94% |
| Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen | | | 98% |
| Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy | | | 94% |
| **Cancer waits – 62 days** | | |  |
| Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer | | | 85% |
| Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers | | | 90% |
| Maximum 62-day wait for first definitive treatment following a consultant’s decision to upgrade the priority of the patient (all cancers) | | | 90% |
| **Category A ambulance calls** | | |  |
| Category A calls resulting in an emergency response arriving within 8minutes – (75% standard to be met for both Red 1 and Red 2 calls separately) | | | 75% |
| Category A calls resulting in an ambulance arriving at the scene within 19 minutes | | | 95% |
| **Mixed Sex Accommodation Breaches** | | |  |
| Minimise breaches | | | 0 |
| **Cancelled Operations** | | |  |
| All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient’s treatment to be funded at the time and hospital of the patient’s choice. | | | 0 |
| **Mental health** | | |  |
| Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period | | | 95% |
|  |  |  |  |
| **Additional measures NHS Commissioning Board has specified for 2013/14** | | | |
|  |  |  |  |
| **Referral To Treatment waiting times for non-urgent consultant-led treatment** | | |  |
| Zero tolerance of over 52 week waiters | | | 0 |
| **A&E waits** | | |  |
| No waits from decision to admit to admission (trolley waits) over 12 hours | | | 0 |
| **Cancelled Operations** | | |  |
| No urgent operation to be cancelled for a 2nd time | | | 0 |
| **Ambulance Handovers** | | |  |
| All handovers between ambulance and A & E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. Financial penalties, in both cases, for delays over 30 minutes and over an hour. | | | 0 |
|  |  |  |  |
| **Targets included within planning guidance** | 2013/14 | 2014/15 |  |
| IAPT - The proportion of people who have depression and/or anxiety disorders who receive psychological therapies | 12% | N/A |  |
| IAPT recovery rate | 50% | N/A |  |
| Dementia diagnosis rate | 56% | 60% |  |