Health and Wellbeing Board

14 May 2015

Clinical Commissioning Group Planning Progress Update and Final Commissioning Intentions 2015-16

Report of Nicola Bailey, Chief Operating Officer, North Durham & Durham Dales, Easington and Sedgefield Clinical Commissioning Groups and Stewart Findlay, Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group

Purpose of the Report

1. The purpose of this report is to update on progress of the refresh of North Durham Clinical Commissioning Group (ND CCG) and Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG) two year operational plans.

Background

2. Durham Unit of Planning developed a five year strategic plan which was aligned to the Joint Health and Wellbeing Strategy (JHWS). The CCGs already contribute to the performance measures within the JHWS and this feeds into the process for planning and identifying any gaps.

3. The Durham Clinical Commissioning Groups (CCG's) were required to develop two year priorities based on this overall strategy in March 2014.

4. The national Five Year Forward View was published in October 2014; there is a requirement to refresh commissioning plans for 2015/16 in light of this most recent guidance.

National Planning Guidance

5. The final planning guidance was published in late December 2014. This included details relating to:

- Any new 2015/16 requirements (mental health access is expected to be the only major new requirement).
- Requirements for NHS Constitution standards.
- The immediate implications of the Forward View.
- Emerging system changes.
- Revised financial planning assumptions, allocations and drawdown envelopes.
- Revised activity planning assumptions.

- Strategic enablers, including workforce, estates and IT.

6. The minimal planning requirements are designed to enable CCGs and providers to focus on improving quality, meeting NHS constitution requirements and financial sustainability.

7. Commissioning intentions for 2015/16 are focussed on current priorities as set out within the two year operational plan. DDES CCG Final Commissioning Intentions 2015-2016 are attached at Appendix 2 and North Durham CCG Final Commissioning Intentions 2015-2016 are attached at Appendix 3.

8. Commissioning priorities will continue to be based on the strategic aims reflecting the JHWS to ensure that there is a close link between the planning refresh and the refresh of the JHWS.

Quality Premium Indicators

9. Both CCG's will need to refresh their outcome trajectories and select quality premium indicators in line with guidance published by NHS England. Durham County Council is represented on the planning group where these issues are discussed.

10. The Quality Premium Indicators (QPI's) are intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

11. The national guidance on the QPI's has recently been published and sets out the measures for 2015/16 and the levels of improvement for CCGs to achieve in order to qualify for the quality premium. It includes the actions to be taken by CCGs with Health and Wellbeing Boards, NHS England and local NHS England teams, required to agree the local measures and levels of improvement in preparation for 2015/16.

12. Two national Quality Premium indicators are mandated to CCGs for inclusion and these correspond to supporting delivery of the NHS Constitution Standards. These national mandated indicators are as follows:

    - **Reducing potential years of lives lost through causes considered amenable to healthcare - 10% of total funding available.**
    - **Improving antibiotic prescribing in primary and secondary care - 10% of total funding available.**

13. There are several indicators that CCGs need to choose in conjunction with the Health and Wellbeing Board. These are from pick lists in the areas of Urgent and Emergency Care and Mental Health. In addition, local indicators also need to be selected, which align to the Joint Health and Wellbeing Strategy. Further detail in relation to the range of QPI's

available is included in Appendix 4, with the proposed indicators outlined below.

14. It is proposed that the CCG selects one indicator from the Urgent and Emergency Care list as below with the full value of 30% of the funding available attributed to this indicator:

    - **'Reduction in delayed transfers from care.'**

    This indicator links to a number of key projects such as the Intermediate Care Plus pilot, vulnerable adult wrap around services (VAWAS) schemes and frail elderly. There has also been a real focus between commissioners, providers, the local authority and other partners to improve performance for this indicator.

15. It is proposed that the CCG selects the following indicators from the Mental Health list, with 12.5% of the funding available attributed to the first two of these indicators and 5% funding allocated to the final indicator:
    - **Reduction in the number of people with severe mental illness who are currently smokers.**
    - **Increase in the proportion of adults in contact with secondary mental health services who are in paid employment.**
    - **Improvement in the health related quality of life for people with a long term mental health condition.**

    All of the indicators are challenging. Work has been carried out in 2014/15 with the local mental health provider to reduce smoking for service users. In addition to this the CCG has commissioned a number of pilot services such as the 'recovery college' which may help to achieve the necessary improvement around paid employment.

16. It is proposed that the CCG selects the following local indicators, with each indicator worth 10% of the funding available.

    - **% of patients on a palliative care register.**
    - **% of patients on a diabetes or COPD register that have received a flu immunisation AND**
      % of patients on a COPD register that have received Pneumovacc. (Composite indicator)

System Changes

17. The overarching direction of travel for the local health economy is outlined within the Five Year Forward View. This describes new models of care which focus on integration between settings and across health and social care.

18. A number of system changes have already begun to take shape, this includes:

    - Primary care co-commissioning.
    - Specialised service co-commissioning.
    - The introduction of integrated personal commissioning. (IPC)

Primary care co-commissioning

19. New guidance has emerged detailing the next steps. There are to be three levels of responsibility for CCGs to decide upon:

    1) Greater involvement in primary care decision-making.
    2) Joint commissioning arrangements.
    3) Delegated commissioning arrangements.

20. Both Durham CCGs are now delivering delegated arrangements for primary care co-commissioning as of the 1st April 2015. This addition to CCG remit has been added to both sets of commissioning plans.

Specialised Service Co-commissioning

21. NHS England has established a task force for specialised commissioning to analyse the current commissioning arrangements; to address a number of challenges causing significant pressures across the system; and to identify options for future commissioning models.

22. Following the outcome of this any planning guidance will identify the specific services to be included under the CCG's commissioning remit.

23. There will be guidance on whether funding will be based on populations or place.

Integrated Personal Commissioning

24. In July 2014, NHS England announced plans to pool funding across local authorities, CCGs and specialised commissioning for certain population groups.

25. The aims of this approach, to be known as Integrated Personal Commissioning (IPC), will be to test new commissioning and funding models including joined-up capitated funding approaches, and to explore how individuals can have more control over how the funding is used through personalised care and support planning.

26. Durham CCG's and Durham County Council submitted a bid to be a pilot site for IPC implementation which was unsuccessful. All partners are working together to understand how this work can be taken forward.

Alignment of Plans

27. Better Care Fund plans were submitted in September 2014 which included a target reduction in emergency admissions. A refresh of CCG operational plans will require this ambition to be reflected in activity plans.

28. Work will also be needed to ensure consistency between commissioner and provider plans.

Durham Unit of Planning CCG Priorities

29. Durham Unit of Planning priorities are:

- Mental Health.
- Learning Disabilities.
- Urgent Care.
- Diabetes.
- Frail and Elderly.
- Primary Care Transformation.
- End of Life Care.

Recommendations

30. The Health and Wellbeing Board is recommended to:

- Note the content of this report.
- Note the final CCG commissioning intentions 2015/16 (Appendices 2 and 3).
- Agree the CCG Quality Premium Indicators (paragraphs 9-16 and Appendix 4).

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Appendix 1: Implications

Finance
All priorities will require clear financial plans on potential disinvestment and investment required. All plans have to support the achievement of financial balance.

Staffing
Individual commissioning priorities may have an impact on staffing. Individual impact assessments will be undertaken.

Risk
Individual commissioning priorities will be impact assessed in terms of the risks and mitigating against these.

Equality and Diversity / Public Sector Equality Duty
There is a commitment to ensure that equality and human rights are integral to the planning process.

Accommodation
No implications at this stage.

Crime and Disorder
No implications at this stage.

Human Rights
No implications at this stage.

Consultation
Both CCGs have utilised their own engagement models as part of this process.

Procurement
No implications at this stage.

Disability Issues
No implications at this stage.

Legal Implications
The CCGs must comply with statutory obligations as laid out in *'The Functions of a CCG'* (NHS England, 2013) that includes the duty to prepare, consult on and publish a commissioning plan. The approach and arrangements outlined in this report are intended to fulfil these duties.

APPENDIX 2

Durham Dales, Easington and Sedgefield CCG
Commissioning Intentions List
2015/16

Priority Area	What	Why	Rationale
Cancer	Improvements required in cancer 52 day performance, improved diagnosis rates and mortality	National must do and links to a number of key targets	National must do and links to a number of key targets
Primary care Macmillan nurses	Recruitment of 3 Primary care nurses to work funded by Macmillan for 3 years	Funding required for costs of employment	Pre-commitment
Tier 3 Weight Management - children	Enhancement to DCC commissioned tier 2 service to provide tier 3 equivalent with psychology input	To be compliant with NICE guidelines following DCC de-commissioning of paediatric obesity service	NICE requirement
Intermediate Care	Continuation of the Intermediate Care Plus service pilot	Need to reduce emergency admissions to hospital or facilitate early discharge where appropriate	Legacy commitment
Frail elderly	Increase community services that provide support to people in their homes and in the community to enable patients to leave hospital sooner or avoid admission	Pilots should become self-funding through non elective activity	Existing project
Personal health budgets	Ensure that those who are eligible for PHB are supported to use them, giving control over decisions	Improve the health and take ownership of their own health provision	National must do to implement personal health budgets, but the amount of investment required for this is uncertain
Better Care Fund	Funding for the Better Care Fund	National requirement	National must do

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Priority Area	What	Why	Rationale
HELS re-procurement	Re-procurement of the HELS service	Procurement is underway	Existing project
Wheelchair service re-procurement	Re-procurement wheelchairs service	Different models of service are in place across DDES. There are unacceptably long waits in some services.	Existing project
OPAT	Alternative pathway for community IV therapy for cellulitis grade 2	Avoiding unnecessary admissions and provide care closer to home	Existing project
Learning Disabilities inc Winterbourne	Need to ensure the requirements of the Winterbourne Review are fully implemented	Gaps in current pathway identified. Different models of care need to be implemented.	National must do
Recovery college	Assists patients to return to a full and fulfilled life following an episode of mental illness.	To aid recovery following an episode of mental illness	Need to await outcome of the review to identify if service should be continued
CAMHS crisis (self-harm) service	A pilot service was developed by TEWV to support children who self-harm	DDES have very high levels of childhood self-harm.	Need to await outcome of the review to identify if service should be continued
Mental health intensive support service	Pilot specialist intensive support service. for individuals who have been identified as needing a level of support above that which can be offered by community mental health teams and more long term than the intensive home treatment offered by crisis teams.	Agreed pilot continues into 2015/16. A decision on further continuation would be taken based on the evaluation of the service	Need to await outcome of the review to identify if service should be continued

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Priority Area	What	Why	Rationale
Crisis care concordat	Need to ensure that any improvements required following development of the concordat and action plan are understood and implemented	Need to be compliant with national standards	National must do
Place of safety for adults and children (S136)	We need to ensure that we have commissioned a place of safety for patients in mental distress under S136 of the mental health	Need to be compliant with national standards	National must do
Implementation of national mental health strategy via County Durham Mental Health implementation plan	Implementation of the County Durham mental health implementation plan	Improve access to MH services and achievement of national Mental health targets and reduce reliance on hospital treatment	National must do
Tier 3 Weight Management - adults	Procurement of a Tier 3 Weight Management service	To be compliant with NICE guidelines	NICE requirement
Diabetes - interim service	Development of pilot community diabetes services across three DDES Federations	Ensuring no gaps in services for patients, and provide close to home, sustainable service	Existing project – pre commitment
Diabetes - longer term service re-design	Re-design of diabetes service to develop an outcome based model delivered out of hospital	Ensuring no gaps in services for patients, and provide close to home, sustainable service	Existing project
COPD/Respiratory	DDES are piloting a COPD nurse co-ordinator	To improve standards of care for COPD	Existing project
Demand management	Fund a team of staff to focus on demand management	To manage pressures on acute budgets	Existing project

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Priority Area	What	Why	Rationale
Ophthalmology - managing demand and improving quality	MECATS and IOP pilots	Pilot services to provide care in the community and reduce demand on secondary care services	Existing project
AQP – re-procured	Re-procurement of AQP services where contracts are due to expire(Podiatry - June 15, Adult hearing - June 15, INR - January 15)	Must do as contracts due to end	Contracts expired - must do
Tele -dermatology	Service that enables remote access to a clinician opinion using digital images	To reduce referrals to secondary care outpatient services	Existing project
Paediatric SALT/OT – TUPE risk	Provision of funding to mitigate TUPE risk following re-procurement of services	To ensure there were no barriers to new providers entering the market	Completion of staff transition following procurement process
Prescribing - waste management programme	Continuing to focus on medicines waste	Opportunities for QIPP	Existing project
Workforce (focus on primary care)	Ensure that there is a sustainable primary care workforce for DDES.	Large number of GPs coming up to retirement age and difficulties recruiting to DDES practices	Links to Primary Care strategy
Primary Care - 7 day working	Extension of the DDES weekend opening scheme	Need to consider extension of the current scheme depending on whether we are successful through PMCF	Impact on urgent care and A&E demand
LES	Locally agreed primary care provision over and above core contract responsibilities	Avoiding unnecessary admissions and provide care closer to home	Pre-commitment

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Priority Area	What	Why	Rationale
LIS	Primary Care Local Incentive Scheme	Support integration provide services in primary care and QIPP	Pre-commitment
Primary Care Co-Commissioning	Commissioning of primary care services	To improve commissioning of integrated pathways across healthcare services. To improve quality of primary care. To ensure primary are services are sustainable	
Urgent care review	Review of urgent care services across DDES	National Urgent Care Review expected to mandate standard service levels for urgent care. Demand for services is growing. There is inequity of services across DDES.	Existing project
GP out of hours procurement	Out of hours GP Services must be reproduced under an APMS Contact (currently wrapped up in Urgent Care Standard NHS Contract)	Contract has expired	Contract has expired
Readmissions	Need to establish new process in relation to monitoring & reinvestment of 30 day readmissions monies under PBR Contract	To ensure that the money is re channelled back to support patient care	Contractual requirement
Ambulance performance issues including Teesdale/Weardale	Clinical senate are carrying out an audit of cases and the need for two paramedics on ambulances in Teesdale and Weardale	Improve ambulance response times and reduction in delayed transfers of care	Performance improvement is a national must do

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Priority Area	What	Why	Rationale
Intrahealth unregistered list	Funding for the walk in service for unregistered patients at Healthworks	Continuation of existing service	Continuation of existing service
System Resilience	Review of 14/15 pilots to identify if any should be continued	Some may have demonstrated effectiveness	To reduce pressures on urgent and emergency care system
Securing Quality in Health Care Services (SeQIHS)	Review of clinical standards at NHS acute hospitals across Durham and Darlington	To ensure that services area sustainable	Regionally agreed project
Pulmonary Rehab	Commissioning of pulmonary rehabilitation service	To improve patient outcomes and ensure equity of provision across DDES. To be moved into contracts as a recurrent service line.	Evidence based programme. To provide equity of provision across DDES
Prescribing Incentive Scheme	A local primary care initiative	Ensure prescribing of the most beneficial and cost effective medicines and help patients stay well	Reduce precribing costs
7 day working - acute	County Durham and Darlington are a national pilot site for seven day working	Possible funding requirements, but amount not known at this point	National must do
Macmillan- Peterlee Talking Cancer Service	Need to support the review of current Macmillan services	No funding required for 15/16, but may be a call for 16/17. Need to participate in review of service	Need to be involved in review and development of potential future service options

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Priority Area	What	Why	Rationale
Children's self-harm acute pathway	Pathway review for paediatric admissions for self- harm	County Durham has one of the highest rates of admission for children who self-harm. It was part of the CDDFT SDIP to review the pathway, but this was not carried out in 14/15 so it is proposed this rolls over into 15/16	Meets organisational priorities
Paediatric continence Review	Review of pathway for paediatric continence services	Review required in light of new NICE guidance and changes to Local Authority commissioning.	New national guidance has been published.
Lymphedema	Further develop and invest in lymphedema services.	To address current service delivery pressures and secure delivery access	Work is ongoing to review existing spend and outcomes. Paper coming to a future exec on this.
Palliative and EoL - consultant staffing	To employ palliative care consultants	To support 24/7 access to advise and 7 face to face assessments	Work is ongoing to review existing spend and outcomes. Paper coming to a future exec on this.
Palliative and EoL Single point of access	Re procure rapid response service	To support 24/7 crisis patient care and family support	Work is ongoing to review existing spend and outcomes. Paper coming to a future exec on this.
Delayed Transfers of Care	Review of systems and processes to reduce delayed transfer of care	Reduce unnecessary delays for patients	National must do
District nursing re-design	A review of the current service and explore opportunities to re-design services	Long standing service need to understand the service provision and potential gaps	Links to development of multispecialty community providers

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Priority Area	What	Why	Rationale
Specialist nursing re-design	A review of the current service and explore opportunities	Long standing service need to understand the service provision and potential gaps	Links to development of multispecialty community providers
Maternal mental Health	Review of maternal mental health pathway in light of new guidance	New NICE guidance has been published. It may be that funding is required at some point, but until the review is concluded this is not known.	Need to review pathway in light of new guidance
Review of EIP (Early Intervention Psychosis) service	To review the EIP service to ensure that new national targets can be met	Need to meet the EIP targets	Need to ensure we meet new EIP targets
IAPT services	Review and potential re-procurement of IAPT services	Contract for services expired and re-procurement is required	Contract has expired and we need to take a decision on procurement options.
Counselling services	Review of counselling services	Waiting times are below the new national target (6 weeks). Data reporting requirements need to be embedded in contracts	Need to meet national targets for IAPT and waiting times
Dementia prevalence and implementing the dementia strategy	Improve diagnostics and review patient pathways	Improve diagnostics of people in early stages, improve dementia treatment patient experience and health outcomes	National must do

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Priority Area	What	Why	Rationale
CAMHS Review	Review if Child and Adolescent Mental Health Services (CAMHS)	There is currently a review of CCG commissioned services underway and due for completion 31.3.15. Changes to the service may be made as a result of the review (the TEWV SDIP for 15/16 will note this and prepare the trust to receive feedback and propose changes in year)	Existing project
Crisis review - Adults	Consider the recent review of the crisis service and consider gaps in current services	Crisis Telephone Triage Service which was a recommendation of the Crisis Review. Joint funding with ND	Need to do further work to identify if any additional funding or enhancement to services is required.
Primary care CPN	Implementation of primary care based Mental Health Nurses	To better integrate primary and secondary care mental health services and reduce demand on secondary mental health services	Propose we look at this as part of the wider primary care mental health re-design model
Primary care Suicide Model	Review and potential expansion of the current pilot in Sedgefield	Reduce suicides in DDES following a recent cluster	Need to link his with the primary care CPN proposal to identify if we need to invest in both
Outpatient Review	A review of outpatient services to support primary and secondary care working together	To improve integration, transfer care closer to home and improve outcomes for patients	Existing project
Choose and Book	Implementation of E-referral system delayed until April 15 at the earliest.	Respond to changes in national guidance	National must do

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Priority Area	What	Why	Rationale
Clinical Systems Improvement (CSI)	Continued development of referral guidelines for GPs	To supportive effective clinical decision making	Existing project
Prostate pathway	Out of hospital cancer follow up in Primary care	Fully implement prostrate shared care arrangements	This has been an on-going project which requires completion
111 DOS and 111 Review and capacity	Improve range of dispositions available. Reduce referral to A&E & Urgent Care	To reduce referral to A&E and Urgent Care and work more closely with primary care	Part of the urgent care strategy action plan
GP support to paramedics	Rapid access to a GP for advice for paramedics	Reduce unnecessary conveyances to A&E	Existing project
DUCT and other transport	Service provided since February 2009. Originally 3 year contract with added 2 year extension until March 2014. Agreed to extend for further 12 months however contract needs to be formalised to prevent using non-recurrent funds year on year.	Potential efficiencies to be achieved by contract review. Needs to link into out of hours re-procurement	Existing project
Haematology - 2B services	Review of level 2 haematology services and re-design following closure of services at North Tees hospital	A medium-long term solution needs to be developed following the closure of services at North Tees	Commitment to providers develop a long term solution
Child exploitation	Funding to support multi agency work to tackle child sex exploitation	To omplement local action plns to tackle child sex exploitation	Multi agency commitment
Adult's safeguarding	Contribution to costs of adult safeguarding board	CCGs will be formally part of the membership of the Board in future	Multi agency commitment

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Priority Area	What	Why	Rationale
Lead Provider Framework	Procurement of commissioning support services - financial support for projet management	National requirement to do so before April 2016	National must do
Clinician involvement in projects	Funding for clinical input into commissioning projects e.g. CSI	Clinical input into commissioning development is crucial	To support effective commissioning processes
Enhanced activity management	Fundig for additional support for activity management processes	Secondary care activity continues to grow whereas GP referrals are decreasing	To mitigate financial over performance
Palliative and EoL Hardwycke Ward	Re-development of Hardwycke Ward	DDES has no palliative care beds within it's boundaries	EoL is a priority area. The project is ongoing
Community stroke	Review of post discharge stroke services	Commitment given following re-design of stroke services in County Durham	Commitment made to review services following redesign of stroke services in County Durham
Boilers on prescription	Pilot scheme where boilers are prescribed for patients with diseases that are exacerbated by living on cold damp conditions	To reduce demand for healthcare services	Pilot is ongoing and evaluation will be presented once it is complete
Radiology/Diagnostics	Procurement of additional diagnostics capacity.	Not consistent access to diagnostics across DDES. Waiting times have been long in some areas.	Existing project
Physiotherapy review	Review of community physiotherapy	Potential efficiencies to be achieved.	Range in provision and cost. Potential to provide in the community at a reduced cost.
Back pain pathway	Nice Guidance - implementation and roll out of lower back pain and radicular pain pathway	Northern Forum agreed this project	Agreed by Northern Forum

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Priority Area	What	Why	Rationale
Trauma Rehabilitation	Gaps in rehabilitation following major trauma	Gaps in current pathway identified. Business case has been produced by NuTH	It was previously agreed that trauma rehabilitation services would be reviewed following establishment of Major Trauma Centres
Ambulatory care pathways	Review potential to expand ambulatory care County Durham and Darlington NHS Foundation Trust have implemented RAT & Ambulatory Pathways in ED at DMH & UHND from April 2014	To enable ambulance crews to arrange direct admissions	Existing project, links to urgent care review, potential QIPP
	Funding for 3 Locality Health Networks		Continuation of existing service
Learning Disabilities inc Winterbourne	Eye care in the community. Specifically for patients with learning disabilities from the age of 14.	Pilot scheduled for review in August 2015. Decision then required about the future of the service.	

APPENDIX 3

North Durham CCG Commissioning Intentions List 2015/16

PRIORITY AREAS		AIMS TO BE ACHIEVED BY MARCH 2016
1. UNPLANNED / EMERGENCY CARE		**CLINICAL LEAD - Dr JAN PANKE**
1a	Resilience Planning - Winter Pressures	Resilience plans agreed through the County Durham and Darlington System Resilience Group
2	QE Gateshead	Agree divert policy and commission additional bed capacity within GHFT Urgent and Emergency Care Centre
3a	Urgent Care model	Continue to support the minor injuries service (in Hours) at Shotley Bridge
3b		Renegotiate urgent care tariff (in hours activity)
3c		Update of the 111 Directory of Services
3d		Re-procurement of out of hours service
3e		Complete review of Durham urgent Care Transport (DUCT). Agree and implement in year changes to contract
3f		Further roll out 111 remote booking of practice appointments
3h		Review unplanned discharge transport service through decommissioning policy

2. FRAIL ELDERLY		CLINICAL LEAD - Dr Neil O'Brien
1a	Frail Elderly – Primary care	Design and implementation of the primary care services pathway to focus on care planning for high risk/vulnerable patients
1b	Frail Elderly – Secondary care	Redesign/integration of the secondary care services pathway to provide a front of house rapid assessment service
1c	Frail Elderly – Nursing homes	Design and implementation of one GP – one community matron – one care home, community matrons aligned to GP practices
2	Intermediate Care +	Implementation of phase 1-3 (double running services, de-commissioning previous services, bringing online new service).
3	Home Equipment Loans Service	Procurement and implementation of service
4	Wheelchair Services	Procurement and implementation of service to reduce waiting times and quality of service
5	Post Diagnosis Support	Improve Dementia Services to provide support to patients diagnosed with dementia

3. END OF LIFE CARE		CLINICAL LEAD - Dr PHILIP LE DUNE
1a	Keeping People at home (Palliative Care Consultant and Middle Grade Doctors)	Recruit to additional wte palliative care consultant and current vacant post; Recruit additional middle grades doctors to support palliative care services
1b	Specialist Lymphedema service	To have service in place for North Durham
2	Palliative/End of Life Strategy	Continued Implementation of the Palliative / End of Life Care Strategy
3	Palliative Care in Primary Care	To confirm whether Local Quality Premium for palliative care registers can be continued into 2015/16 to support continued momentum and service improvement.
4	Rapid response teams CDD (palliative care)	Full service review to commence February 2015 to provide CCG with overall picture of what the service would look like this will then form the basis for procurement

4. PRIMARY CARE		CLINICAL LEAD - Dr NEIL O'BRIEN (Dr David Graham)
1a	Primary Care Co Commissioning	GP Weekend Opening (Summer 2014 and winter Federated practice Model) – Review and consider continuation of scheme and focus of the scheme
1b		Enhanced Services (Phase 1 and 2 reviews) - Decommission Insulin Initiation, Continue Near Patient Testing, Reduce Minor Injuries spec
1c		Enhanced Services - Shared Care: Prostate Cancer Follow up - Review current numbers on Shared Care Prostate Cancer Follow up Scheme
1d	Primary care outcomes scheme	Review and agree plans for year 2 Evaluate the impact of the Scheme
2	Clinical Support Information	Expecting any clinical areas outstanding from 14/15 to be completed, plus 6 new areas, plus 3 month reviews of existing guidelines
3	Primary Care Strategy Implementation	Develop and implement Primary Care Strategy

5. MENTAL HEALTH		CLINICAL LEAD - Dr RICHARD LILLY
1	Continence (MH Patients)	
2a	No Health without Mental Health - Implementation of the National Strategy priorities for 2015/16	Re-commission IAPT services
2b		Counselling Service Improvements - new spec
2c		Mental Health Navigator Model
2d		Improved ambulance response times for Mental Health Patients
2e		Parity of Esteem - develop and implement CQUIN re physical health checks for people with Mental Health issues
2g		Care Crisis Concordat - Implement national and local requirements defined by the Crisis Care Concordat
2h		Place of Safety (Adults and Children) – NFR in place to provide crisis resource in terms of places of safety – need to evaluate – further funding likely to be required.
2i		service review of respite and recovery services
3a	Continuous improvement of Mental Health Services	Review of EIP services and requirement for additional resource following end of resilience funding
3b		Psychoanalytical Therapy service review
4	Child & Adolescent Mental Health Services (CAMHS)	Review of service and production of new interim strategy and final strategy

6. LEARNING DISABILITY		CLINICAL LEAD - Dr CHANDRA ANAND
1a	Transforming Care	Enhancement of Community Based Adult Learning Disability Service (TEWV 2 yr pilot)
1b		Increase Provision of Integrated Community Based Housing Support for Complex Cases
1c		Commissioning plan developed to support recommendations from Care and Treatment Reviews.
1d		Commissioning plan developed to support discharges from offender health (early mapping)
2	Improve Health Services for People with Learning Disabilities	Additional Support to Primary Care to improve uptake of AHC/HAPs - including awareness training around reasonable adjustments

7. DIABETES		**CLINICAL LEAD - Dr PATRICK OJECHI**
1a	Develop a Community Based Model of Care for Diabetes	Design and implement community based model of care for diabetes
1b		Continue to develop and roll out education programme for primary care
1c		Improve uptake and delivery of structured education for high risk and newly diagnosed diabetics
1d		Improve care planning and self-management
2a	Review of Podiatry Specification (all elements)	Review of Podiatry Specification
2b		Decommission / extension of AQP Podiatry contracts

8. 'OTHER PROJECTS'		
1	Increase roll out of personal health budgets	Commission additional CHC capacity to maintain delivery of personal budgets throughout 15/16
1b		Develop a service model to provide ongoing support the delivery of personal health budgets - including expansion to childrens / SEND
2a	Demand Management	O/P Review Programme - Reducing outpatient appointments to gain efficiencies and productivity
2b		Demand and Activity Management
2c		Black Box Medical pilot
3a	Cardiology Diagnostics	Re-evaluation of ECG interpretation service
3b		Develop clear pathways for cardio diagnostics - including ECG interpretation, Echo and Holter monitoring
4	Obesity - Community Tier 3 Weight Management Service (Adults)	Continue current interim service. Implement revised service following agreement of regional specification for tier 3 and 4 services.
5	Breast service review	Recommendation following provider review to reduce breast services from 4 to 2 sites. Continue to work with provider to minimise impact on patients and maximise quality and outcomes.
6a	Childrens services	CAMHS Review
6b		SEND Reforms
6c		Post diagnostic support - autistic children

APPENDIX 4

DRAFT QUALITY PREMIUM 2015/16

1.0 Background

The Quality Premium is intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities. The value is equivalent to £5 per head of a CCG's population. This is approximately £1.2m for North Durham CCG and £1.4m for Durham Dales, Easington and Sedgefield (DDES) CCG.

Each CCG is required to publish an explanation of how it has spent a quality premium payment.

The CCG achieves funding for achievement of improved performance for key areas. There is a corresponding deduction for non-achievement of the following four constitutional standards:

- maximum 18-week waits from referral to treatment,
- maximum four-hour waits in A&E departments,
- maximum 14-day wait from a urgent GP referral for suspected cancer, and
- maximum 8-minute responses for Category A red 1 ambulance calls (overall provider performance)

This effectively means there is a 25% deduction of quality premium funding for each constitutional target failed.

The quality premium guidance is updated annually. This guidance sets out the measures for 2015/16 and the levels of improvement for CCGs to achieve in order to qualify for the quality premium. It includes the actions to be taken by CCGs with Health and Wellbeing Boards and NHS England local NHS England teams to agree measures to be selected from menus, local measures and levels of improvement in preparation for 2015/16.

CCGs are able to set their own quality premium indicators although work has been done to align the selection across DDES CCG and North Durham CCG (ND CCG) as both CCGs form the County Durham Unit of Planning.

2.0 2015/16 Guidance

2.1 Nationally mandated indicators

There are two nationally mandated indicators which are:
Reducing potential years of lives lost through causes considered amenable to healthcare - 10% of total funding available
The target improvement is (TO BE ADDED)
Improving antibiotic prescribing in primary and secondary care - 10% of total funding available
The target improvement is (TO BE ADDED)

2.2 Urgent and emergency care pick list

This indicator(s) is worth 30% of the total funding available.

There is a menu of measures for CCGs to choose from which must be agreed by the Health and Wellbeing Board. The CCG can select one, several, or all measures from the menu (below) and also the proportions of the 30 per cent that is attributed to each measure.

1. Reduction in emergency admissions (composite measure)
2. Reduction in delayed transfers from care
3. Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays.

It is proposed that the CCG selects one indicator as below with the full value attributed to this indicator:

'Reduction in delayed transfers from care'

This indicator links to a number of key projects such as the intermediate care plus pilot, vulnerable adult wrap around services (VAWAS) schemes and frail elderly. There has also been a real focus between commissioners, providers, the local authority and other partners to improve performance for this indicator.

2.3 Mental health pick list

This indicator(s) is worth 30% of the total funding available

There is a menu of measures for CCGs to choose from which must be agreed by the Health and Wellbeing Board. The CCG can select one, several, or all measures from the menu (below) and also the proportions of the 30 per cent that is attributed to each measure.

1. Reduction in the number of patients attending an A&E department for a mental health-related need who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E.
2. Reduction in the number of people with severe mental illness who are currently smokers
3. Increase in the proportion of adults in contact with secondary mental health services who are in paid employment.
4. Improvement in the health related quality of life for people with a long term mental health condition

It is proposed that the CCG selects indicators 2, 3 and 4 with 12.5% weighting for 2 and 3 and 5% for indicators 4.

All of the indicators are challenging. Work has been done in 14/15 with the local mental health provider to reduce smoking for service users. In addition

to this the CCG has commissioned a number of pilot services such as the 'recovery college' which may help to achieve the necessary improvement around paid employment.

The target improvement is (TO BE ADDED)

2.4 Local indicators

The CCG is required to select two local measures that are worth 20% of the quality premium (10% each).

The indicators must be based on local priorities, should align to Joint Health and Wellbeing Strategy and must be agreed by both the Health and Wellbeing Board and NHS England. They should also use national data sources wherever possible.

It is proposed that the following indicators are selected:
% of patients on a palliative care register

% of patients on a diabetes or COPD register that have received a flu immunisation AND
% of patients on a COPD register that have received pneumovacc