NHS
Wiltshire
Clinical Commissioning Group

Clinical Commissioning Group Governing Body
Paper Summary Sheet
Date of Meeting: 22 March 2016

For: PUBLIC session ☒ **PRIVATE Session** ☐

For: Decision ☒ **Discussion** ☐ **Noting** ☐

Agenda Item and title:	**GOV/16/03/13 - Wiltshire CCG 2016/17 Operational Plan**
Author:	David Noyes – Director of Planning, Performance and Corporate Services
Lead Director/GP from CCG:	David Noyes – Director of Planning, Performance and Corporate Services
Executive summary:	The 2016/17 Operational Plan represents the culmination of this years planning round, which has once again been formulated by a combination of scrutiny of benchmarking and performance data, our aspiration to continue on our transformation journey to achieve the new model of care set out in our 5 year strategy, the input of local clinical leaders, and shared approaches with our major system partners. The plan sets out how we will achieve our three ambitions for Wiltshire in 2016/17 to: • Contain the cost of commissioned care within available resources • Continue to manage down growth in non elective activity and restrict growth in planned care whilst investing in primary care • Meet constitutional targets By achieving these ambitions we will also: • Meet the nine “must do’s” set out in the 2016/17 planning guidance • Improve health outcomes for people in Wiltshire The plan also represents the first stage of our Sustainability and Transformation plan.
Evidence in support of arguments:	National and regional data benchmarking utilised throughout the formulation of the plan, performance trends, financial data and consultation with clinical leadership at each stage.

Who has been involved/contributed:	Engagement across the CCG groups/localities, and liaison with colleagues within Wiltshire Council (Public Health & Social Care), provider partners and co-Commissioners.
Cross Reference to Strategic Objectives:	To deliver strategic plans which address the needs of the local population and involve patients, practices and partners.
Engagement and Involvement:	Engagement with Council colleagues, NHSE, neighbouring CCGs; emergent findings were shared at CCG Stakeholder day and directly with stakeholders via regular engagement with Director leads.
Communications Issues:	We will need to include the major themes in our enduring communications with our population
Financial Implications:	Enactment of the plan is required to ensure that the CCG remains in a financially viable position.
Review arrangements:	Ongoing via Integrated Performance Report
Risk Management:	This addresses the CCG identified risk regarding the delivery of QIPP and long term financial viability
National Policy/ Legislation:	Coherent with the Five Year Forward View and the emergent STP requirements
Equality & Diversity:	Equality Impact Assessments will be required for each project arising, as is the standard requirement imposed by the rigour of the Programme Management Office.
Other External Assessment:	Progress with and delivery of CCG plans is regularly monitored by NHS England Area Team
What specific action re. the paper do you wish the Governing Body to take at the meeting?	It is recommended that the Governing Body: • Agree the Plan. • Note that significant scoping work on the programmes described within the Annual Plan has been achieved, and we now need to focus on mobilisation in order drive delivery.

NHS
Wiltshire
Clinical Commissioning Group

Wiltshire CCG

2016/17 Operational Plan

Working Draft

15 March 2016

Contents

EXECUTIVE SUMMARY

Our Operational Plan for 2016/17

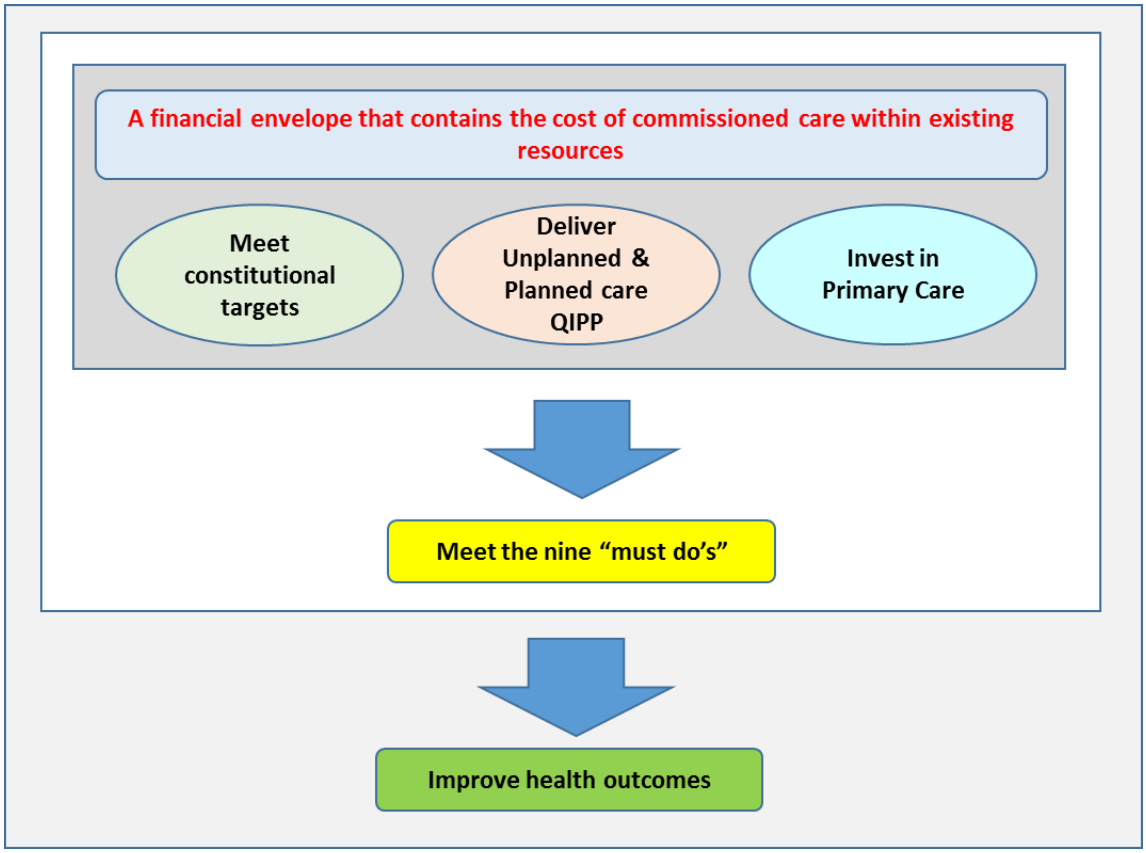
Our operational plan sets out how we will achieve our three ambitions for Wiltshire in 2016/17 to:

- Contain the cost of commissioned care within available resources
- Continue to manage down growth in non elective activity and restrict growth in planned care whilst investing in primary care
- Meet constitutional targets

By achieving these ambitions we will also:

- Meet the nine "must do's" set out in the 2016/17 planning guidance
- Improve health outcomes for people in Wiltshire

Our plan will deliver our ambitions and improve health outcomes



Containing the cost of care within available resources

We have developed a financial plan that offers our providers a fair share of the increase in resources we have received for 2016/17. Our capacity planning shows that this will fund sufficient activity required to meet the standards of the NHS constitution.

Our approach of offering 1% growth will incentivise reductions in demand and activity so the CCG is in balance and will help the system as a whole return to balance, thereby helping to address the financial sustainability challenge.

Meeting constitutional targets

We are fully committed to meeting the targets set out in the NHS Constitution in 2016/17. We have identified the risks to achieving the standards and are working proactively with providers to develop, putt in place and execute plans that will ensure the standards are achieved in 20161/7.

Our plans will ensure we meet the NHS Constitution standards in 2016/17

Standard	2016/17 plan	How the standard will be met
Get back on track with access standards for A&E and ambulance waits	We plan to meet these standards during 2016/17, recognising that A&E and Red 2 are the biggest risk areas	These risks are being addressed through remedial actions in RUH and GWH for A&E standards and with SWAST for ambulance performance
Improvement against and maintenance of the standards for RTT	We plan to meet these standards during 2016/17	For the RUH, this will be delivered by the middle of 2016/17 through remedial actions We will continue our ongoing monitoring of the position at GWH and if necessary, shift activity to alternative providers with available capacity to help achieve this target during 2016/17
Deliver the NHS Constitution 62 day cancer waiting standard	We plan to achieve these standards in 2016/17 and have a history of delivery of the constitutional standards quarterly measurement	Although we have experienced pressure on endoscopy, referral growth and identified a risk around breast cancer at RUH, we are working closely with providers to manage these and expect the standards to be met

Delivering QIPP in Planned and Unplanned care

We have developed a range of QIPP plans in Planned and Unplanned care that are aligned with the first two of our three ambitions for 2016/17 and will deliver improved care in Wiltshire. These initiatives are also aligned to transformational change plans that will be delivered not just in Wiltshire, but across the wider BSW footprint.

Our QIPP schemes will deliver a range of improvements in Planned and Unplanned Care

Care area	Action area	Impact
Planned Care	MSK Outpatients Ophthalmology Advice & Guidance Cardiology	Reduce over intervention, unnecessary or inappropriate treatment Deliver more care in Out Of Hospital settings instead of through acute bed based treatment Improve the interface between primary and secondary care to improve the appropriateness of referrals
Unplanned Care	Rapid support close to home in crisis Strengthening community admissions avoidance Enhanced community team led case management and intervention Targeted referral management and communications	Reduce Delayed Transfers of Care Increase the range and scale of Out Of Hospital care to avoid secondary care admissions and facilitate faster discharge from secondary care when secondary care is the appropriate care setting Improve community led case management to use existing Out Of Hospital capacity and resources optimally and avoid using secondary care bed capacity

Investing in Primary Care

From 2016/17 we will invest in Primary Care through our Primary Care Offer - a three year programme to transform the commissioning, and delivery of primary care services.

The Primary Care Offer will move us towards "place based commissioning" to deliver the CCG vision of integrated out of hospital services by supporting the development of locality working to deliver primary care services at scale.

Meeting the nine "must do's"

Part of our actions to meet the nine "must do's" set out in the 2016/17 planning guidance relate to Mental Health and our plans to improve access and the services themselves.

We are also implementing actions to improve Mental Health access and services

Action area	Plan for 2016/17
Achieve and maintain the two new mental health access standards	We expect to meet the required standards in 2016/17. We have implemented actions to improve early intervention in psychosis and a new IAPT service model with a centralised booking service. Our dementia diagnosis rate has improved significantly and we continue to target practices that have a low rate of diagnosis.
Deliver actions set out in local plans to transform care for people with learning disabilities	The Wiltshire Learning Disability Intensive Support Service went live in November 2015 and will deliver benefits in 2016/17 including rapid response through 24/7 cover, avoiding inpatient admissions and reducing lengths of stay

The actions discussed above combined with our development work on the Sustainability and Transformation Plan (STP) means we will deliver the required nine "must do's".

Improving health outcomes

The actions in our 2016/17 Operational Plan, together with the wide range of collaborative and other programmes undertaken with our colleagues in Public Health, will also help improve the health outcomes of people in Wiltshire.

The three major improvements in health outcomes that we anticipate are:

- **Outcome 1** –
- **Outcome 2** –
- **Outcome 3** -

How our Operational Plan relates to the Sustainability and Transformation Plan to 2020/21

This operational plan forms year one of the five year Sustainability and Transformation Plan (STP) which is being developed for the BSW (BaNES, Swindon and Wiltshire) footprint. We will deliver the STP at the end of June by working closely with commissioning partners in BSW.

Whilst we will work at scale across BSW to transform services and care delivery over the five year horizon of the STP, we are focusing on four Wiltshire planning themes in 2016/17 to deliver our local ambitions in Wiltshire. These four themes include integration of care as a key element of service development in the initial stages of moving towards an ACO structure:

- Urgent care
- Planned care
- Growing Primary care
- Integrating community health and social care at scale across Wiltshire

We will work with partners to mitigate risks and successfully deliver our plan

We recognise that there are financial and service risks within our plan. We will work closely with partners across the Wiltshire care system as well as the wider BSW footprint to mitigate these risks and successfully deliver our 2016/17 operational plan.

We believe that our success will improve the health and wellbeing of people in Wiltshire and begin our five year journey within Wiltshire and across BSW to:

- Close the health and wellbeing gap
- Drive transformation to close the care and quality gap
- Close the finance and efficiency gap

Status of this plan

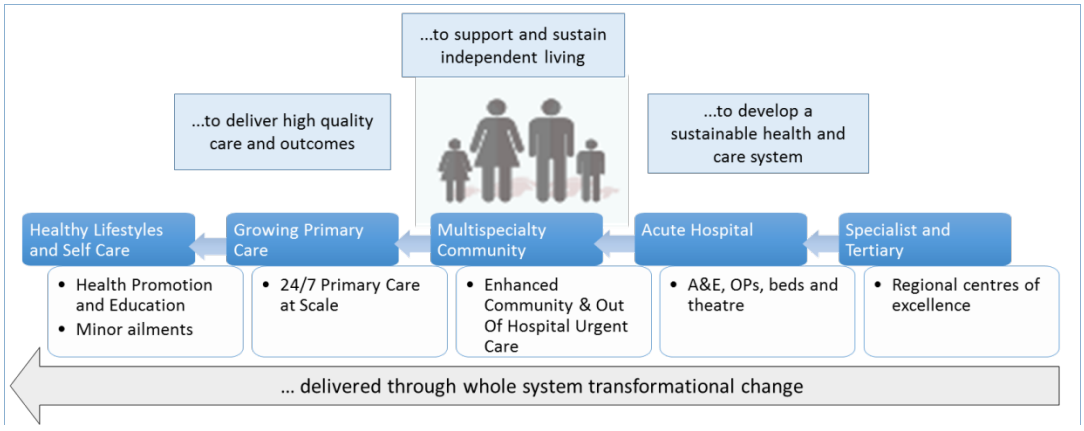
Our plan was agreed and signed off by the Governing Body on 22 March 2016 – on the agenda (KLOE A11)

How our plan is aligned with the objectives of the health economy and will deliver year one of the 5 year STP (KLOE A12)

Our aims and vision

1. Wiltshire CCGs vision is that Health and Social Care services in Wiltshire should support and sustain independent healthy living based on three principles:
   - People are encouraged and supported to take responsibility for, and to maintain/enhance their well-being
   - Equitable access to a high quality and affordable system, which delivers the best outcome for the greatest number
   - Care should be delivered in the most appropriate setting, wherever possible at, or close to home:
     - Where acute care is one-off or infrequent, there should be formal and rapid discharge
     - Where care is on-going (e.g. chronic conditions) the default setting of care should be primary care
2. The three commissioning partners within the BSW footprint (BaNES, Swindon and Wiltshire) have each developed compelling visions to meet local needs. There is a high degree of congruence in the visions of the three commissioning partners in BSW, which is reflected in the emerging shared vision for the BSW footprint.
3. Common across the three areas is the desire to deliver high class quality and outcomes for patients through promoting good health and independence, person centred care, plus targeted preventative services whilst offering safe and effective health and care services that reduce the need and dependency for hospitalisation.
4. Partners in BSW recognise that the goals of the Five Year Forward View (FYFV) and the need to work effectively across BSW requires us to develop a compelling shared vision which will drive future working across the footprint, that will be completed by June and set out within the Sustainability and Transformation Plan (STP.
5. This process will be led by the STP Leaders Group, which includes the senior leaders of commissioning and provider organisations across BSW.
6. This Operational Plan therefore reflects and continues to operationalise the current Wiltshire CCG strategy. Because the strategies of the three commissioning partners within BSW are closely aligned, our Operational Plan will also be aligned to the STP.
7. We have already begun to develop a shared vision, which is shown below. This draft will be further refined, socialised and agreed in the coming weeks as we formulate the STP.

We are developing a shared vision for BSW



8. Our vision has been designed and structured to address the triple aims of:

   - Closing the health and wellbeing gap
   - Driving transformation to close the care and quality gap
   - Closing the finance and efficiency gap

Our vision will be brought to life through the STP

9. The STP will set out how we will transform care at scale across BSW by 2021. We recognise that the STP must:

   - Be the product of genuine co-production from across the BSW system. This is the only way that the STP will encompass both the scale of change and ownership which is required.
   - Be delivered at pace and meet the timetable for development and submission. Therefore, there is a need for intensive effort and prioritisation. The leaders across BSW are committed to developing a compelling STP which meets the needs of BSWs population and which will be judged as a plan which deserves support and which should move swiftly to implementation to achieve the required level of transformation.
   - Maintain and improve current service delivery. In this context we are planning to achieve both of these objectives and to ensure that the STP is clearly linked to our local Operational Plans.

We will transform care delivery across the BSW footprint

10. The combined total population for the agreed catchment is in the region of one million people and a joint health commissioning budget in excess of £960million. This is the whole health budget and does not include the social care and public health budgets. Work is required to identify the system budget for the pathways in scope.

11. We recognise the need for flexibility and that some plans will involve organisations outside our footprint e.g. planning and delivery partnerships/networks built on specific need and dependent on population need, demand, capacity and geographical complexities.

12. This work should include physical health and mental health, including 111, OOH, primary care, integrated community health and social care services, ambulance services and the acute sector.

13. In achieving systems alignment we will map the balance of 'local' and 'at scale' priorities based on the following workstreams and areas:

   - Prevention and self care
   - Long term conditions, frailty and the elderly
   - Maternity and Paediatrics
   - Mental Health and Learning Disabilities
   - Planned and specialist care
   - Urgent and emergency care
   - The digital road map/interoperability
   - Engagement

14. Planning and delivery would build on the following groupings:

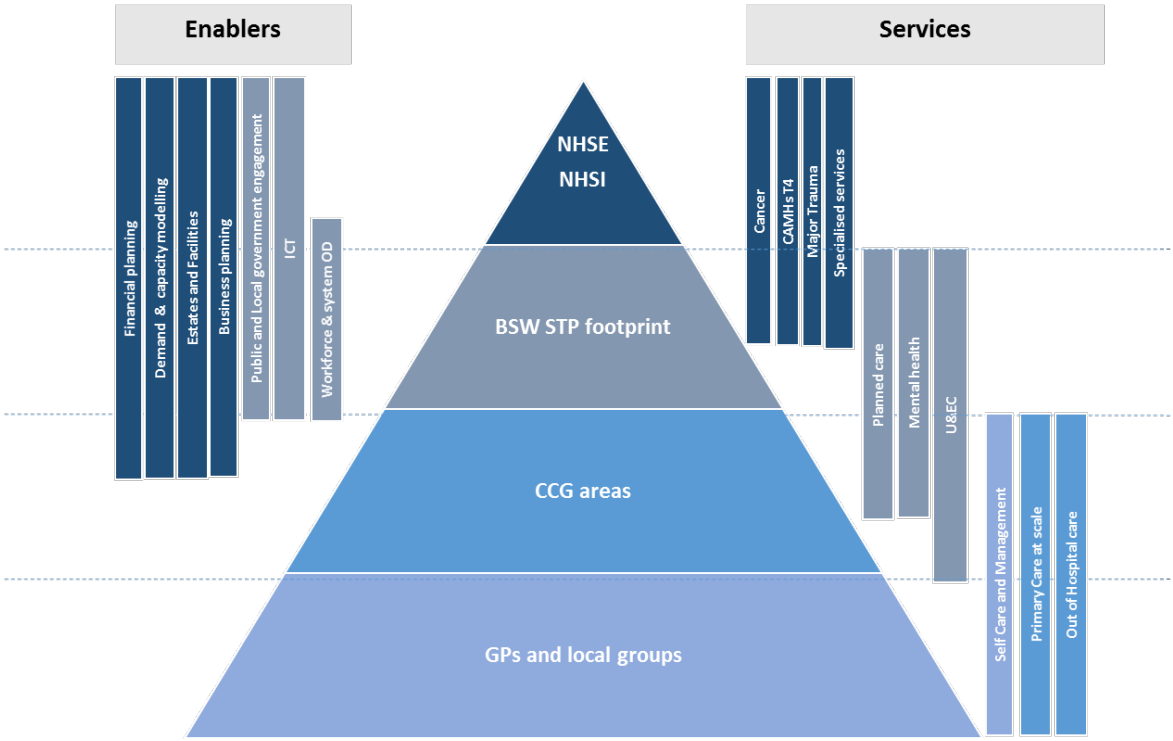
- GP practices and localities
- CCG wide
- BaNES, Swindon and Wiltshire
- Larger footprint with NHSE and NHSI where indicated e.g. more specialised services and mental health

We will work at scale across BSW

15. The diagram below illustrates how 'local' and 'at scale' priorities will be addressed across BSW, highlighting the services and enablers at different levels of the footprint.

16. This Operational Plan will highlight the specific areas that will be implemented in 2016/17 forming Year 1 of the STP, aligning with footprint level objectives and plans that encompass the whole of BSW.

How we'll work at scale across the BSW footprint



How this Operational Plan forms year one of the STP

17. Through the initial stages of developing the STP, the three partners identified Urgent & Emergency Care and Planned Care, along with a series of enablers as the first areas that should be planned and delivered at scale across BSW. These transformational plans will be underpinned by the expansion of integrated Health and Wellbeing services and Primary Care at scale, and taking advantage of the opportunities available through the new arrangements for community services.

18. This approach reflects the emerging BSW vision and existing CCG strategies, which demonstrates that the Operational Plan and the STP are aligned.

19. The three BSW partners have begun to develop detailed footprint wide plans that encompass the key transformational areas and the enabling activities that underpin them.

20. As we continue to jointly develop the STP, we will complete the more detailed plans that set out the actions and milestones for each of the "at scale" priorities and the workstreams that facilitate their implementation across the footprint.

21. This detail will be included in the STP which is scheduled to be completed by June 2016.

Risks, constraints and mitigations

22. Our work with system partners in BSW has identified a number of risk and constraints relating to our developing STP. This assessment is part of a range of actions to develop and implement the STP whilst ensuring that the Operational Plan for 2016/17 is integrated seamlessly into the STP.

23. As our plans for the footprint mature, we will continue to identify risks and constraints as well as formulating and implementing mitigating actions, so the plans are implemented successfully.

How we will address the risks and constraints we have identified

Area	Risk/constraint	Mitigation plan
Capacity and capability to deliver	There are considerable resource requirements associated with delivering a programme of Transformation at this scale. Sufficient organisational capacity across the footprint will be a key determinant of the likelihood of successful changes in the Urgent and Planned Care models Clinical leadership and change capabilities will determine not only the legitimacy of the models developed but the likelihood of improvements being sustainable in the longer term.	One of the first priorities for the STP process is to identify and put in place the capacity and capability required to implement planned initiatives in the short to medium term A key area of focus will be the development of strong clinical leadership and clinical buy in across both primary and secondary care for each of the transformational initiatives
Challenge in reaching common language and goals	We have already identified differences in the definitions of discharge criteria, clinical assessment, clinical diagnosis , performance and quality indicators These are just a few of the areas where inconsistent language and goals may affect the chances of successful collaboration	The STP Leaders Group and programme teams will work collaboratively to quickly develop common definitions and a common understanding which will support collaboration and the implementation of the shared vision going forward
Constraints in contracts and facilities	The duration of some major contracts and facilities leases may affect the ability of the system to mobilise rapidly to make significant change in the shorter term	We will identify quick wins and pilot schemes that can be adopted in the short term with a clear longer term road map in place to deliver the wider scale changes across the BSW footprint
Changes in national priorities	It is unlikely that national priorities will move away from the principle outlined in the FYFV and Strategic Planning approach Learning from early adoption of new models of care such as the Urgent Care Vanguards may lead to shifts in thinking around care approaches and the design of care models, which supersede the plans set out in the STP	Partner organisations may have to be flexible in their application of the principles in the FYFV, should the local or national political environment change Urgent Care and Planned Care will continue to be the principal areas of focus, so we will need to take account of learning, experience and innovations that may affect the design of new models we develop and implement through the STP

The key health economy issues (KLOE A1.1)

24. There are four key issues in the Wiltshire health economy. To address these issues, we have structured our 2016/17 plans around three local ambitions for 2016/17 that will deliver high quality care for people in Wiltshire.

Health economy issues and our local ambitions

Health economy issues	Three local ambitions for 2016/17
a) **Overtrading** - we are spending more money than is or will be available; the cost of the system is greater than the income available b) **The need to reduce demand** - the system delivers care which is not always appropriate or necessary so we need to focus our resources on care that delivers good outcomes c) **Changing the care that is delivered** - care at home or the community is an affordable, safe and effective alternative to inpatient care in hospital d) **Overall costs need to fall** - this means that fewer people will be employed to deliver care in the future; in the acute sector this means fewer beds and fewer heads	a) Contain the cost of commissioned care within available resources b) Continue to manage down growth in non elective activity and restrict growth in planned care whilst investing in Primary Care c) Meet constitutional targets

How our plan meets local requirements, (KLOE A3)

25. This operational plan builds on a layered structure of planning and delivery as described above. It initiates the first phase of the five year strategic plan by embedding the initial local improvement outcomes through joint transformation plans and contracts with providers.

26. Our three local ambitions for 2016/17 will be achieved through four planning themes. These planning themes align with the emerging STP, confirming again that our operational plan for 2016/17 will align with the STP.

Our planning themes are designed to deliver our three local ambitions for 2016/17

Three local ambitions	Four planning themes to deliver the local ambitions
a) Contain the cost of commissioned care within available resources b) Continue to manage down growth in non elective activity and restrict growth in planned care whilst investing in Primary Care c) Meet constitutional targets	a) Urgent care b) Planned care c) Growing Primary care d) Integrating community health and social care at scale across Wiltshire

27. Our plan also aims to create a new outcome baseline embedded in contracts for acute hospital planned care, emergency care, access and recovery. These development themes are focused on Wiltshire and its localities.

The level of ambition described in the plan (KLOE A13)

28. The table below highlights how our operational plan for 2016/17 has been developed to meet our three local ambitions.

How we meet our three local ambitions

Three local ambitions	How met
Contain the cost of commissioned care within available resources	We have developed a financial strategy that maximises the resources we allocate to providers and remains within available resources, whilst incentivising transformation of care delivery in Wiltshire
Continue to manage down growth in non elective activity and restrict growth in planned care whilst investing in Primary Care	The levels of growth in 2015/16, together with the actions taken to date and within our plans will continue to dampen down demand. We judge 1% annual activity growth set out in our activity and financial plans as sufficient and deliverable in 2016/17. Our transformational initiatives in both unplanned and planned care supported by a range of QIPP schemes will also improve efficiency in the delivery of care
Meet constitutional targets	We will work with our providers to implement our plans and commission sufficient activity to meet constitutional targets, where necessary using capacity across the system to reduce pressure in particular providers and specialties

29. The following sections of our operational plan show that:

- The financial implications of our three local ambitions have been addressed through our financial plans (KLOE A1.2)
- How we will continue to proactively address problems in meeting RTT and other constitutional targets

30. The scale of change required to meet these plans is more ambitious than that delivered previously, but we are confident that our plans and supporting processes are robust enough to deliver the requirements (KLOE 13).

Meeting the financial and non financial requirements of the national planning guidance (A2.0/A2.01)

How we meet the financial requirements

31. There are a range of financial requirements set out in the planning guidance. These are summarised in the table below, confirming that we meet all the requirements.

Summary of 2016/17 financial requirements and how we meet them

Requirement	How met
Reconcile finance with activity and where a deficit exists, set out clear plans to return to balance	We have reconciled recurrent activity plus new and non recurrent activity pressures and matched these to available financial resources. Our approach of offering 1% growth will incentivise reductions in demand and activity so the CCG is in balance and help the system return to balance
Set out planned contribution to efficiency savings	Our plans for efficiency in acute pathways (£2.9m) and primary care prescribing (£1.9m) contribute to improving system efficiency – more detail is set out in the section on QIPP

Requirement	How met
Deliver a cumulative reserve (surplus) of 1 percent. If unable to meet the cumulative reserve (surplus) requirement must deliver an in-year break-even position.	Our plans show we will deliver the required 1% surplus
Plan to drawdown all cumulative surpluses in excess of 1 percent over the next three years	There are no cumulative surpluses over 1% to draw down
Plan to spend 1 percent of the allocations non-recurrently, consistent with previous years. The 1 percent non-recurrent expenditure should be uncommitted at the start of the year	We have included this 1% non recurrent spend within our plans and the expenditure has not been committed at the start of the year
Hold an additional contingency of 0.5 percent, again consistent with previous years	This additional 0.5% contingency has been included within our plans
CCGs and councils will need to agree a joint plan to deliver the requirements of the Better Care Fund (BCF) in 2016/17. BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care	We have a well developed joint approach to BCF and explicit plans to support reductions in unplanned admissions and delayed transfers of care
Commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase.	Our investments in mental health will match or exceed the increase in our allocation

How we meet the nine "must do's"

32. The table below summarises the actions put in place which will help us meet the nine "must do's". In a number of areas, our actions in 2015/16 provide a solid platform for delivery in 2016/17.

33. Appendix A shows the trends in performance against the constitutional standards over time and Appendix B provides a more detailed overview of how we meet each of the nine "must do's".

Summary of how we meet the nine "must do's" for 2016/17 (KLOE A2.1 to A2.9)

"Must Do" from guidance	How this is met by our plan
Develop a high quality and agreed STP, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View.	We have worked closely with BaNES CCG and Swindon CCG to confirm our footprint and create a plan to develop credible STP. The STP will demonstrate how our plans and actions achieve the triple aims. We have identified the key development areas, demonstrating that this operational plan is aligned with the STP and delivers year 1 of the five year STP – to be completed by 11 April submission
Return the system to aggregate financial balance	Work has been on-going, via the health delivery group, to bring providers and commissioners together to ensure that the health economy works as one to meet the sustainability challenge that we face. Our financial plan develops provider envelopes by utilising recurrent outturn positions, adjusting for inflation and growth, to ensure that a sustainable level of activity is commissioned, which remains within available resources set out in the 2016/17 allocations. The next stage of this is to evaluate provider capacity and to realign commissioned activity levels across our system where capacity constraints exist – ***to confirm position in April submission***.

"Must Do" from guidance	How this is met by our plan
Develop and implement a local plan to address the sustainability and quality of general practice	This will be delivered from 2016/17 through our Primary Care Offer - a three year programme to transform the commissioning, and delivery of primary care services. Through the Primary Care Offer we will move towards "place based commissioning" to deliver the CCG vision of integrated out of hospital services by supporting the development of locality working to deliver primary care services at scale.
Get back on track with access standards for A&E and ambulance waits	We plan to meet these standards during 2016/17, recognising that A&E and Red 2 are the biggest risk areas. These risks are being addressed through remedial actions in RUH and GWH for A&E standards and with SWAST for ambulance performance
Improvement against and maintenance of the standards for RTT	We plan to meet these standards during 2016/17. For the RUH, this will be delivered by the middle of 2016/17 through remedial actions. We will continue our ongoing monitoring of the position at GWH and if necessary, shift activity to alternative providers with available capacity to help achieve this target during 2016/17
Deliver the NHS Constitution 62 day cancer waiting standard	We plan to achieve these standards in 2016/17 and have a history of delivery of the constitutional standards quarterly measurement. Although we have experienced pressure on endoscopy, referral growth and identified a risk around breast cancer at RUH, we are working closely with providers to manage these and expect the standards to be met
Achieve and maintain the two new mental health access standards	We expect to meet the required standards in 2016/17. We have implemented actions to improve early intervention in psychosis and a new IAPT service model with a centralised booking service. Our dementia diagnosis rate has improved significantly and we continue to target practices that have a low rate of diagnosis.
Deliver actions set out in local plans to transform care for people with learning disabilities	The Wiltshire Learning Disability Intensive Support Service went live in November 2015 and will deliver benefits in 2016/17 including rapid response through 24/7 cover, avoiding inpatient admissions and reducing lengths of stay
Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures	We have clear expectations on quality which are managed through quality schedules in contracts and ongoing work with co-commissioners and providers. Our key focus in 2016/17 will be on mortality and reduction of avoidable mortality

34. Wiltshire has strong links with our Armed Forces and we recognise that the relocation of service personnel back to the UK in the coming years will have an impact on the care we provide and therefore forms part of our medium term thinking. We are also aware of the circumstances and needs of veterans and developing care services to meet their specific needs.

Is the financial plan aligned to expectations? (KLOE A4)

Financial context

35. In November 2015 we drew up our Financial Recovery Plan because financial projections, including existing mitigations, showed that the CCG would only deliver £0.7m of the £5.5m surplus required by NHS business rules. The FRP identified additional gross savings of £2.8m, above those already being actioned, that would be delivered by 31 March 2016 to address the in year gap.

36. Our current projections show that we will achieve at least a £3.3m surplus and if the risks we are currently managing are fully mitigated, then it is anticipated that this position will be able to be further improved towards the required £5.5m surplus.

37. Our initial financial projections for 2016/17 showed an in year QIPP gap of £28m. The actual allocations have resulted in Wiltshire receiving £31m of additional resources, compared to the anticipated £10m. After taking into account the various preconditions, such as additional BCF funding, Mental Health Parity of Esteem and CAMHS initiatives, the QIPP gap for 2016/17 is £12.9m – this position is still subject to agreement of contractual positions with key providers.

Our approach to financial planning for 2016/17

38. Our approach to financial planning is designed to begin to address the challenges identified as part of the development of broader health system themes, namely:

- **The system is overtrading** - we are spending more money than is or will be available; the cost of the system is greater than the income available
- **We need to reduce demand** - the system delivers care which is not always appropriate or necessary so we need to focus our resources on care that delivers good outcomes
- **All parts of the system should change the care they deliver** - care at home or the community is an affordable, safe and effective alternative to inpatient care in hospital
- **Overall costs need to fall** - this means that fewer people will be employed to deliver care in the future; in the acute sector this means fewer beds and fewer heads

39. Whilst the allocations for 2016/17 have increased available resources, this should be seen against a background of an estimated financial shortfall across the BANES, Swindon and Wiltshire footprint of over £70m, which includes the RUH, GWH and SFT. Work has started to confirm the financial gap across the footprint and to support the plan for closing the shortfall.

Headlines of the 2016/17 financial plan

40. Our 2016/17 financial plan has been developed by working with providers to formulate a financial settlement that provides an equitable and practical balance between:

- Providing additional funding
- Incentivising providers to reduce activity and costs

41. The headlines of the plan are:

- A provider baseline that reflects the full recurrent outturn for 2015/16 with any fines and reduced CQUIN delivery added back into the position. This position will be inclusive of the 30% marginal rate adjustment for non-elective activity and readmissions adjustments with both being based on 2015/16 values
- A net 1.1% [CONFIRM ONCE OFFERS CONCLUDED] increase in budgets to reflect increases in costs of 3.1% (which incorporates pension increases and other mandated cost pressures) and a 2% efficiency requirement
- A further 0.7% will be added to acute providers who provide emergency services and maternity services to cover the increase in CNST costs
- A 1% increase to the recurrent outturn position to reflect demographic and non- demographic growth (recognising the application of the growth across patient types and specialties will vary). This is based on a review of activity trends over the last two years. The RTT backlog is assumed to be funded over and above this offer
- If extra activity is required over and above this cap then this will need to be delivered by improved productivity in line with the NHS transformational challenge. Work will also be focused on achieving

a sustainable level of supply and demand that is affordable and delivers the constitutional access targets – this may result in the need to reallocate where this activity is being delivered across our healthcare providers

42. This creates an overall contract sum which represents the ceiling or "cap". However, there is no "floor", so if the contract underperforms with lower levels of activity than planned, we would not reduce the amount paid. This incentivises providers to do less activity whilst delivering all constitutional targets.

43. We will work with providers to both ensure no perverse incentives are created that impact on patient access and equally that whilst patient choice remains, that this does not create overall system capacity growth. True market shifts will only be reflected where evidenced. The CCG will not fund extra activity where there has not been a comparable reduction in another setting. If evidence can be provided then variations between contracts will be made.

44. The CCG is working with providers to identify the RTT backlog. The CCG is assuming that the backlog will either be covered from within existing capacity of from headroom. If both assumptions cannot be delivered then this will represent a significant risk to the CCG and its financial plans

45. This approach is underpinned by activity planning which is discussed below so that:

- The QIPP requirement for unplanned and planned care of £2.9m is accounted for within activity plans and then into agreed financial plans
- Parity of Esteem investments and any additional activity required to meet NHS Constitution targets are include within the overall quantum of planned activity for 2916/17

Assessment of Financial Risks in 2016/17

46. The financial plan for 2016/17 has identified a number of financial risks that have been assessed as the following:

- RTT backlog is yet to be fully quantified at commissioner level by providers. The backlog is assumed to be over and above the contract proposals set out by the CCG to providers and would need to be the first call on the contingency fund (£1.7m)
- Assessment of the current QIPP schemes for prescribing and CHC have been identified a level of risk (£0.8m)
- Moving to the Maternity pathway at the RUH could result in a financial risk as the current modelling is only able to forecast on 4 months data (£0.1m)
- Should the national policy position contained in the NHS contract for readmissions be renegotiated then the CCG would lose an income stream for funding reablement services which is embedded into the BCF (£1.7m)
- At the point of reporting the difference between the provider start points compared to the proposals provided by the CCG cannot be mitigated (£5m)

47. In summary the gross risks identified in the financial plan are £16.1m with a risk adjusted value of £9.7m being currently identified. Of this risk £2.9m can be mitigated from the application of the 0.5% contingency leaving a residual risk of £687m. If these risks came to fruition then this would result in a deficit of £0.9m given that the 1% headroom cannot be accessed by the CCG.

Activity plans

Growth assumptions and additional activity (KLOE A5)

48. Our activity planning process is aligned with our financial planning assumptions:

- The start point is the recurrent forecast outturn for 2015/16 based on month 8 year to date activity. This will be updated in the final plan using month 9 activity
- An uplift for population growth – this is based on increases in practice list size, which is larger than the ONS projections. Increases in practice list size reflect local population changes more fully than ONS projections
- An aggregate 1% growth has been added to the overall forecast outturn
- Within the aggregate 1% growth, we have recognised that there are areas where there will be additional growth, for example the two week wait for cancer referrals, where we are modelling 9.3% growth due to current growth patterns, cancer awareness campaigns and NICE referral guidelines

49. Although we have planned for additional cancer referrals, experience has shown that the increase in referrals is driven by primary care and is not reflected in a parallel increase in the incidence of cancers and requirement for treatment. This will therefore mitigate the impact of increased referrals on the level of secondary care treatments.

50. Our projections therefore start with an agreed baseline and with a net uplift of 1% to take account of population growth. Our planning and projections show that these increases in the overall activity totals should provide sufficient planned activity to meet constitution standards.

Our growth assumptions are valid whilst being lower than those proposed by NHS England

51. Our growth assumption is an aggregate 1% added to the 2015/16 forecast outturn. This is considerably lower than NHS England's recommendation of additional growth of 2.2% to 2.4% in key points of delivery.

52. NHS England's recommendation is based on the IHAM tool. Our assessment of the tool and analysis of its outputs is that it does not fully take account of current year growth and the success of actions taken to damp down demand.

53. A detailed briefing note summarising our analysis is included in Appendix C. This sets out the reasons why we judge 1% annual activity growth as sufficient and deliverable in 2016/17.

Unexpected variances between NHS England templates and CCG analysis

54. We have used NHS England's standard templates, which include pre populated 2015/16 data. The CSU have modelled forward applying NHS England's prescribed methodology and algorithms to SUS data in our data warehouse.

55. Applying the standard NHS algorithms to add 1% to forecast outturn has not produced the expected output with variations of between -3% to +3% in some areas. This is currently being investigated and discussed with NHS England to understand the reason for this and to find a way to correct the apparent error.

Aligning our activity plans with providers (KLOE A6)

56. Our approach is to work directly with the provider sector, particularly our three principal providers to identify and understand differences between CCG and Trust plans and then to ensure that our plans are aligned, by:

- Identifying and agreeing RTT backlogs, differentiating recurrent run rate from non recurrent backlog
- Aligning these to provider capacity plans

- Confirming providers have sufficient capacity to deal with RTT backlogs
- Where there is insufficient capacity, finding alternative capacity at referral stage so NHS constitution standards are met

57. Our objective is to take a whole system view of available capacity. Whilst NHS England's plans are based only on SUS activity, our work with providers uses SLAM data, which is a more complete picture of commissioned activity as it includes the full range of non PBR activity and local tariff arrangements.

58. We are exploring the management of the backlog at CCG level, diverting activity at source and maximising the plurality of the provider market – matching demand to supply using our Referral Support Services.

59. We anticipate that by the time our final submission is made in April, we will have agreed the detailed position with all our principal providers and our plans will match.

QIPP (KLOE A7 and A8)

Developing our QIPP plans

60. One of the first steps in developing our QIPP plans was reflecting on the lessons learned from previous experience with QIPP. These were set out in our FRP, namely that we needed to:

- Align commissioner and provider outcomes, as part of a system wide approach
- Improve the level of ownership from providers for QIPP schemes
- Put in place enough delivery capacity, working in joint delivery teams with provider colleagues

61. We have addressed these by:

- Developing a financial and activity plans that incentivises providers to do less work and take out cost
- Identify project managers that will dedicate a proportion of their time to work with providers to deliver agreed QIPP plans
- Working closely with providers, using workshops and deploying individual project managers to formulate joint delivery plans

The make-up of our QIPP plans (KLOE A8)

62. We undertook a structured process to identify, evaluate and shortlist potential initiatives for our QIPP shortlist. We used a number of sources, which were then followed up by a local "deep dive" to understand the reasons for apparent variances. Sources included:

- Right Care analysis to identify areas of care with significant variation
- The CSU opportunity locator which used benchmarking against peer groups to identify areas of variation
- Analysis of the Atlas of Variation
- Review of the CCGs relative position against BCBV indicators
- Actions following up from initiatives identified in the FRP
- Acute commissioning proposals that had been identified by the CCG
- Collaboration between primary and secondary care clinicians in specific clinical areas
- The applicability of recommendations by Monitor in its efficiency reports on elective care and care closer to home
- The scope for technical actions and solutions

63. The overall QIPP total for 2016/17 is £12.9m. The table below sets out our proposed approach to addressing our QIPP gap:

- £2.9m of transformation within acute pathways
- £1.9m of improvements in primary care prescribing
- The remainder addressed principally through technical actions and solutions

Approach to addressing the 2016/17 QIPP gap of £12.9m

Area	Target (£m)
BCF integration	3.1
MH resource mapping	0.6
MH demographic growth	0.3
Acute pathways	2.9
Prescribing	1.9
Quality premium	0.5
Running costs	0.5
Slippage on investments	0.8
CHC	0.5
If 2015/16 surplus improves	1.8
Total	**12.9**

64. We are currently developing detailed plans for prescribing and acute care pathways. The make-up of initiatives within acute pathways and the range of potential benefits is shown in the table below. Once development work is completed and implementation plans agreed, we are confident that the plans for acute pathways will yield greater savings than the £2.9m requirement.

Current position of proposed QIPP actions for acute pathways

Acute area	Opportunity	Min £m	Max £m
Planned care	MSK	0.5	0.5
	Outpatients	0.2	0.3
	Ophthalmology	0.15	0.3
	Advice & guidance	0.1	0.2
	Cardiology	0.2	0.2
	Clinical priorities/policies	0.3	0.5
Unplanned care	BCF programme	1.4	1.4
Total		**2.85**	**3.4**

65. We are/have developed robust plans for the QIPP schemes within acute pathways and in prescribing. This includes agreeing with provider colleagues:

- The objectives and scope
- Quantifying the activity impact and whether this will be cash releasing
- A timetabled implementation plan, which includes a benefits profile

66. The plans are attached as an appendix to this Executive Summary – to be added to final submission

Profiling activity plans (KLOE A7.1)

67. Activity plans are both realistic and achievable, underpinned by detailed analysis to identify the level of growth required to meet demand in the system. This has been discussed in detail under KLOE A5 and A6 above.

68. Our activity plans are profiled to take account of a range of factors, including historic activity patterns, seasonality and the impact of bank holidays. There are different profiles for planned and unplanned care, reflecting the different patterns of activity in each point of delivery.

69. Our assessment of the impact of seven day working in 2016/17 is that there is will not be a material increase in capacity that results in increases in activity. Instead we believe that there will be some shift of existing activity into the weekend, which will not have any significant impact on activity profiles.

Profiling QIPP plans (KLOE A7.2)

70. For planned care we have developed a profile for each QIPP scheme which shows:

- The key project milestones, including clearly setting out when new services or approaches will be in place
- What benefits will be realised – full and part year effect
- When benefits will be realised

71. There are similar profiles for each of the unplanned care initiatives too, although it should be noted that some two thirds of initiatives for unplanned care are already underway.

72. These profiles have been developed through a structured process and agreed with provider colleagues. The detail is contained within the annex to this document which sets out our QIPP plans for 2016/17 – ***will be in final submission***.

Plans for use of the Better Care Fund (KLOE A10)

How we work together

73. Commissioning, service delivery and transformation have been jointly developed by the council the CCG and provider partners and there is a strong commitment to delivering the key schemes, with all plans jointly agreed and signed off by the Wiltshire Health and Well Being Board.

74. The Wiltshire Health and Well Being Board has all provider organisations as members and this ensure a strong ongoing public commitment to the programme.

75. Our key aim remains to continue to reduce DTOCs across the system and to reduce NEL admissions, as well as LOS by circa 2 days.

BCF achievements

76. Since 2014 the Better Care Plan in Wiltshire has played a key part in integrating services at the point of need and delivering a range of effective out of hospital services. The BCF in Wiltshire was one of only five national fastrack sites and has had a demonstrable impact on service provision , namely

- Reducing average number of delayed days by 20% and reducing number of delayed transfers of care significantly in comparison with last year.
- Reducing non elective admissions for patients (age 85+) by 2.6% in comparison with the previous year. The average age of patient being managed by the BCF schemes is circa 86.7. We have also successfully managed growth for the over 65s – successfully managing demographic growth for this age group by circa 2.9%

- Significantly increasing the number of patients who remain independent 91 days post discharge and reducing the number of long term placements in nursing and residential care. The key message here is not only are our schemes managing crisis they are also reducing dependency throughout the pathway

Reducing DTOCs

77. A Wiltshire wide system DTOC board which has been in place since September 2014 and oversees all the key schemes relating to discharge and performance manages the whole system

78. Our key scheme relevant to DTOCs focus very much focus on early mobilisation, transfer and ensuring longer term independence of the service user. As such the key schemes are:

- The Wiltshire wide home first programme which focuses on moving patients home as soon as they are "medically stable "with enhanced domiciliary and health care in the patient's own home. We have started the proof of concept and plan a system wide roll out in 16/17, this service will also enhance crisis management in the patient's home.
- Intermediate care and rehabilitation – we have redesigned intermediate care provision in Wiltshire with a movement towards 70 cohorted ICT beds which are spread across 9 homes which have become centres of excellence and we have already seen reductions in length of stay, eradication of readmissions and long term independence for our service users.
- Discharge from the front door – through our enhanced Access to Care Programme we aim to discharge patients directly from A&E and AMU
- Additional investment into home based domiciliary care " in reach " rehabilitation into acute trusts

79. We have also launched a new approach to managing patient Choice Across Wiltshire which has overseen a reduction in choice related delays and has been adopted as an area of good practice by our neighbouring CCGs

Actions to reduce non-elective admissions

80. We are building on a range of initiatives designed to reduce non elective admissions, with interventions at different points on the patient pathway.

Highlights of key actions designed to avoid admissions

Action	What we are doing
Rapid support close to home in crisis/admission avoidance	• Robust "interface care" building on the ATL model, the focus here is on avoidance of admissions at the front door with 3 x models scoped and proposed for each acute hospital. This will need to link in with the contractual work being undertaken in relation to ambulatory care. • Enhancing the successful urgent care at home model with more EOL capacity and rapid access reablement. • Targeted discharge and the "in reach" for the increased EBD and front door pressures related to respiratory and COPD. • Community IV – aware there is in place in parts of the county and need to build on what we have asap and ensure patients are directed for community IVs where they are available, again this builds on some of the key recommendations from the community hospital review. • Continued enhancement of the Step up beds model, enhancing the access to teams such as SWAST and hospital clinicians in terms of "front door turnaround". • Commissioning more step up care at the patient home through the Wiltshire Home First Model.

Action	What we are doing
Strengthening community admission avoidance	Aim to further enhance the community hospital bed model in areas such as: • Step up • Speciality level discharge and management • IVs and transfusions • EBD targeted discharge
Enhanced community team led case management and intervention	With our new community provider we will maximising the opportunity for more community led case management and intervention transitioning towards targeted pathways ,caseloads and cohorts
Comprehensive Geriatric Assessment	Three community geriatricians now in place across the county, models of CGA being developed by community provider Aim to increase levels of acuity and complexity that can be managed in community
Targeted referral management and communications	• Revised/targeted comms to all referrers and key stakeholders in relation to key alternative schemes, referral pathways and support guidance. • Development of shared care protocols with ambulance trust and mental health Trust • Ensure alignment with the Wiltshire wide capacity management with focus on "making best use of existing capacity".

The approach to managing winter in 2016/17 (KLOE A9)

Our approach

81. The CCG operates a system resilience group (SRG) as a subcommittee of the governing body with membership made up of all system providers, neighbouring CCG's and NHSE.

82. This group is the key decision making group for the allocation of additional investment available to providers to support capacity management pressures and delivery of the urgent care agenda as influenced by national policy.

83. The CCG also support two Urgent and Emergency Care Networks (UECN) and has to ensure that work programs it supports are aligned to the direction of travel being signalled by the UECN, recognising the challenge between a centralist solution and a local solution for Wiltshire that is aligned to the CCG published strategy for service reconfiguration.

84. The SRG monitors investment against an agreed set of key provider performance indicators and these are reviewed at each meeting, with providers being held to account for performance and or recovery actions

85. It has become standard practice for the SRG to undertake a 'lessons learned' exercise to provide clarity on how capacity challenges were met, and to identify if actions in place were successful.

86. We continue to share best practices with neighbouring SRG's, by joint representation in each other's group and by engagement with NHSE via 'winter review group'

Winter plans for 2016/17

87. The SRG is aware that the Urgent and Emergency Care Review (UECR) signals that capacity management solutions cannot be delivered by traditional escalation within the acute provider, but need greater innovation to prevent secondary care admission. To support this it is likely that in 2016/17 a greater proportion of resources will be directed to out of hospital solutions.

88. In additional to secondary care investment, further developments will centre upon:

- Support for NHS 111 services to reduce flow into the service by expansion of pharmacy and clinical validation expertise
- Engagement with the ambulance trust to support an urgent care response that can work within and with primary care to manage the frail elderly.
- Further expansion of out of hour's services to support better integration of health and social care solutions.
- Development of an local integrated clinical hub, incorporating expertise from NHS 111, the ambulance service and the out of hours service.
- Development, within the wider changes happening with primary care provision, of a more local solution to urgent care provision

89. The SRG will be inviting providers to make a case of investment to support capacity management, and as a prequel to this we have asked each provider to compile a report detailing the performance and system improvements delivered following the 2015/16 invest round.

How our plans take account of lessons learned from 2015/16

90. It should be recognised that 2015/16 should not be viewed in isolation, but as a period that has built on lessons learned from previous years.

91. We recognise that some of our secondary care providers have struggled to delivery national performance standards in a number of areas, and as a consequence have benefitted from support by Emergency Care Intensive Support Team (ECIST). The SRG is supporting and will continue to support investment in areas that have material performance benefits as recommended by ECSIT.

92. We will also take account of the recommendations from the UECR, via the network work plan that is in development to support greater integration of 'up-stream' services

93. The delivery of urgent care for the patients of Wiltshire will continue to be aligned to additional primary care services supporting people within their normal place of residence, be that their own home of a care facility. We will build on this strategy during 2016/17 as primary care responds to the service reconfiguration within the CCG five year plan.

94. Our current plans and approaches will be meshed together with those for the wider footprint, as initiatives for urgent care are developed and linked to ongoing improvements in managing winter capacity.

Workforce requirements and developments aligned to activity (KLOE A14)

Workforce risks

95. We have recognised that a risk to both system wide operational delivery and the implementation of our future model of care is our ability to staff our ambitious plan, both in terms of workforce capacity and skills development. Our model of care, and in particular our strategy to provide more care at or as near to home as possible requires a transformation of the workforce providing those services across the system at a time when we know that our population of working age is reducing. We have worked with providers to demonstrate that there are benefits on collaborating on workforce issues and have developed a system wide workforce strategy.

A system approach to addressing workforce risks

96. This important work is overseen by the Wiltshire Institute of Health and Social Care, which is a virtual institute, jointly delivered by health, social care and education partners. Its purpose is to provide and foster learning and collaborative working which will:

- Develop, enhance and support Wiltshire's health and social care workforce;
- Enable innovation in health and social care provision for our residents;
- Create and capitalise on opportunities that are only accessible through collaboration.

97. The institute is continuing to develop links across organisations, identifying where commonalities or opportunities exist for closer working. This work is already addressing cross-organisational staff training, for example the creation of a leadership development and a coaching register, a Wiltshire-wide staff 'skills passport' for statutory/mandatory training, and care staff being trained in some health tasks (dressings, blood glucose monitoring). Future work will continue to identify opportunities for closer partnership working and the Institute's Operational Group is developing key priorities for action around the themes of: recruitment problems, rapid turnover of staff/retention problems, and greater integration across the system.

98. The operational group, or Wiltshire Workforce Action Group (Wilts WAG) has representation open to all adult health and social care providers to collaboratively work on solutions to common issues and in so doing encourage a more system wide perspective. In addition a post of Workforce and OD Lead for the Better Care Plan has been funded and that role also links with external agencies such as Health Education England to encourage a more integrated approach to workforce issues across health and social care. The development of a primary care development network across Wiltshire is planned for 2016/17 as a result of additional support from Health Education England and the local Academic Health Science Network.

99. The Wilts WAG is presently looking at development across the following main areas, with a philosophy of starting small and allowing each to grow at an appropriate rate. The initiatives include:

- **Leadership Development** - shared courses with a consistent content and open to health and social care staff.
- **A shared coaching register** – to enable coaches to coach people from other organisations on a reciprocal arrangement.
- **Pan Wiltshire Staff Passport** - (to avoid duplication of training when people move to work within different organisations within Wiltshire) starting with selected statutory/mandatory training courses.
- **Care staff trained to undertake selected health tasks** – starting with wound dressings and now looking at blood glucose monitoring.
- **Shared Wiltshire career resources** – to share at careers fairs etc. that identify and inform about the plethora of different health and social care providers within Wiltshire and the potential roles and career pathways available.
- **Rotations and placements in different setting** – developing some innovative staff rotations through different employers and different settings, probably starting with newly qualified registered professionals.

100. Further work is ongoing around developing the skills of an out of hospital workforce where more care is provided at or as near to home as possible. In 15/16 this included rehabilitation training for staff working in care homes providing intermediate care beds and piloting health coaching as a method of staff engaging differently with patients to encourage patient self management.. Plans in 2016/17 include further opportunities for staff to learn health coaching and developing a consistent requirement for the workforce to have more skills in caring for people with dementia, linked to our dementia strategy.

101. We are also supporting the workforce development needs of staff working in new transformed services. These include the development of a new seamless discharge pathway out of hospital and an evaluation of the learning and support needed to develop robust integrated teams.

102. Our plans for 2016/17 will require us to further develop our approach to leading workforce development and innovation across an integrated health and social care system.

Meeting statutory safeguarding requirements (KLOE A15)

103. The *Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (2015)* sets out the roles and responsibilities of CCG's. CCG's are required to have appropriate systems in place to discharge their statutory duties in terms of safeguarding.

104. Wiltshire CCG successfully fulfils its statutory duties with the mechanisms set out in the table below.

How we fulfil our statutory safeguarding duties

Area	Mechanism for fulfilling duties in each area
Quality Assurance and Governance	a) Safeguarding Children and Adult standards are included in CCG contracts with commissioned services. This supports monitoring of the delivery of effective Safeguarding arrangements. b) There is a clear line of accountability within the CCG, with responsibility for safeguarding sitting in the portfolio of the Director of Quality. c) The Director of Quality is supported by the CCG Safeguarding team which includes: ▪ Head of Adult Safeguarding, Mental Capacity Act and Deprivation of Liberty ▪ Designated Nurse Safeguarding Children ▪ Designated Doctor Safeguarding Children ▪ Named GP Safeguarding Children ▪ Designated Nurse for Looked After Children ▪ Designated Doctor for Looked After Children d) Regular reporting to the CCG Governing Body and the Quality and Clinical Governance Committee. e) The CCG has in place an appropriate safeguarding policy. The safeguarding team actively contribute to the development and review of multi-agency policies, procedures and guidelines through membership of the Adults and Children's Safeguarding Boards. The CCG Safeguarding Leads also support provider named professionals in the development of their own safeguarding policies and procedures. f) The CCG's procedure for managing Serious Incidents includes the review of incidents against safeguarding criteria and evidence that the Duty of Candour has been applied. g) The CCG monitors reports and action plans resulting from CQC inspections and reviews and reports progress against these to the Quality and Clinical Governance Committee. h) As a member of the Wiltshire Safeguarding Boards, the CCG actively participates in the monitoring of action plans (health) from Serious Case Reviews (SCR) and other reviews which do not meet the SCR threshold. i) The CCG has a Quality Surveillance Group which meets regularly with the Local Authority and CQC to discuss providers of concern and also attends the Regional QSG. Safeguarding is represented at these meetings

Area	Mechanism for fulfilling duties in each area
Training and supervision	a) Safeguarding training is incorporated into NHS Wiltshire CCG induction for all staff. Mandatory online Safeguarding training is provided for all staff at a level appropriate for their role. b) The CCG Safeguarding team provide training for primary care c) All GP practices have a nominated lead for safeguarding. d) The CCG Children's Safeguarding team facilitate three network meetings annually for provider safeguarding leads and GP practice leads. e) Regular supervisions are offered to provider safeguarding professionals to support them in fulfilling their roles and responsibilities.
Partnership working and information sharing	a) Wiltshire CCG is committed to inter-agency working and is a full member of both Wiltshire Children's and Adults safeguarding boards and is actively engaged in the sub-groups. b) The Wiltshire MASH provides a co-location of services which includes Children's Social Care, Police and Health and this allows information-sharing to be undertaken in a timely way to identify vulnerable children earlier. The CCG Designated Nurse is fully engaged in the support of the MASH

Planned safeguarding developments for 2016/17

105. We also have a range of safeguarding developments planned for 2016/17, as part of our process of continuously improving the effectiveness of our safeguarding function:

- The CCG is currently developing a Provider dashboard for Wiltshire Care Homes which include safeguarding concerns, local authority activity such as embargoes and will also include CQC inspection reports.
- Development of Primary Care quality assurance sub-group to include safeguarding issues and support to practices following CQC inspections.
- The CCG will continue its review of the Deprivation of Liberty Safeguards where these apply to Domestic DoLS
- Comprehensive primary care training strategy for Adult Safeguarding
- Scope potential for named safeguarding professional for primary care

How our plans are linked to the public health agenda (KLOE A16)

106. Our CCG has been proactive in developing close relationships with Wiltshire Council and other stakeholders to integrate services. All partners recognise that we need to do more than to deliver reactive services that address illness once it manifests itself.

107. We and our partners are therefore committed to:

- Identifying areas where health and wellbeing is relatively poorer
- Developing and delivering services that address these issues

108. This approach is linked to the first of the triple aims in the FYFV – Closing the health and wellbeing gap.

109. The table below sets out a number of key areas where there is scope to improve the relative health and wellbeing of people in Wiltshire, together with examples of the services and plans put in place across the system to address the identified health and wellbeing issues. Our approach includes encouraging self care which aligns with our strategy and key elements of the FYFV.

Examples of services and plans in place that address health and wellbeing issues

Key area	How addressed in services and plans across the system
Alcohol	• We will work with Wiltshire Council to ensure that assessment of alcohol use becomes routine in primary care appointments rather than just in relation to those appointments which directly relate to alcohol, and will raise awareness of the impact of alcohol on other conditions both physical and emotional within primary and community care.
Smoking	• We will support Wiltshire Council and primary care to reduce the smoking prevalence in the population with a focus on reducing smoking prevalence in routine and manual working groups, those aged 15 years and in women at the time of delivery.
Excess weight in adults **Physical inactivity in adults** **Childhood obesity**	• The CCG will support Wiltshire Council and primary care to implement the Wiltshire Obesity Strategy and improve referrals and uptake of services (e.g. NHS Health Checks, Health Trainers, weight management, walking schemes, and Active Health) and also encourage improvement in all patients' levels of physical activity. • Both NHS Wiltshire CCG and Wiltshire Council recognise that childhood obesity presents one of the most significant challenges to the future health and wellbeing of our population. Primary care will contribute to delivery of our joint Obesity Strategy by enhancing our support to families identified as obese through the National Child Measurement Programme, including providing advice and support and referral to targeted services. • NHS Wiltshire CCG's contracts with acute and community health care providers will include obesity prevention for children and adults, as part of service specifications and plans.
Diabetes	• Our Diabetes Programme includes working with primary care to increase the number of GP practices participating in the National Diabetes Audit and to increase the percentage of people receiving the NICE key processes of diabetes care.
Patient activation and self care	• We will work with Wiltshire Council to provide a programme of joint communications on prevention with Area Boards. Through the Better Care Plan Prevention Programme Board NHS Wiltshire CCG will work with partners to develop and deliver interventions for self-management and promote the use of the Wiltshire 'Your Care Your Support' information portal through primary care

SECTION BREAK!

Appendix A – Meeting the requirements of the NHS Constitution

This appendix shows how Wiltshire CCG will meet the requirements of the NHS constitution in 2016/17.

Indicator	Org.	2014/15	2015/16 (Dec)		2016/17 plan - March 2017	Comment
			Target	FOT		
Referral To Treatment waiting times for non-urgent consultant-led treatment						
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	CCG	**94.0%**	≥92%	**93.1%**	**92%**	RUH are not planning to achieve in first half of 2016/17 and the CCG has concerns about current slippage at GWH. The overall impact will be that the CCG will achieve the RTT 92% standard during 2016/17 but it will not be achieved at the beginning of 2016/17
Number of patients waiting more than 52 weeks	CCG	**132**	0	**129**	**0**	
Diagnostic test waiting times						
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	CCG	**0.42%**	≤1%	**0.90%**	**0.90%**	The CCG has seen pressure on Endoscopy waits due to increased demand, but expects the target to be achieved in 2016/17
Cancer waits – 2 week wait						
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	CCG	**94.0%**	≥93%	93.9%	**93%**	There has been significant Cancer referral growth in 2015/16 although quarterly standards have been maintained. There is a Breast Cancer risk with the RUH. The standard will be achieved during 2016/17
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	CCG	**95.3%**	≥93%	94.1%	**95%**	

Indicator	Org.	2014/15	2015/16 (Dec)		2016/17 plan	Comment
Cancer waits – 31 days						
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	CCG	**97.5%**	≥96%	**97.9%**	**96.4%**	The CCG has continued to perform above the quarterly target throughout 2015/16 and will achieve the standard in 2016/17
Maximum 31-day wait for subsequent treatment where that treatment is surgery	CCG	**97.3%**	≥94%	**99.4%**	**98.4%**	
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimens	CCG	**99.9%**	≥98%	**99.6%**	**98.2%**	
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	CCG	**97.9%**	≥94%	**99.0%**	**97%**	
Cancer waits – 62 days						
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	CCG	**87.2%**	≥85%	**88.3%**	**87.4%**	The CCG has continued to perform above the quarterly target throughout 2015/16 and will achieve the standard in 2016/17
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	CCG	**97.4%**	≥90%	**96.7%**	**93.8%**	
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	CCG	**85.3%**	≥90%	**90.0%**	**100%**	
Mixed Sex Accommodation Breaches						
Breaches of Mixed-Sex Accommodation	CCG	**82**	0	**276**	**0**	The CCGs total MSA will be lower than 2016/17 and significantly lower at SFT because of the remedial actions put in place during 2015/16

Indicator	Org.	2014/15	2015/16 (Dec)		2016/17 plan	Comment
PROVIDER BASED INDICATORS						
A&E waits						
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department (A&E and MIUs)	RUH	**90.1%**	≥95%	**89.3%**	≥95%	Wiltshire is the lead commissioner for STF whose performance is satisfactory. We are working with other commissioners through a formal Remedial Action Plan process for both RUH and GWH. The RAPs will be implemented in 2016/17 to improve performance
	SFT	**95.2%**		**95.6%**	**97.20%**	
	GWH	**91.7%**		**93.4%**	≥95%	
Category A Ambulance Calls						
Category A (Red 1) calls resulting in an emergency response arriving within 8 minutes	SWAST	**75.4%**	≥75%	**75.7%**	≥75%	See notes below
Category A (Red 2) calls resulting in an emergency response arriving within 8 minutes	SWAST	**71.4%**	≥75%	**67.0%**	≥75%	
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	SWAST	**93.6%**	≥95%	**91.4%**	≥95%	
Cancelled Operations						
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days.	RUH	**42**	0	**20**	0	We plan for zero cancelled operations. This is linked with and managed through the RTT process
	SFT	**0**		0	0	
	GWH	**10**		8	0	

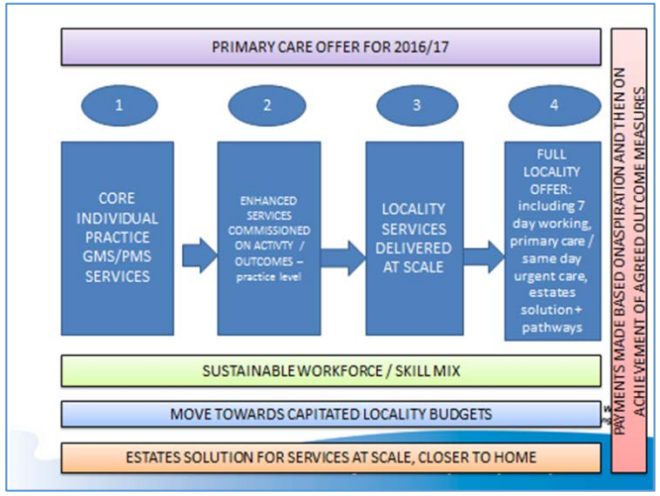
Ambulance Calls standard:

- **Red 1** – We achieved this standard in 2015/16 and expect to continue to achieve this standard in 2016/17
- **Red 2** – We recognise that Red 2 performance deteriorated during 2015/16 in part because of the implementation of the Ambulance Response Programme (Dispatch on Disposition). The SWAST North division which covers Wiltshire, BaNES, BNSSG, Gloucester and Swindon, is currently migrating to a common dispatch system which should increase the proportion of "hear and treat", which should in turn improve dispatch capability and therefore improve Red 2 performance
- **19 minute standard** - We are working with the CCGs that contract with SWAST and NHS 11 to implement additional clinical resources that review 111 disposition for "Green" ambulances, to improve performance against the 19 minute standard

Appendix B – Meeting the nine "must do's" in 2016/17

This appendix shows how Wiltshire CCG will meet the nine mandatory requirements of the NHS Planning Guidance in 2016/17.

"Must Do" from guidance	How this is met by our plan
Develop a high quality and agreed STP, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View.	The STP footprint covers BANES, Swindon and Wiltshire. It will develop and deliver within a planning framework with footprints at 5 levels. i. At GP and local level: self-care, prevention and family health services – for populations of some 20,000 - ii. At Locality groupings level: enhance primary care and locality health and social care – for populations of some 100,000 iii. At CCG wide level, specialist community services for urgent care, LTC, OP, dementia etc – for our population of some 485,000 iv. At collaborative CCG – STP footprint: acute hospital (urgent and emergency care, planned care, critical care etc) and other cross county services – for a population of some one million people v. At regional level: specialised services, cancers, major trauma etc Critical milestones: • *By end March 2016* – agree collaboration priorities, shared governance and shared programme delivery arrangements. • *By end May 2016* – agree inter STP collaboration requirements, where provider organisations work across STP footprints – to reduce complexity, create further consistency and align processes, resources and delivery timelines
Return the system to aggregate financial balance. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the Right Care programme in every locality.	The 2016/17 plan submitted by the CCG shows that the CCG is aiming to increase its surplus position from 0.6% to 1% to ensure compliance with NHSE business rules. The plan also develops provider envelopes by utilising recurrent outturn positions, adjusting for inflation and growth, to ensure that a sustainable level of activity is commissioned – the next stage of this is to evaluate provider capacity and to realign commissioned activity levels across our system where capacity constraints exist. Work has been on-going, via the health delivery group, to bring providers and commissioners together to ensure that the health economy works as one to meet the sustainability challenge that we face. Our QIPP planning included a detailed analysis of Right Care and other comparative data, which has focused our QIPP on areas of high variation. Through this process we identified four care areas that are relative outliers – Orthopaedics, Gastroenterology, Cardiology and Respiratory. Our QIPP schemes will focus on these areas to bring the CCG to an improved position.

"Must Do" from guidance	How this is met by our plan
Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues.	Wiltshire CCG is developing a Primary Care Offer as a three year programme (2016-2019) to transform the commissioning, delivery and monitoring of enhanced service from GP Practices in Wiltshire, over and above core GMS/PMS services; moving towards "place based commissioning" to deliver the CCG vision of integrated out of hospital services; supporting the development of locality working to deliver primary care services at scale to support increased efficiencies, and the address issues of recruitment and retention of primary care workforce to deliver high quality services. This will commence from April 2016, as shadow year before delegated commissioning of primary medical services in 2017. This will be a block contract type arrangement - setting out the total funding available for 2016 to cover the specified services to be delivered to meet the needs of locally registered population in return for meeting the outcomes required. The underpinning principles are: • To reimburse work on a consistent, transparent and fair funding stream (i.e. remove inconsistencies of payment for activity vs capitation, raw vs weighted, geography) – equity not equality • To commission certain services at scale not individual practice e.g. leg ulcer care, care homes, and TCOP • To move towards a full "locality offer" based on capitated or place based budgets including 7 day services, same day urgent primary care hubs, clinical integrated pathways, and agreed estates solutions aligned across the county i.e. NOT 56 practices, and aligned across out of hospital services. • To support the development of organisations with general practice at their heart, such as groups of practices, localities, or federations – for a future model of primary care service delivery, whilst maintaining the independent contractor status • Recording of activity will be assumed to be kept at practice level to ensure records will be available for auditing 

"Must Do" from guidance	How this is met by our plan
Get back on track with access standards for A&E and ambulance waits, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.	We plan to meet these standards during 2016/17. The biggest risk areas are: • A&E at the RUH and GWH • Ambulance Red 2 and 19 minute standard The A&E risks are being addressed through remedial actions plans at the RUH and GWH We are also working with SWAST to improve ambulance performance: • Red 2 – migrating to a common dispatch system which should reduce unnecessary dispatches and improve Red 2 performance • 19 minute standard – implementing additional clinical resources to review 111 disposition for "green" ambulances
Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice.	We plan to meet these standards during 2016/17, recognising that there are issues at the RUH and GWH. • For the RUH, this will be delivered by the middle of 2016/17 through remedial actions. • We will continue our ongoing monitoring of the position at GWH and if necessary, shift activity to alternative providers with available capacity to help achieve this target during 2016/17
Deliver the NHS Constitution 62 day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.	We plan to achieve these standards in 2016/17 and have a history of delivery of the constitutional standards quarterly measurement. We are working closely with providers to manage the following pressures and issues that we have experienced: • Pressure on endoscopy • Referral growth • A risk around breast cancer at RUH

"Must Do" from guidance	How this is met by our plan
Achieve and maintain the two new mental health access standards: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.	***Early Intervention in Psychosis*** Wiltshire CCG ring-fenced £104,000 parity of esteem funding in 2015/16 to work with AWP to develop the Early Intervention in Psychosis service to meet national guidelines. Against the 50% referral to treatment target the Wiltshire EIP team achieved 80% compliance for November 2015. As of December the team introduced a duty rota system which will enable assessments to be offered within 72 hours of referral receipt, and therefore allocation of care co-ordinator to take place. Achievement of the referral to receipt of assessment and care co-ordination allocation occurring within two weeks will still be at risk from delays caused through delayed identification of psychosis by other teams, and delayed onwards referral to EIP. However the team remain confident that they will sustain achievement of and exceeding the 50% target. With the introduction of the duty system and recruitment of two additional band 5 care co-ordinators to the team the capacity of those with NICE compliant skills/able to deliver NICE compliant interventions have increased i.e the team are able to deliver in excess of 1800 CBT sessions (over 3 years), 1280 are required to support their full caseload. ***Improved Access to Psychological Therapies*** Wiltshire has consistently met the access targets for IAPT. However during 2015/16 there have been recruitment and retention issues that have reduced the capacity of the service. The service was reviewed and the CCG is working with the service to reduce the range of services offered (41 different courses) to the pure IAPT service model of 8 standard courses from April 2016, and introducing a centralised booking system. ***Dementia Diagnosis Rate*** The Dementia Diagnosis rate has improved significantly over the last 3 years, and in December 2016, Wiltshire experienced the national decrease in diagnosis rate where the rate decreased marginally from 65.2% in November to 64.7% in January 2016. We are taking action especially with Practices with the greatest shortfalls in delivery The Dementia LES will be reviewed, and the Memory Service is currently undergoing a service review. Support is being offered to practices where there is still a significant gap in terms of numbers between the target and the numbers with a diagnosis.
Deliver actions set out in local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.	Since Winterbourne View significant progress has been made in Wiltshire in developing and implementing plans, in consultation with people with a learning disability and their carers and families. We believe, from NHSE colleagues, that there are 7 people from Wiltshire currently in in-patient accommodation. Of these, one has been in in-patient accommodation for more than 5 years. Wiltshire Learning Disability Intensive Support Service was commissioned in 2015/16 to support people in line with their crisis plans, or to support carers or care providers when a crisis occurs. The service provides 24/7 cover (on-call cover out of hours). The team started to become operational in November 2015. The implementation of the service is being supported by a joint "blue light protocol" and there have already been examples where in-patient admissions have been avoided or length of stay reduced to a few days while the Care and Treatment Review was undertaken to establish appropriate care and treatment in the community

"Must Do" from guidance	How this is met by our plan
Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of avoidable mortality rates by individual trusts.	The CCG has clear expectations for quality in 2016/17 which is articulated through its quality schedules which have a consistent focus on continuous improvement and learning to embed change and improve patient outcomes. These schedules have been based upon performance in the previous year and the analysis of themes and trends which have been seen through feedback from patient experience, Primary care and review through our Quality and Clinical Governance Committee. The CCG is committed to implementing a rigorous approach to achieving early identification of any trend which shows that standards have fallen below that expected and in gaining assurance that the provider has acted swiftly to mitigate further decline and address the concern. We will develop a risk profiling of providers in 16/17 and will work closely with both local and regional quality surveillance groups to identify early any areas of sub optimal quality. We will ensure that we work closely with co-commissioners to agree a formal process for managing failing services and Trusts. We have commenced the development of enhanced quality assurance of care homes with Local Authority partners to identify those providers who require any additional support in advance of a regulatory inspection with the aim of preventing a poor outcome. We are promoting a partnership working approach to the sharing of best practice and any quality initiatives across our providers to ensure that there is effective use of resource and less duplication in terms of quality improvement initiatives and to aid this, promote the involvement of providers in clinical networks. The CCG is committed to developing relationships with providers which promote collaboration on specific quality work streams utilising networks such as the Academic Health Science Network to promote system wide learning and quality improvement. The CCG plans to set up a Wiltshire Forum to include our co-commissioners in our system footprint to address emerging concerns on a multi-provider level. We will develop the Executive level contact for quality and promote an open and honest culture of information sharing. The CCG is committed to supporting those providers who have fallen below the expected standard as evidenced in a CQC inspection and where this occurs in NHS Trusts the CCG would be in close dialogue with a Trust regarding the areas which require improvement to ensure that the Trust is supported to implement its action plan. The CCG would also work closely with Monitor, CQC .and NHS England and co-commissioners to develop and agree a coordinated approach to addressing any system wide quality improvement plans to ensure that the improvement is sustainable. When developing quality improvement plans with providers which are affordable the CCG will ensure that it prioritises those improvement measures in conjunction with the provider to assure patient safety whilst considering cost effectiveness and best value For 2016/17 the focus will be the continued scrutiny on mortality with the purpose of reducing avoidable mortality. The CCG will continue to monitor Trusts and require action to address diagnosis groups which benchmark above expected mortality levels. Mortality data is reviewed regularly and feeds into the evidence review to select annual provider assurance audits required in the Quality Schedule. The CCG receives assurances on an annual basis from providers in relation to the Trusts' policy and process for carrying out Mortality Reviews. The CCG is aware of the developing national level approach to mortality reviews and will be working with providers to ensure compliance with the new regime which evolves from this process. The CCG is additionally monitoring mortality across the 7-day period and from 16/17 onwards is requiring assurance from providers in respect of actions taken to review their mortality rates across the week. A key objective for the CCG will be the Sign Up to Safety Campaign which the CCG intends to sign up to and pledge to deliver. The approach to CQUINS will be to incentivise the healthcare system to deliver greater effectiveness, as well as supporting the delivery of QIPP initiatives, incentivising changes in clinical practices in known areas of quality concern and supporting the achievement of the NHS Outcomes Framework and Constitutional commitments.

Appendix C – NHS Wiltshire CCG Activity Trends Briefing

Background

The 2016/17 Planning ProvCom UNIFY2 template had the 2015/16 baseline data pre-populated by NHS England and these cells were locked-down on the template file. 2016/17 planning guidance stated that the planning should use SUS data. At the start of the 2016 there was a national task and finish group established to consult on the planned methodology to pull the SUS data. The SCWCSU in conjunction with NHS Wiltshire CCG responded to the consultation and the latest feedback has now appeared on UNIFY2 on 24th February 2016 in the form of a FAQ document. The CSU consultation response was on behalf of all CCGs supported by the SCWCSU footprint.

The CSU has already had numerous conversations with NHS England about the baseline figures and how they differ to the local SUS data extracts.

Reconciliations

The NHS Wiltshire CCG 2016/17 plans are based on running the baseline data using the national SUS algorithms on the CSU data warehouse. Therefore the CCG replicated the technical guidance provided. I attach a file that shows the reconciliation between the NHSE and the CCG baseline data (see CSU vs NHSE tab for differences). The files demonstrate differences in both the 2015/16 month 6ytd and 2015/16 forecast outturns (see columns E and H of the differences tab in the file).

2015/16 Month 6ytd

I believe the main reason for the month 6ytd variances is due to the identification of responsible commissioner in SUS. NHSE did not share the detail behind the way they did this although it appears NHSE purchaser identification was a derived field whereas the CCG used the Provider submitted purchaser identifier. Also the timing of the SUS data extraction can make a difference if Providers are correcting CCG contract challenges and making retrospective corrections to SUS required as part of SUS to SLAM reconciliation issues. There were no detailed extracts at patient level for the CSU to further validate prior to submission.

2015/16 Forecast Outturns

NHS England forecasting is significantly different to CCG view. NHS England did not provide supporting information to enable the CCG to fully understand their forecasting methodology. However the CCG has local knowledge about non-recurrent and part-year impacts affecting year-end forecasts and the CCG forecast outturns were generated using local intelligence from Finance colleagues which also takes account of the impact of phasing within plans which would only be known at a local level.

The CCG has looked at triangulating the Provider cuts of CCG activity submitted to SUS. The CCG understand the reasons for the main differences between CCG and Trust submissions. The CCG has liaised with the main Providers to ensure that these triangulation variances are reduced for the next 2016/17 ProvCom submission. However there remain some differences in expectations of 2015/16 forecast outturns and 2016/17 planned growths that are being worked through as part of ongoing local contract negotiations.

2016/17 Planned Activity Growth

The CCG has looked at the IHAM tool produced by NHS England. The main weakness in the tool is that is does not take enough account of activity growth seen in the current year. NHS Wiltshire CCG has been investing in Better Care Fund and TCOP schemes to dampen down elderly non-elective admission growth.

The table below shows an analysis of 2015/16 month 9ytd annual activity growth.

2016/17 SUS Activity Analysis

CCG Total M9YTD	Year-to-date			
	14/15	15/16		
	Actual	Actual	Growth	FOT
A&E	100,292	100,438	0.1%	135,731
NEL (All specs)	36,223	36,571	1.0%	49,880
DC (G&A)	34,525	35,754	3.6%	
OE (G&A)	8,306	7,896	-4.9%	
Total EL (G&A)	42,831	43,650	1.9%	57,071
1st OPA (GP, G&A)	73,341	71,930	-1.9%	148,397
FUP OP (All Specs)	252,917	250,608	-0.9%	262,407

The analysis demonstrates that so far in 2015/16 that the CCG has 0.1% A&E attendance growth and that non-electives have increased by 1%. However within the 1% the CCG has analysis to show that the age-band split is >65s = 0.5%, working age = -0.4% and younger people = 8.7%. The CCG has successfully contained older peoples NEL growth especially has this age-band has seen the greatest demographic growth. The NEL growth is seen in younger people and there is renewed focus on this cohort with schemes that started in 2015/16 quarter 4 and others for 2016/17. Some of the NEL growth is non-recurrent as GWH had a part-year impact of a reporting switch from OP to NEL for their surgical assessment general surgery activity.

Elective growth is currently +1.9%. The CCG has seen an increase in Cancer related activity especially endoscopies. The CCG is revisiting referral guidelines and there is a known non-recurrent impact prior year Choose and Book suspension, e.g. ophthalmology and dermatology, which is therefore overstating the annual growth rate. 2016/17 plans include a review of the proportion of activity undertaken as an day case verses outpatient procedure and revised, tighter INNF policies that should reduce activity specifically targeted at source of referral.

The CCG has therefore been very successful at containing 2015/16 activity growth to levels well below that shown in the IHAM tool. The CCG's 2016/17 elective activity growth projection also takes account of the fact that the total RTT Incomplete pathways (waiting list) has remained at broadly the same size in 2015/16 with only a +123, which represents a +0.5% increase over the past 10 months.

The planning guidance from NHSE is suggesting that Wiltshire should be planning on the following growth levels in 2016/17:

POD	Growth %
Outpatients	4.10%
Elective	2.40%
Non elective	2.40%
A&E	2.20%

Conclusion

Based on the actual annual levels of activity growth seen NHS Wiltshire CCG believes that a general 2016/17 planned 1% activity growth is deliverable.

NHS Wiltshire Clinical Commissioning Group

Equality Impact Analysis – the EIA form

Title of the paper or Scheme: Wiltshire CCG – Operational Plan 2016/17

For the record	
Name of person leading this EIA – David Noyes	Date completed 16 Mar 16
Names of people involved in consideration of impact None	
Name of director signing EIA – David Noyes	Date signed 16 Mar 16

What is the proposal? What outcomes/benefits are you hoping to achieve? The operational plan describes the work which the CCG intends to undertake in the next 12 months in order to deliver our future strategic vision

Who's it for? The population of Wiltshire

How will this proposal meet the equality duties? By supporting the CCG in taking forward the delivery of our 5 year strategy, part of which is the elimination of health inequalities

What are the barriers to meeting this potential? None evident

2 Who's using it?

Refer to equality groups

What data/evidence do you have about who is or could be affected (e.g. equality monitoring, customer feedback, current service use, national/regional/local trends)? As per overarching analysis for 5 year strategy, adjusted to reflect the latest benchmarking data and JSNA

How can you involve your customers in developing the proposal? Any changes arising will be subject to the usual consultation, albeit the overall direction of travel is entirely coherent with our 5 year strategy, which we have shared widely with our population.

Who is missing? Do you need to fill any gaps in your data? (pause EIA if necessary) Nil

3 Impact

Refer to dimensions of equality and equality groups
Show consideration of: age, disability, sex, transgender, marriage/civil partnership, maternity/pregnancy, race, religion/belief, sexual orientation
and if appropriate: financial economic status, homelessness, political view

Using the information in parts 1 & 2 does the proposal:

a) Create an adverse impact which may affect some groups or individuals. Is it clear what this is? How can this be mitigated or justified? None

What can be done to change this impact? N?A

b) Create benefit for a particular group. Is it clear what this is? Can you maximise the benefits for

other groups? Benefit for all population groups

Does further consultation need to be done? How will assumptions made in this Analysis be tested?

No

4 So what? Link to business planning process

What changes have you made in the course of this EIA? None

What will you do now and what will be included in future planning? Our standing obligation to consult and engage

When will this be reviewed? monthly via the integrated performance report

How will success be measured? By metrics associated with each major strand, improvement in health outcomes, financial balance and achievement of constitutional targets