Brighton and Hove Commissioning Intentions 2014-2016

Contents

1. Introduction

This document sets out the commissioning intentions for Brighton and Hove Clinical Commissioning Group (CCG) for the years 2014/15 and 2015/16.

These commissioning intentions reflect the direction of travel outlined in our 5-year Strategic Commissioning Plan namely to:

- increase capacity and capability in primary and community services so that we focus on preventative and proactive care – particularly for the most frail and disadvantaged communities;
- Design high quality urgent care services that are responsive to patient needs and delivered in the most appropriate setting;
- Align our commissioning to the health needs of our population and ensure we are addressing health inequalities across the City;
- Integrate physical and mental health services to improve outcomes and the health and wellbeing of all our population;
- Plan services that deliver greater integration between health, social care and housing and promote the use of pooled budgets;
- Deliver a sustainable health system by ensuring our clinical care models, commissioning and procurement processes and internal business practices reflect the broader sustainability agenda and deliver on our duties under the Social Value Act.

2014/15 will be a year in which we expect to see the full year effect of QIPP savings released from our urgent care programmes as people are supported to be maintained in the community through improved pathways of care and increased community capacity. In re-commissioning a number of integrated pathways for elective care we expect to deliver a better quality of service but also provide greater value for money. We are therefore confident that our QIPP challenge of £4-£6m will be delivered in 2014/15.

We recognise that in order to make the paradigm shift required to meet the growing demand for healthcare in future years we will need to radically transform the way in which health services are configured. 2014/15 will therefore be a year in which we fully utilise our 2% non-recurrent reserve. We will invest in enablers such as IM&T to facilitate greater integration between services. In addition we will be making significant investments in preventative care and community services in order to keep people well and rebalance the health system. Our intention is to maintain people at home and in the community wherever possible, ensuring any stay in hospital is kept to a minimum and facilitated by effective early discharge. We will do this in collaboration with providers of services and our commissioning colleagues to ensure alignment of

our commissioning plans and delivery of essential improvements such as the 3Ts capital development of the Royal Sussex County Hospital.

2. Developing our plans

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

i. our member practices:

- we have identified primary care based clinical leads for each of our key commissioning areas whose role it is to link back to member practices;
- bi-monthly discussions with each of our three Localities on commissioning plans including urgent care, diabetes, dermatology, substance misuse etc;
- on-line surveys on specific re-commissioning issues;

ii. patients and the public:

- quarterly public events discussing key themes such as use of urgent care services, the constitution – rights an obligations etc.
- regular meetings with third sector organisations contracted to provide feedback from traditionally excluded groups such as LGBT, gypsies and travellers, disabled people etc;
- quarterly meetings with Healthwatch to triangulate feedback on services;
- Feedback from PPG members via newly elected Patient Reps on Locality Management Groups, newly established PPG network etc;
- A summary document on our draft commissioning intentions will be send to all members of Patient Participation Groups across the City and a public event is planned for November where PPG members and Third Sector Organisations will be invited.

iii. The City Council,

- We have a regular Joint Officers Group where our draft commissioning intentions have been discussed at the earliest stage and co-designed. The Council are represented on our CCG Governing Body where commissioning plans are regularly discussed;
- Our Plans align with the Health and Wellbeing Strategy for the City and will go to the Health and Well-being Board's November meeting for information;
- Plans for the Integrated Transformation Fund are being discussed with the Health and Wellbeing Board and our governance structures around strategic planning and operational delivery of integrated plans are being strengthened.

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

- We have a memorandum of understanding with neighbouring CCGs to act as a co-ordinating commissioner for Brighton and Sussex University Hospitals. As such we have lead the process on developing commissioning intentions for the Trust on behalf of our neighbouring CCGs and ensuring these align with NHS England and longer term strategic aims around the 3Ts Development. There are robust governance mechanisms in place to ensure collaboration between commissioners and with the Trust.

3. Financial and planning context

In the absence of any national guidance, initial planning assumptions as reported in table 3.1 below have been discussed and agreed for local use, by Chief Finance Officers.

Table 3.1: Initial Planning Assumptions

	2014-2015	2015-2016
Growth on CCG Opening Allocations	2.00%	2.00%
Tariff (Mandatory)	-1.10%	-1.10%
Non Mandatory (Non-PbR, Tariff)	-1.30%	-1.30%
Activity Growth	2.35%	2.35%
CQUIN	2.50%	2.50%
Prescribing Inflation (before new drugs)	5.00%	5.00%
Contingency	0.50%	0.50%
Integrated Transformation Fund (est)	0.30%	3.00%
Non Recurrent Expenditure Reserve	2.00%	2.00%
Planned Surplus (1)	3.50%	1.50%

The CCG intends to increase its surplus in 2013/14, which will enable it to plan for a greater surplus in 2014/15 and be available to fund the major service transformation needed in future years.

Currently we are planning for a 3.5% surplus (£11.6m) in 2014/15, which would require us to make savings in the region of £6m.The intention to protect our surplus at 3.5%, needs to be balanced against the need to ensure that we also set a realistic and achievable level of saving, so we can ensure that we remain focused on the longer term transformational change and efficiencies and savings in future years.

Table 3.2:

	2014-2015 £'000's	2015-2016 £'000's
Growth	6,636	6,769
Return on prior year surplus	5,269	11,613
Additional surplus	6,969	
QIPP & Efficiency Savings-FYE	968	
QIPP & Efficiency Savings-New	5,383	7,781
Total Funding Available	**25,225**	**26,164**
Cost Pressures	2,000	2,000
Growth/Inflation/Tariff/CQUIN	6,790	7,109
Re-Establish Non-Rec Support	2,500	
Contingency	1,659	1,692
ITF	995	10,153
Top Up Non-Rec Expenditure Reserve	(333)	133
Planned Surplus	11,613	5,077
Total Funds Utilised	**25,224**	**26,164**
Non-Rec Expenditure Reserve	**6,636**	**6,769**

4. Service Specific Commissioning Intentions

4.1.Community Services

Providing responsive pro-active care in the community is a key priority for Brighton and Hove CCG. The population is ageing and many are living with more than one long term condition. We know from feedback from patients and their carers that they want services to be more holistic and more personalised. They want services to be supportive of them to achieve self-care and to be able to plan their future care (care planning); services which involve them in decisions about their care (shared decision making) and services which support them in their own homes without having to go to hospital if there are alternatives (care closer to home).

In Brighton and Hove we have recently redesigned a number of care pathways as part of this strategic approach including:

- Development of more community based dementia services in line with the National Dementia Strategy;
- Redesign of the End of Life Model of Care to support more people dying at home;
- Redesign of the Falls Care Pathway that prevents unnecessary attendance at hospital;
- Development of Integrated Primary Care Teams that provide pro-active care in the community using a case-finding approach;

- Redesign of the Community Short Term Services Model of Care into a single integrated provider model that provides more support to people in their own homes and less in bed based services.

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

The CCG in collaboration with Brighton and Hove City Council and other local partners intend to develop an Integrated Frailty Care model as part of the CCGs longer term for a more radical integration of health and social care at a whole system level. The CCG has outlined a two year programme for this major transformational change programme which will have an impact on the current contractual arrangements for all local providers of care. We will work collaboratively with all local providers and other stakeholders over the next year to design the model. The preferred contractual route to secure the model of care will be developed as part of the business case process and we plan implementation from 2015-16.

Prior to the new model of care being introduced the CCG will continue to strengthen community services during 2014-16. Pathways that are in the process of being redesigned and will be re-commissioned are summarised in table 4.1.1 below.

Table 4.1.1:. Community Services Work Streams

Work stream	Description
Integrated frailty care	The CCG intend to develop an outcome based commissioning model for the delivery of integrated frailty care. We will fundamentally redesign the frailty model ensuring care is integrated and based in the community wherever possible.
Diabetes	We will develop an integrated community based model of care based on a multi-disciplinary team approach. We anticipate the new model of care being in place from April 2015.
Integrated Community Equipment Service	We are exploring the possibility of jointly procuring the community equipment service with Brighton and Hove City Council &West Sussex County Council.
Anti-coagulation Service	We will review the service model in light of changes to guidance and new drugs and tender a contract for an updated model of care which will start from April 2015.

4.2.Mental Health

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

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

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

Table 4.2.1: Mental Health Work Streams:

Work stream	Description
Mental Health and Substance Misuse	We will develop an integrated model of care for people with a dual diagnosis of mental and substance misuse issues for people with more serious mental illness. This will form part of the Substance Misuse procurement process being led by Brighton and Hove City Council. The new model of care will be in place form April 2015.
Eating Disorder Pathway	We will commission a local comprehensive eating disorders service covering the spectrum of mild to severe disorders; improving physical health care as well as maintaining the health of those with more severe disorders . The new service will be in place from April 2014.
Psychological Support for Survivors of childhood sexual abuse	We will review pathways for psychological support for survivors of childhood sexual abuse with a view to developing improved streamlined care pathways.
Money Advice	We will review the current arrangements for provision of Money advice and ensure that we commission a comprehensive service across inpatient and community settings.

Work stream	Description
Pro-Active Crisis Prevention Pathway for Adults with Learning Disability	We will explore the development of an intensive response service for adults with learning disability with complex needs, for example with behavioural challenges and/or mental health conditions. The aim is to provide more preventative support in the community, preventing unnecessary use of out of area hospital placements.

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

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

4.2.1 Integration of Physical and Mental Health

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

4.3.Urgent Care

Urgent and emergency care has been the subject of much focus at a national level. It is suggested that the current system is unaffordable and unsustainable and national figures highlight overall levels of activity and spend increasing year on year despite significant investment in alternatives. We have seen a loss of public confidence in GP out of hour's services and a shaky start to the implementation of the NHS 111 services.

In response to this NHS England has established a national review of emergency and urgent care services and has published four emerging principles:

- Provides **consistently** high **quality** and **safe** care, across all seven days of the week;
- Is **simple** and guides good choices by patients and clinicians;

- Provides the **right care** in the **right place**, by those with the **right skills,** the **first time;**
- Is **efficient** in the delivery of care and services.

At a local level, we know that despite the positive changes we have made in the system:

- Patients and the public still find it complicated and difficult to navigate;
- Patients are calling 999 and being taken to hospital when they could be supported on alternative community pathways;
- Our local acute hospital has struggled to achieve the 4 hour A&E standard and ambulance handover delays are a frequent occurrence;
- Despite year on year decreases in emergency admission, some patients are still being admitted to hospital for conditions that could be managed at home.

Our focus over the next two years will be to:

- Support patients and the public to make the right choices in accessing urgent care services;
- Streamline and integrate urgent care services so that patients get the right treatment first time however they choose to access care;
- Build capacity in primary care to manage urgent care demand;
- Work alongside the local acute hospital to achieve sustainable improvement in the A&E 4 hour standard and ambulance handover delays;
- Maximise the opportunities provided by technology to improve information sharing between professionals about patients in urgent care settings;
- Deliver a further reduction in avoidable ambulance conveyances;
- Develop and implement an integrated 24/7 urgent care model.

The proposed work streams to support this focus are summarised in Table 4.3.1 on the following page.

Table 4.3.1:Urgent Care Work Stream

Work stream	Description
GP Out of Hours	We will work with other CCGs to implement the new specification for GP out of hours from April 2014. This service will continue to be delivered from the Royal Sussex County site and be closely linked with A&E minors. We will continue to commission redirection pathways to OOHs from adult and paediatric A&E and weekend review clinics.
Supporting patients and the public to access care	We will continue to develop and implement our local communications strategy building on the work already started via the We could be heroes campaign.
NHS 111	We will work with our commissioning partners to ensure full delivery of the service specification for NHS 111 and the Professional Support Line (PSL) including achievement of key performance and quality indicators.

Work stream	Description
Building capacity in primary care	See Primary Care
Non admitted pathway	Following an audit of emergency admissions with a 0 length of stay, we will seek to develop a non-admitted care pathway for those patients whose care cannot be completed with the 4 hour A&E standard but who do not need to be admitted to a hospital bed.
Delivering the 4 hour A&E standard	We will continue to work in collaboration with our local acute hospital to achieve sustainable improvement in the 4 hour A&E standard and in ambulance handover delays.
Rapid Access Clinic for Older People (RACOP)	We expect to see the full implementation of the revised service specification for the Rapid Access Clinic for Older People (RACOP) including re-emphasising the urgent nature of the service and increasing same day appointments and direct referrals from A&E. We also intend to move to a locally agreed tariff from April.
Reducing ambulance conveyance	We will build on the findings of the supported conveyance pilot to secure a significant reduction in the number avoidable conveyances to hospital aiming for a maximum of 50% of patients being conveyed to A&E. We will work with other CCGs to develop a local approach to contracting and commissioning of ambulance services that is much more responsive to local need and priorities.
Using technology to support patient care	We will maximise the opportunities that technology offers to support information sharing between professionals in urgent care settings e.g. A&E access to SCR and anticipatory care plans.
Integrated Urgent Care model	We will commence a two year change programme to develop an integrated primary care led service as the entry point to urgent care in the city. We will be aiming for implementation 2015/16 and it is likely we will contract on an outcome based prime provider model which will include walk in centre, GP out of hours and A&E minor injury and illness. During 2014/15, following the piloting of the primary care navigator and GP in A&E roles, we will be seeking to implement a primary care stream in A&E minors.

4.4.Planned Care

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

- Provide support and education to primary care;
- Are based on evidence based clinical pathways and referral guidelines;
- Provide seamless and integrated care and so that the patient sees the right person the first time;
- Are convenient for the patient offering one stop facilities wherever appropriate;
- Enable patients to make informed choices about treatment options;
- Have sufficient focus on supported self-care and shared care wherever appropriate;
- Take account of the psychological as well as physical wellbeing of the patient;

- Are efficient and value for money and avoid duplication.

The work streams intended to facilitate these aims are summarised in table 4.4.1 on the following page. Also included in this table are examples of our work with the Clinical Network and Sussex Collaborative Delivery Team.

Table 4.4.1: Planned Care Work Streams

Workstream	Description
Peer review and education	We will develop and implement in conjunction with the Primary Care team, a structured approach to mentoring, supporting and feeding back to practices about referrals supported by clear referral criteria and evidence-based guidelines.
Advice and Guidance	Subject to the outputs of an evaluation, we will be seeking to commission the Advice and Guidance service on a recurrent basis at the non-face to face outpatient tariff.
MSK	Brighton and Hove, along with other CCGS, will conclude the procurement of a new integrated musculoskeletal service. This service will be contracted on a prime provider basis with the financial envelope including all MSK activities including secondary care spend. The CCGs will be looking to implement the new service from October 2014.
Dermatology	Following completion of the procurement process, we will be commencing the implementation of an Integrated Dermatology Service in July 2014. This service will include all dermatology activity currently provided via the integrated dermatology service plus outpatient paediatric dermatology. This service will be contracted on a prime provider model.
Nurse Follow ups	We would like to all review nurse led outpatient activity with a view to implementing a local tariff.
Consultant to consultant referrals	We are currently reviewing consultant to consultant referrals and this may lead to changes in process.
Cancer	We will link with the SEC Strategic Clinical Networks and Senate, Public Health England and the Department of Health regarding national campaigns and consider the impact of these on contractual arrangements with providers for 2014/2015. We will use our NAEDI money to roll out a programme of work with our newly appointed Cancer Clinical Leads (GP and nurse) work with practices around early detection of key cancers.
Armed Forces	Continue to work, though the Sussex Collaborative, to deliver our obligations under the Armed Forces Covenant, ie ensure appropriate and timely treatment of the health needs of armed forces personnel and their families. This will include programmes relating to homeliness, mental health and prosthetics.
Endo Bronchial Ultra Sound	We will, through the Sussex Collaborative, complete the procurement of EBUS to take full effect from 01-04-2014

4.5.Children and Young People

In the light of national changes in commissioning structures the Section 75 Agreement was amended in April 2013. The agreement now outlines how the City Council will deliver service improvements acting as Lead Commissioner for a range of community based services for children with disabilities and children and young people with mental health problems. The strategic aim is to ensure good integration with other services provided by the Council and across the City. The CCG will undertake a further review of this arrangement in 2014/15.

Children and Young Peoples Services are provided in the City via a number of commissioning arrangements summarised in table 4.5.1 below.

Table 4.5.1: Children and Young People Commissioning Arrangements

Lead Commissioner	Service Area
NHS England - Public Health	Health visiting, family nurse partnership and screening programmes
Public Health Team in the Council	School nursing, sexual Health, teenage Pregnancies, substance and alcohol misuse and local health promotion programmes
Brighton and Hove Clinical Commissioning Group	Acute health care including planned and urgent care, maternity and routine new-born services
Brighton and Hove City Council Section 75 Agreement with the CCG	Community health servicesincluding community pediatrics, the Integrated Disabilities Team, therapies and child and adolescent mental health services

Strong collaborative working on shared agendas is essential to ensure children and families receive joined up care. There are a number of key work streams in table 4.5.2 below which illustrate this.

Table4.5.2: Children and Young People's Workstreams (CCG and the City Council)

Workstream	Description
Child and adolescent mental health services	We will undertake a multi-agency review of young people's mental and wider health issues. This will focus on early intervention, prevention and resilience building. Key to these developments will be effective working between children's and adult's services and improved and smoother transitions processes. We will continue to support initiatives such as online counselling and seek to engage further with digital and social media. We will undertake further work with adult services to develop the available support for children and young people who have experienced sexual abuse, recognising the long term impact of such abuse and the importance of early intervention.
Children's disability	Continued multi-agency partnership work to develop greater use of personal budgets across education, health and social care. As part of the achievement of Best Practice Tariff in children's epilepsy outpatient care the Children's Hospital have recruited an epilepsy nurse specialist. A parallel development in the community

Workstream	Description
	for children with disabilities will allow for greater collaboration between acute and community. We will work collaboratively with all partners to ensure appropriate access to therapies, equipment for daily living and wheelchairs to ensure children are enabled to access education and remain healthy.
Psychological support for unwell children	A limited additional psychological resource from CAMHs has been provided to work within the children's hospital to support the wellbeing of unwell children and those with long term conditions. Joint work with the children's diabetes team has led to the development of a screening tool to help identify those children that require psychological input. An evaluation intended to take place in 2014 will inform the further roll out of a model for integrating physical and mental health, particularly for children with long term conditions.
Transition (adolescent services)	We will undertake a review with key stakeholders to map transition from children's diabetes to adults. Engagement work with families and patients will be a key part of this. Joint work to define the transition pathway from community paediatrics to adult hospital/GP services will be undertaken. We are working with the Children's hospital to review their adolescent services with the local voluntary group for young people - Right Here.
Children's Community Team (Hospital at Home)	A joint review of this team based at the children's hospital will enable a specification with key performance indicators to be developed for this service and help to understand the gaps and how to improve integrated pathways with the community.

4.6.Maternity

Maternity services in Brighton and Hove are provided by Brighton and Sussex University Hospitals Trust; there is an Obstetric Led Unit at the Royal Sussex County Hospital site or women can choose to have a home birth which accounts for about 5% of local births. Brighton does not provide full choice of birth place as it does not have a midwifery-led unit. Following initial delays there are now plans being developed for such a service that will provide for increased capacity, a co-located birth centre and a women's health centre for both ante natal and gynaecology outpatients. The current timescale for the completion of all this work is 2015.

Performance at Brighton has improved steadily in the last 2 years against the key performance indicators. Recentadditional investment in midwifery posts has seen an improvement in the midwife: birth ratio, bringing it down to 1:30 from 1:34;it will also impact on the homebirth rate

as a 24/7 Home Birth Service has been implemented. C- section rates, however, provide a very variable picture from month to month despite work to promote a culture of normalising birth. An audit of the Birthing Choices Clinic is proposed in 2014 to understand in more detail the choices women make with regard to child birth.
Brighton and Hove CCG will continue to monitor all maternity key performance indicators for our local population and work with our parent – led Maternity Services Liaison Committee to ensure that local women continue to have a positive and safe experience of maternity services.

4.7.Medicines Management

We will continue to build on the excellent work the team has achieved with partners across Sussex and in our local health community to promote medicines optimisation.
The Medicines Management Team will continue to provide expert input to the commissioning of services and will also deliver a Medicines Optimisation Projects which will outline the key work plans for 2014-15 aligned to the following priorities:

- Promoting efficient medicines use by focusing on GP practice and clinical variation;
- Medicines optimisation in care pathway redesign, and further integrating the medicines management team with the commissioning teams;
- Local decision making and managing innovation;
- Quality and safety improvement;
- Continue to build on the work on blueteq with partners to manage the Payment by Results Excluded Drugs;
- Collaboration with partners through the Brighton Area Prescribing Committee.

Table 4.7.1; Medicines Management Work streams 2014-2016

Workstream	Description
Continue to develop and implement the Joint Formulary, and create a paediatric joint formulary	We will continue to review and implement the joint formulary. We aim to develop a paediatric formulary in 14/15. We will continue to monitor adherence to the joint formulary using the eclipse system. We will feedback variance to adherence to all GP practices and other users.
High Cost Medicines Management	We will continue to develop and monitor Blueteq. We will work with providers to develop a CQUIN around high cost drugs. We will also audit the use of high cost drugs in selected specialities. We will develop closer links with finance teams and contracts within CSU to enable more timely challenges to be made on invoices for high cost items
Wound Care Project	We will roll out the ONPOS system and work with the community trust and DNs to tighten up the formulary choices. We will monitor the use of dressings and work collaboratively with our partners in the local health economy to optimise the use of dressings. We will monitor the effectiveness of ONPOs. This will help reduce wastage and improve adherence to the dressings element of the formulary.
Continence, stoma and Catheter supplies	We will embark on a project to optimise the use of these items and collaboratively develop guidance on appropriate choices and

Workstream	Description
	quantities. We will explore different procurement and ordering options and scope the options available. We will then implement the most efficient system throughout the CCG .
Care and Nursing Homes Medicines Management Support	We will continue to commission IRx to deliver the medicines management reviews to our care and nursing homes. We will build on this year's work and look to address systems issues highlighted in last year's and this year's work. We will continue to deliver QIPP savings without compromising on high quality care for the residents. The wound care project and continence project will help underpin the work in the homes.
Area Prescribing Committee	We will work with our two neighbouring CGGs and the provider trusts to ensure a robust work plan is in place. We will also ensure that all decisions are effectively communicated to stakeholders inc patients.
Primary Care Prescribing Project	The CCG will continue to provide support to GP practices (including dedicated practice-based technicians) across the city to ensure optimisation of efficiencies in standard prescribing through the use of script switch etc.

4.8.Continuing Health Care

We are committed to meeting our obligations under the National Framework for Continuing Health Care - in particular to provide assessments within the 28 day standard and to conduct regular reviews. The team has struggled, however, to meet the standards defined within the Framework given the increasing numbers of referrals and growing caseload as a result of *the retrospective requests for assessments of eligibility for cases* during the period 2004-12.

We have invested in additional nurse assessment capacity to address the backlog of patients during 2014/15 and to ensure we meet standards on an ongoing basis.

From April 2014 we will be offering the choice of personal health budgets to all adults and children eligible for CHC.

4.9.Vulnerable Communities and Traditionally Excluded Groups

Need to complete this section on Martin's return

5. Reducing Inequalities

Life expectancy in the Brighton and Hove City is higher than it has ever been. Women in the City can expect to live on average to 82.6 years and men 78.5 years. This is lower than the national

average by 2.5 months and almost three months respectively for women and men. Additionally, within the City we see a significant difference in life expectancy between wards. Women living in the most deprived parts of the city have a life expectancy of 80 years compared to 84.4 years for women living in the least deprived area. For men there is a gap of 10 years with men in the most deprived and least deprived areas expecting to live to 71.7 years and 81.7 years respectively.

In order to address the gap in life expectancy and improve mortality and morbidity in the City overall, the CCG plans to commission a range of high impact, evidence based interventions to improve health outcomesin 2014/15.

The type of evidence based interventions being considered is summarised in the table 5.1 below. These will be prioritised for investment following the outcome of the local Preventing Premature Mortality Audit.

Table5.1: Evidenced based interventions to improve health outcomes

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

Delivering successful interventions of the type described above will depend on building capacity within primary care. Drawing on examples of successful models elsewhere and building on our

primary care development strategy we will work with member practices on potential models for delivery which will also address:

- Greater consistency of achievement for QOF clinical indicators associated with premature mortality within and between General Practices;
- Higher achievement of QOF clinical outcomes moving closer to ONS peer comparators and England average;
- Reducing the prevalence gap between those with risk for conditions not yet identified in the community and those on Practice registers;
- Promoting peer challenge and learning based on benchmarking of achievement and identification of good and effective practice in General Practice;
- Identification of the clinical indicators within General Practice most strongly associated with premature mortality;
- Agreement of acceptable thresholds for exception reporting for clinical indicators most strongly associated with premature mortality;
- Enhancing the reach of primary care to identify those with risk – improve access and reach;
- Increasing capacity within General Practice to assess risk, register, treat and review new patients for major killers: COPD, CHD, stroke, diabetes;
- Incentivising higher achievement for clinical indicators associated with reducing premature mortality;
- Incentivising reducing exceptions for agreed indicators;
- Enhancing CQUINS in acute settings: e.g.
- smoking cessation;
- completion of stage 4 cardiac rehabilitation.

6. Primary Care Development

Primary care is considered to be the bedrock of NHS care provision, offering direct entry into the health care system and accounting for 9 out of every 10 patient contacts. Demands on general practice have never been greater with primary care professionals seeing more patients than ever with complex co-morbidities. In addition to an ageing population, rising patient expectations and persistent health inequalities illustrate the challenges facing primary care. In the UK the number of people with multiple long term conditions is set to rise from 1.9 to 2.9 million from 2008 to 2018.

There are also significant challenges within the primary care workforce. In Kent, Surrey & Sussex, 22% of GPs are over the age of 55, 20 % of Practice Nurses are over 55 with a high proportion of single-handed practices and part time workers. A shift to the management of long-term conditions in primary care has resulted in the need to facilitate longer patient consultation in general practice, and a subsequent impact on capacity.

In order to develop primary care we will focus our support and resources on three interlinked priority areas; **primary care infrastructure, workforce and organisational development.**

Delivering the highest standards of quality primary care for patients is paramount, alongside developing a quality workforce in our member practices that is sustainable, and can meet the challenges that lie ahead in general practice.

During 2013 we have established a Primary Care Development Team, including three Locality Member Group (LMGs) each with a General Practitioner (GP) Chair supported by three Practice Nurses, four Practice managers and more recently six locality patient representatives. We will continue to engage with members of the public through our public events to ensure that we are driving changes in care that are patient centred at all times. The LMG teams will be working with our member practices and also engaging with the public, to develop primary care across Brighton & Hove CCG.

Our focus over the next two years will be to:

- Develop an infrastructure to maximise the IT systems across general practice to enable a sharing of data and benchmarking for quality improvement;
- Collaborate with charity partners such as Macmillan Cancer Support & Prostate Cancer UK to pilot initiatives including the National Early Detection & Awareness Initiatives (NAEDI)and pilot a Prostate Cancer Charity Primary Care Nurse to offer support and information for men considering having a screening test for prostate cancer calledProstate Specific Antigen (PSA) testing in the community;
- Develop local and national outcome based quality indicators, to gain an evidence base of quality improvements in general practice. Exploring the commissioning of a best practice scheme across the practices;
- Systematically start to quantify those patients with unmet needs and those in the community whose risk has not yet been detected;
- Undertake a pilot of primary care workforce development-Community Education Providers Network (CEPN) to build a future workforce across primary care;
- Support our member practices to explore amongst themselves new models of collaborative working to develop as organisations and providers of primary care;
- Ensure that appropriate resources follow the patient when services move to primary care settings;
- Build and support capacity in primary care to meet increasing urgent care demands;
- Continue to develop a primary care strategy across Brighton & Hove CCG.

Table6.1: Primary Care Commissioning Intentions

Workstream	Description
IT systems	We aim to develop IT systems across General Practice to enable a sharing of data and benchmarking – including GP Data Extractions and continue with Quest Browser, developing requirements for CCG and Practice GP performance dashboards. We will also support the Preventing Premature Mortality Audit to create an evidence base of those patients not on disease registers

Workstream	Description
Building capacity for the future	We will work with the LMG to identify those areas that require existing and new premises developments led by the Area team. Alongside those practices which could maximise space and capacity in innovative way with new partners.
Working with our Local Member Groups	We will continue to develop and support our LMGs and our patient representatives to be fully involved in clinical commissioning and primary care development ensuring robust two way communication and feedback which reaches each member of the primary care workforce and including the patient population of the practices
Workforce Development	We are committed to taking part in a Kent Surrey Sussex (KSS) Health Education England (HEE) Pilot a city-wide Community of Education Providers Network (CEPN) . This will develop a multi-professional ethos of education in primary care In phase 1 nurse tutors will be identified and trained across Brighton & Hove CCG to develop a new primary care workforce We will facilitate clinically led peer review process and shared learning, based on benchmarking of achievement and identification of best practice in General Practice. This will enable our member practices to share best practice and drive quality improvements
Organisational development	The LMG will lead a 6 month Pilot of the Innovations Forum to develop new ways of working together for our member practices We will support our member practices to have discussions about models and functions of collaborative working to support the sustainable future of General Practice
Reducing health inequalities and supporting outcomes	We will develop and work with charity partners such as Macmillan Cancer Support & Prostate Cancer UK to pilot initiatives with National Early Detection & Awareness Initiatives (NAEDI) and pilot a Prostate Charity Development Nurse to sign post men for PSA testing in the community. We will utilise the data from the Primary Care Audit Tool & indicators and develop locally agreed outcome indicators to look at best practice. We will explore differing models of commissioning and supporting best practice in quality improvements in primary care. We will develop a systematic way to quantify those patients with unmet needs and those in the community whose risk has not yet been detected
Impact on primary care from service redesign	We will work with our patients, members of the public member practices and commissioning teams in the CCG to identify those services that could be provided more closer to home

Workstream	Description
	We will then ensure that consideration is given to ensuring that appropriate resources (including workforce) follows the patient when services move to primary care settings
Supporting Urgent Care	In conjunction with the unscheduled care team we will implement a range of initiatives to build capacity in primary care including: Developing the primary care workforce to support urgent care in primary care, including trial of 'pop up clinics' and development of Practice Nurse skills & competencies Peer review and education to reduce variation in clinical practice Supporting the utilisation of the urgent care dashboard to support decision making Pilot Dr First within the LMG Supporting & embedding the urgent care standards Collate data from indicator practices on activity in primary care to understand the pressures within the whole system and how to action plan accordingly

7. Integrated Transformation Fund

The Integrated Transformation Fund (ITF), announced as part of the Spending Round in June 2013 makes £3.8bn available (in 2015/16) for local deployment through pooled budget arrangements on integrating health and social care. The aim is to transform outcomes (and use of services) in the most vulnerable and frail in our community and address criteria such as 7 day working. Whilst £1.9bn is already in system i.e. in budgets for carers breaks, re-ablement funding etc, an additional £1.9bn NHS funding will be made available. The financial implications for Brighton and Hove are estimated below.

Table 7.1: Financial Implications of Integrated Transformation Fund for Brighton and Hove

Elements of the Integrated Transformation Fund	£mill
Social Care Grant	4.3
Additional Funds 14/15	1.0
DoH – Capital Grants	1.7
Reablement Funding	1.4
Carers Breaks Funding	0.6
Additional Funds 15/16	9.1
Total	**18.1**
Existing	8.0
New	10.0

Further guidance on the use of the fund is expected in November as part of 2014/15 planning round but the CCG in collaboration with the Council are developing plans for extending integrated commissioning and delivery into the frailty pathway and homeless service which are detailed below.

7.1.Integrated Frailty Pathway

The re-design of the frailty pathway is being led by the Urgent Care Clinical Forum. A two-year programme of work to fully scope and implement the integrated pathway is being initiated and funding for a Programme Manager, working across the CCG and Council has been agreed. A key early element of the programme will be to quantify the pump-priming and double running costs required of the 2% non-recurrent reserve and fully describe and quantify patient outcomes and impact elsewhere in the system. Discussions with stakeholders and providers will be initiated to understand and plan for the most effective delivery model for this new community based service.

7.2.Integrated Homeless Service:

The model for a Primary Care Lead, co-located in a multidisciplinary team for homeless people in the City – incorporating housing support and third sector provision -was signed off by the Health and Wellbeing Board at its September meeting. Dedicated managerial support has now been secured to scope the integration process, quantify required elements of pump priming and define outcomes and impact in the system.

Both of the above represent significant programmes of work which are key elements of our commissioning intentions and Operating Plans for 2014/15.Proposals for these and the governance surrounding the Integration Programme will go the November 2013 meeting of the City's Health and Wellbeing Board.

8. Quality and Safety

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

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

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

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

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

Our focus over the next two years will be to:

Table 8.1; Quality and Safety Work Streams

Workstream	Description
Patient Safety	We will be hosting the Patient Safety Team for all the Sussex CCGs, building on the benefits of the pan Sussex approach to managing Serious Incident and Never Event reporting and learning. In April 2013 NICE were established in primary legislation, becoming a Non Departmental Public Body (NDPB) and placing them on a statutory footing as set out in the Health and Social Care Act 2012. NICE's role is to improve outcomes for people using the NHS and other public health and social care services . We will monitor the providers compliance with implementing NICE guidance. B&H CCG is committed to ensuring the use of NICE Guidance in its decision making and has committed to work with the local NICE Field Agent to support the development of NICE guidance.
Patient Safety Champions in Primary Care	Working with the NHS England Area Team and the Local Member Group practice nurse representatives and practice nurse forum we will be supporting the development of primary care patient safety champions. Developing a culture and capacity in the workforce to support the ethos of patient safety throughout the pathway of care, building confidence in the system and sharing good practice.
Infection Prevention and Control resources	We will host the jointly commissioned Infection Control Practitioner with Costal West Sussex CCG. This post will lead on infection control and prevention, survey, review and analyse healthcare associated infections (HCAIs) and support cross agency working to facilitate standardised approach to infection prevention and control. Clostridium Difficile (C-Diff): We will be working with provider organisations and across the pathway of care alongside our medicines management team to ensure the reduction in avoidable C-Diff cases. Methicillin Resistant Staphylococcus Aureus (MRSA): There is a zero tolerance to avoidable MRSA. We will continue to work with providers and monitor the outcome of the investigation of any cases.
Decontamination Advice	We will jointly commission, with Costal West Sussex, a decontamination expert in order that B&H CCG has access to technical advice and guidance.

Workstream	Description
	This will support the CCG to manage the safety of patients in current and newly commissioned services.
Quality monitoring	The Quality and Patient Safety team will work alongside the commissioning team and CSU commissioning managers as clinical quality and patient safety advisors. There will continue to be a program of formal quality and patient safety monitoring and challenge through quality review meetings with the 3 large NHS providers. There is a program of meetings with local Care Quality Commission and Health-watch representatives to share intelligence. Local General Practitioners are also responsible for feeding patient experience and issues in to the system via a dedicated email address.
Safer staffing and Workforce Development	We will ensure that individual providers maintain a process of assurance that service redesign and development has Chief Nurse and Medical Director agreement that patient safety will not be compromised. B&H CCG will engage through membership of the Lead Nurse network with the National review of safe staffing underway at present.
Patient Experience	We commit to assure that patient feedback drives the development and improvement of services. The Friends and Family Test is mandatory in acute settings and maternity settings and will form a part of the quality review information. Patient experience feedback will also inform the quality monitoring though CCG held public events, national patient surveys, GP practice patient forum and Local member group patient representative feedback
Safeguarding	Protecting vulnerable adults and children is a multi-agency responsibility and depends of excellent communication and information sharing. Adults: Our Lead Nurse and Director of Clinical Quality & Primary Care is the Executive Lead for Safeguarding. All Quality and Patient Safety managers will also have level 3 adult safeguarding training and are able to undertake Health Investigations. It is anticipated that during the year 2014-15, Adult Safeguarding will become a statutory requirement and will require additional resource both in the form of named doctor (part time) and a financial contribution to theAdult Safeguarding Board running cost. Children: Our Lead Nurse and Director of Clinical Quality & Primary Care is the Executive Lead for Safeguarding and sits on the B&H Local Safeguarding Children's Board (LSCB) We have a WTE Designated Safeguarding Children's Nurse We commission .2 sessions of Designated Doctor sessions per week to support the CCGs strategic responsibilities and planning, and we have a .2 Named GP to support primary Care.
Winterbourne View Concordat	B&H CCG has been working in partnership with the City Council through a section 75 agreement to deliver improvements in the care for individuals with learning disabilities and are in a placement out of the area. Repatriation is the aim where possible. All individuals have a dedicated case manager to support this aim.
Clinical pathway redesign	All Clinical Quality and Patient safety managers employed in the quality governance team will be working with commissioning managers, and

Workstream	Description
	primary care clinical leads to support the development of care pathways and service redesign, assuring a focus on the quality and safety of services
Facilitating partnership working across the system	We will continue to support and facilitate the Nursing Home forum. Bring together clinicians and mangers from the private sector, the acute, community, mental health and primary care providers in order to develop an shared understanding of the challenges and pressures, facilitate the sharing of good practice, and to support the development of partnership working in order to ensure the best outcomes for in particular but not exclusively older people and those who are vulnerable.
CQUINS	We will fully utilise CQUINS as a lever to drive real improvements in quality and patient experience.

9. Sustainability

The CCG, as part of its authorisation process committed to developing a Sustainable Commissioning Plan. We have begun the process of pulling our plan together under the following three areas:

9.1.Commissioning for Sustainability:

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

9.2.Being Sustainable as an Organisation

- Ensuring we have energy efficient business processes;
- Paying our staff the City's living wage;
- Providing a workplace which facilitates health and wellbeing.

9.3.Leading our Member Practices

- Supporting general practice with energy audits and top 10 high impact actions;
- Addressing areas such as medicines wastage;
- Facilitating enablers such as the roll out of electronic prescriptions;
- Agreeing a programme of work with member practices and developing a "sustainability pledge" for members.

A detailed Sustainability Plan will go to the Governing Body for sign off in January 2014 and will inform our commissioning and business processes in 2014/15 and beyond.