NHS
Wiltshire
Clinical Commissioning Group

Clinical Commissioning Group Governing Body
Paper Summary Sheet
Date of Meeting: 24 March 2015

For: PUBLIC session ☒ PRIVATE Session ☐

For: Decision ☒ Discussion ☐ Noting ☐

Agenda Item and title:	**GOV/15/03/11 – Wiltshire CCG 2015/16 Delivery Plan**
Author:	David Noyes – Director of Planning, Performance and Corporate Services Attain Commissioning Services – the CCG's Strategic Planning Partner
Lead Director/GP from CCG:	David Noyes – Director of Planning, Performance and Corporate Services
Executive summary:	Work on the CCG Delivery Plan for the next Financial Year has reached a good level of maturity, having been driven locally by clinical leaders as originally envisaged. The Delivery Plan sets out the key elements of work, activity and performance that the CCG intends to achieve over the next 12 months (ie during FY 15/16). Wiltshire CCG has developed their Delivery Plan cogniscent of the need to continue to work to achieve the headline aspirations set out in the Health and Wellbeing Strategy, and in particular to reinforce the early success of the Better Care Plan, as well as the progress being made in the execution of the CCG's 5 year strategy. The CCG has constructed the plan having engaged widely with system partners, and built on the previously established practice of drawing on local GP expertise to shape the plan.
Evidence in support of arguments:	National and regional data benchmarking utilised throughout the formulation of the plan, and consultation with clinical leadership at each stage. The plan is also supported by significant and detailed activity and financial forecasts
Who has been involved/contributed:	Engagement and consultation across the CCG groups/localities, and liaison with colleagues within Wiltshire Council (Public Health & Social Care at Director level). Also system partners via a series of meetings with Chief Exec/CFO and Strat Director colleagues, and a well attended workshop which enjoyed wide support from operational leads.
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:	The Delivery Plan takes forward the implementation of the CCG 5 year strategy on which we consulted and engaged extensively last year.
Communications Issues:	The CCG will need to continue to communicate the direction we are taking in terms of delivering an out of hospital model of care.
Financial Implications:	Enactment of the plan, and further work, will be required to ensure that the CCG remains in a financially viable position and delivers our QIPP target.
Review arrangements:	Review will be via monthly Performance Reporting.
Risk Management:	This addresses the CCG identified risk regarding the delivery of QIPP
National Policy/ Legislation:	Coherent with the Call to Action and Five Year Forward View
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 CCG 2015/16 Delivery Plan.

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Wiltshire CCG

2015/16 Delivery Plan - Summary

25 February 2015

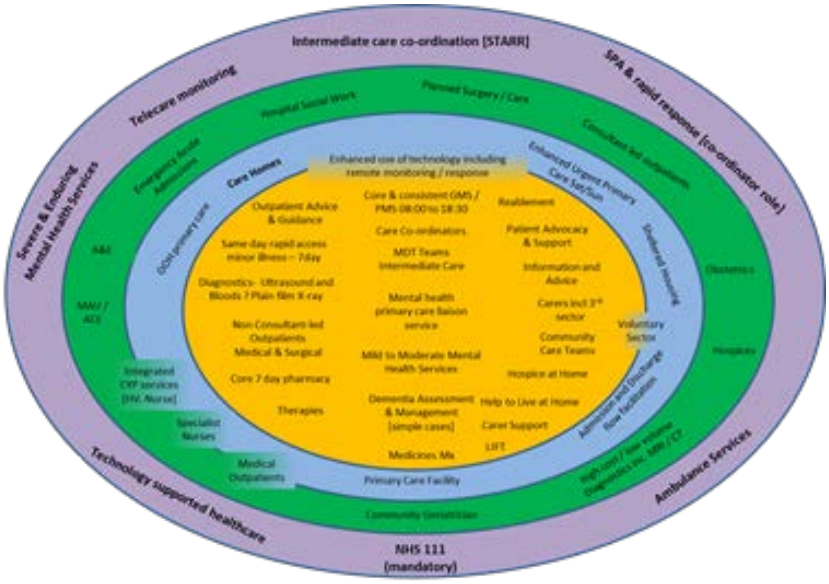
Contents

Introduction

1. In 2014, Wiltshire CCG published its five year strategy with the vision that "Health and Social Care services in Wiltshire should support and sustain independent living". Our Governing Body remain committed to the delivery of that strategy, which is entirely coherent with the broader Health and Wellbeing Strategy, and so also enjoys the strong support of our Health and Wellbeing Board.

2. The strategy envisages a fundamental shift in the balance of care, so that acute bed based care will no longer be the default setting. Instead we will provide a range of services based at home or in the community that will safely and effectively support people and their care needs. The diagram below illustrates the different layers of provision we will deliver in Wiltshire.

Our ambition - a range of care services for people in Wiltshire, tailored to their individual needs



3. The 2014/15 Delivery Plan set out the actions and plans to start this five year journey. Positive steps on the journey included being one of only five health and social care systems that achieved Fast Track status for our joint Better Care Plan, formulated in close co-operation with our partners in Wiltshire Council, demonstrating real whole system working in Wiltshire.

4. The journey has not been as smooth as we had hoped, with our plans taking longer than predicted to deliver and by the autumn of 2014, we reported a financial position that was worse than expected. Whilst the adverse financial position was in part driven by unprecedented service demand, our status as a CCG was changed to "assured with support", requiring us to develop plans to bring us back on track. ***The first two sections of this document show how we are working to address and resolve issues in 2014/15.***

5. Looking forward to 2015/16, our approach is to:

   - Continue with the direction of travel set out in the strategy – the strategy of shifting the balance of care is the right approach to delivering safe and effective care that meets Wiltshire's people's needs. Indeed there is strong resonance between our strategy and the themes set out in NHS England's Five Year Forward View.

   - Internally, learn the lessons from 2014/15 – making sure that our plans are even better worked up, more realistic and that we have sufficient capacity and capability to deliver them.

   - Externally, build on and improve further whole system working – we are working ever more closely with partners across health and social care, using the limitations of the current resource position as an incentive to work together more effectively to implement service change that improves the quality of care provided in Wiltshire.

6. ***The second section of this document shows how we will put these principles into practice in 2015/16.*** We have developed and assured deliverable plans in line with business rules and our five year strategy. The results of the tariff consultation process have changed the planning timetable, so we are continuing to work with system colleagues to develop and deliver plans for 2015/16 in light of NHS England's revised tariff offer of 18 February 2015.

Our Delivery Objectives (ES3)

Our overall objective

7. Our overall delivery objective is to provide high quality care to people in Wiltshire by continuing with the direction of travel set out in our five year strategy. We have taken on board:

   - The requirements of the Five Year Forward View and other policies, incorporating these into our objectives for 2015/16 and beyond
   - Lessons learned from 2014/15 within the CCG to improve our ability to deliver
   - Steps to strengthen whole system working to get better whole system buy in and support for our projects

Main delivery objectives

8. We plan to achieve our overall objectives by focusing on five key areas:

   - **Recovering the 2014/15 financial position:** we have plans in place to actively manage our financial position and address any areas of underperformance in patient services. Appendix A sets out our assessment of the 2014/15 Delivery Plan, the extent to which financial savings in main areas will be achieved and the lessons learned that will be carried forward into 2015/16
   - **Implementing our commissioning plans:** our 2015/16 commissioning intentions set out our approach to developing services across the whole spectrum of care during 2015/16, which include:

     a. ORCP – We will build on our experience of system working in 2014/15 so our investments and support are effective and impactful. We will confirm which current year initiatives should endure and prioritise those that should have the greatest impact and where possible the schemes which support the continued rollout of the CCGs Five Year Plan

     b. Mental Health – We are investing £1.6m into mental health services across all ages and conditions. Developments include enhancing parity of esteem, developing early intervention services for people with emerging personality disorder, continuing with our collaborative work to develop meaningful choice for mental health patients. Mental health professionals will work proactively within Integrated Teams to help identify people with mental health needs and offer support through co-ordinated care so both mental and physical health needs are addressed

     c. Diabetes – We concentrated on prevention, healthy lifestyles and encouraging self-management in 2014/15. In the coming year we will work with secondary care providers across the system to develop a single care model. Through a wide ranging stakeholder engagement and involvement plan we will develop a new pathway that shifts the emphasis of care to personal and primary care. We anticipate the business case will be ready by the end of 2015 and the new pathways in place in April 2016

     d. Personal health budgets – We are working with Wiltshire Council to further develop personalised health budgets through the Integrated Personal Commissioning Pilot, as well as our work with third sector organisations to deliver personal care planning for people with long term conditions and there are plans to develop joint care planning, by piloting processes in the Wiltshire integrated team programme demonstrator sites

e. Arriva transport services – We continue to work actively with Arriva and system partners to ensure that patient transport is available to meet patient's needs and support good access to patient services. Our review of Arriva's service has provided a better understanding of requirements so Arriva can provide sufficient capacity in the core fleet and optimise its use through revised rostering arrangements. We plan to review the service specification during 2015/16 to assess the extent to which it meets the needs of patients across the system and identify any further changes required to the contract.

- **Achieving key delivery priorities:** we are clear that the CCG has to demonstrate it has achieved the right standard of performance in service delivery. Plans are in place for each of the areas we highlight in this document to successfully deliver against key priorities
- **Continuing with 2014/15 plans, including Better Care Fund (BCF):** we will continue to implement plans that were developed in 2014/15 in both planned and unplanned care. We have also added to existing plans, which will be rolled out and have a major impact during 2015/16.
- **Developing new plans for 2015/16:** we implemented a structured process using clinical engagement at CCG, Group and Locality level to identify and develop new QIPP plans for 2015/16. The schemes are set out in the accompanying Excel file which lists our QIPP plans and a further appendix that highlights the key components of each material QIPP scheme. We are very aware of the priority our Acute provider colleagues wish us to place on making improvements to our discharge pathway, and we will place significant emphasis on this element of our work.

Underpinning approach to facilitate delivery

9. Our objectives are facilitated by robust methodologies that include:

- **Whole system approach:** we have actively engaged with our partners at a strategic and operational level to jointly develop plans and get real buy in across the whole system
- **Comprehensive demand and capacity planning:** our demand and capacity model provides a sound estimate of service demand in 2015/16. We have used benchmarking and other analysis to understand our relative performance position, and how this should influence our proposals for 2015/16. We have also shared our planning assumptions and key analysis with partner organisations
- **Assurance process, including lessons learned from 2014/15:** we have a comprehensive assurance process that actively involves both our Governing Body and the Clinical Executive to provide ongoing oversight to the planning process and how we work with our partners across the system to ensure our plans are aligned

2015/16 headlines

10. Our plans for 2015/16 should therefore achieve:

- An in year financial position that delivers a 1% surplus of £5.5m and meets the business rules
- A reduction of non-elective activity to some 47,000 spells, principally through the impact of BCF and TCOP
- All delivery priorities including NHS constitution and RTTs

11. An integral part of our plans is the delivery of a QIPP requirement of £9.5m (1.75% of resources £542m, net of running costs). We have developed projects to deliver a £9.5m reduction in costs. More details of these projects are set out in a separate pack that accompanies this summary. We have assessed risks to the CCGs overall financial position which reflect potential commissioning and activity pressures and identified mitigating actions for the majority of the risks in our plan. ***NOTE*** *– this is based on the Enhanced Tariff Option.*

2014/15 - Managing our current assurance status (ES7)

12. Wiltshire CCGs status is currently classed as "*assured with support*". In January 2015, we submitted a detailed financial recovery plan to the CCGs Finance Committee and Governing Body. The plan was approved and communicated to NHS England's Area Team.

13. The actions set out in the plan are designed to reduce both the in year financial impact for 2014/15 the recurrent financial impact going forward into 2015/16. The main financial recovery actions in the plan are set out below.

Planned financial recovery actions (January 2015)

Area	Proposed actions	Current position
Non recurrent mitigations (£1m)	Material schemes: • Slippage on Single View of the Customer investments (£500k) • Non Contracted Activity challenges (£200k) • Sarum CCG SLA Primary Care Funds (£135k) • Prescribing action plan (£100k)	• Achieved • Not achieved and movement in forecast from increased activity • Achieved • Achieved but movement in PPA forecasts
Other actions (£1.8m)	Potential additional actions: • Quality premium and release of headroom (£400k) • Repayment of unused risk pool for legacy CHC (£1m) • NEW/WWYKD CCG SLA Primary Care Funds (£200k) • PPA forecast reprofiling (£200k)	• Achieved as quality investments made through BCF • £1.2m funding received back • No achieved – funds committed • Not achieved – PPA forecast has increased Also further pressure has arisen from increased activity, reduction in GFV benefit for the ISTC and MH OOA placement costs

14. Between Month 8 and Month 9, we reported a reduction in the CCGs overspend. Unfortunately we have experienced further financial pressure as at month 10, some relating to the realisation of known financial risks that have not been mitigated and some new financial exposure, principally continued activity growth and higher costs at both NHS and Independent Sector providers

15. We have therefore changed our forecast and for 2014/15 are reporting a £3.2m surplus against a plan of a £5.3m surplus

16. We recognise that this financial position will need to be reversed for 2015/16 and that our planned QIPP schemes must deliver the anticipated benefits. We are continuing to work with colleagues across the system, reinforcing the message that has underpinned our whole system approach to planning that "there is only one pot of money for 2015/16" and the challenge is for all organisations in the system to take responsibility for delivering high quality care within that financial envelope.

2014/15 - Recovery plans (ES4)

17. There are four main areas where our performance is not in line with 2014/15 plans. We have critically reviewed each area to develop impactful actions that will bring performance back into line. The table below summarises the issues in each area and sets out the recovery plan actions that have been put in place.

Issues and planned recovery actions

Area	Issue	Action
RTT >52 week waits	There are still capacity issues for Spinal Orthopaedics at North Bristol NHST affecting some Wiltshire patients	Alternative provider capacity is being sought
Cancer 2 week referrals	Wiltshire will achieve in 2014/15 however, there has been a significant increase in referrals following national Cancer Awareness campaigns and capacity is becoming more stretched	The 2015/16 contract activity plans allow for a further increase in cancer related activity
Mixed Sex Accommodation	There have been a moderate number of breaches at Salisbury NHSFT in 2014/15. These have nearly all been due to delayed transfers for critical care	Salisbury are just opening up increased critical care beds with the capability to separate patients by gender
A&E	The target is set at 95%, which is being currently achieved at SFT, but not at RUH or GWH, where Wiltshire CCG is not the lead commissioner	We are supporting system level action through our co commissioner arrangements such as implementing ECISTs recommendations Our 2015/15 QIPP initiatives around BCF, TCOP and ambulatory care should help reduce pressures on EDs by avoiding A&E visits and/or admissions via A&E
Ambulance Response Times	The standard is measured at provider-wide level, however, with Wiltshire being a rural area it has proved difficult to achieve national response targets locally	Wiltshire has adjusted its contract with SWAST to reflect the growth in calls, although Wiltshire is only one of a number of commissioners of services from SWAST
Dementia	Primary care diagnosis of dementia has a national target of 67%, with Wiltshire currently achieving 54%. Some slight improvement is expected by the end of the financial year and we are likely to meet the local target of 55%, although the 67% target will not be met by then	The CCG has analysed performance at practice level and in care homes to plan and target support. We are working with the CCGs largest practices to support GPs and aim for the target We are also receiving assistance from the Area Team who will provide support to practices. In addition, CSU staff are comparing primary and secondary care data to identify diagnoses of dementia in secondary care that are not reflected in primary care, so data on diagnosis is complete in primary care
IAPT	Our IAPT access rate should be 50% by Q4 of 2014/15. At Q3 we had achieved 46%. This shortfall is fundamentally caused by a data completeness issue, not a performance concern	Our IAPT Recovery rate should be 50% by Q4 of 2014/15. At Q2 the CCG achieved 46.4%. This shortfall is fundamentally caused by a data completeness issue, not a performance concern.

18. These plans are robust, should ensure that our service performance meets requirements in each area and provides a sustainable position for 2015/16 onwards.

2015/16 - Key commissioning intentions (ES1)

19. This section provides an overview of our aim to continue our journey to implement the new model of care set out in our 5 year strategy. This is a synopsis of our 2015/16 commissioning intentions, which are based on three principles:

- People 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

20. We will maintain our focus on improving quality and ensuring the future sustainability of the system and are committed to developing a truly integrated system, which is why plans have been developed jointly with partner organisations across the health and social care system.

Commissioning principles

21. Our commissioning plans include following principles:

- Focusing on patient experience, quality and safety
- Commissioning services that deliver clearly defined preventive provisions including self-management
- Identifying local health needs and commissioning services from providers best placed to deliver them
- Working with providers to ensure an integrated approach to provide care as close to home as possible
- Supporting innovation, best practice and consistent pathways across our three main acute providers
- Facilitating collaborative working across the whole system to deliver seamless provision that also contributes to QIPP
- Taking account of demographics so our resources are appropriately targeted
- These plans span the whole spectrum of care along primary, community and acute settings.

Key initiatives in primary care

22. Key initiatives in primary care include:

- Putting primary care back into the driving seat for care delivery and co-ordination. We have established significant clinical leadership by local GPs of the multi-disciplinary teams (our horizontal integration lever), assisted by a bespoke Organisational Development programme, to properly utilise the capability they can deliver. We aim to deliver more services and ambulatory care in the community rather than at an acute hospital
- Encouraging empowerment of non GP clinicians to free up GP capacity, extended hours and provision of locally tailored support targeted to meet the specific needs of our largely rural, but each individual, communities
- Enhancing primary care provision to include greater access to urgent care services without recourse to A&E and using better new technology to improve the patient experience, as well as reducing unnecessary or unproductive clinician/patient contact time

Enhancing community services

23. We have established 20 integrated Multi-disciplinary teams across the county, using 3 lead demonstrator sites to pilot the concept and ways of working. These have made genuinely exciting progress and we have been able to test and adjust to tailor to specific local needs, as well as utilise the learning from each to help speed implementation elsewhere. We have recruited Care Co-ordinators and made significant additional investment in augmenting the current Community Services workforce with 40 additional staff, as well as the application of modern risk stratification techniques.

Shifting the balance of care from the acute sector

24. At the same time we are working with our secondary care colleagues to reshape the delivery of secondary care. As well as our plans to reduce non elective admissions through BCF and TCOP we are:

    - Encouraging a "hospital without walls" approach, employing more consultant expertise in our community and driving all the potential benefits of vertical integration
    - Growing our capacity in intermediate care, not just by utilising our community hospital capacity but by working with our providers to radically upgrade the capability of the full range of intermediate care provision and support
    - Further developing ambulatory care and the provision of faster access to diagnostics and acute opinions to avoid acute admissions
    - Building on our success with work on our Discharge to Assess scheme and other initiatives such as robust rapid response and rehabilitation/re-ablement services; we aspire to achieve one direct pathway for discharge to home for assessment and want to ensure that we have support and services in the community to support discharge to home and response to crisis in the home

25. We will continue to work collaboratively with our three principal acute providers to change the way care is delivered and change the focus of care so an acute admission is no longer the default approach to delivering care.

26. The initiatives in primary care and enhancements to secondary care are designed to provide sufficient capacity and capability to deliver out of hospital care at scale and facilitate the shift of care away from acute bed based activity.

Quantified delivery priorities for 2015/16 (ES2)

27. Our delivery plan for 2015/16 includes a range of priorities that have quantified targets and metrics. The table below summarises these priorities and the expected outcomes in each area.

2015/16 delivery priorities and outcomes

Priority	What's included within our plans	Expected outcome
NHS Constitution quality standards	Our 2014/15 performance together with plans and projections for 2015/16 show us achieving targets in: • RTTs • Diagnostic test waiting times • Cancer waits • Mental health CPA In 2014/15, we implemented measures to address issues relating to achieving: • A&E waits at the RUH and GWH, where Wiltshire is not lead commissioner • Ambulance response times, where SWAST is the provider • Mixed sex accommodation breaches at SFT	We expect to deliver all the NHS constitution quality standards in 2015/16 We put in place actions to improve performance in the areas where we do not currently achieve the quality standards during 2014/15 and have incorporated these into our plans for 2015/16 Our planned outcome where we are the lead commissioner is to end 2015/16 fully achieving all standards

Priority	What's included within our plans	Expected outcome
Seven Sentinel Indicators (only five of the seven indicators apply to CCGs)	The current position for each domain is: • **Domain 1: PYLL for causes amenable to healthcare** - Wiltshire is better than England total but slippage is greater than England total. • **Domain 2: Health-related quality of life for people with long-term conditions** - Wiltshire is better than England total and improvement is better than England total. • **Domain 3: Emergency admissions for acute conditions that should not usually require hospital admission** - Wiltshire is better than England total and improvement is better than England total • **Domain 3: Emergency readmissions within 30 days of discharge from hospital** - Wiltshire is Better than England total but slippage is greater than England total • **Domain 4: Patient experience of hospital care -** Patient experience is better than England total at SFT but worse at RUH and GWH. Experience has dropped at RUH but improved at SFT and GWH • **Domain 4: Patient experience of GP services and GP OOH services** - Wiltshire is better than England total but has slipped in 2013/14 • **Domain 5: Patient safety incidents** – Variable quarterly picture with no discernible pattern	Our plans will continue to support the successful delivery of the trajectory in each of the five areas. Illustrations of the links between specific CCG plans and each domain are: • **Domain 1:** The focus on increasing Out of Hospital care and more sophisticated local multidisciplinary services in primary and community settings should provide better focused and more effective care delivery to address conditions amendable to healthcare intervention • **Domain 2:** Implementation of the CCGs strategy with its focus on long term conditions should support the trend for continuing improvement • **Domain 3:** QIPP schemes for BCF, TCOP and Unplanned to Planned Care should reduce admissions and readmissions by avoiding emergency admissions and providing alternatives to acute care • **Domain 4: Hospital care –** Changes to care models and the shift to Out of Hospital Care should reduce pressure on the acute sector and facilitate an improved patient experience • **Domain 4: GP services** - Locality based plans should develop services that are more sensitive to local needs and therefore improve patient experience • **Domain 5:** Our culture of working with providers to continually focus on quality and safety should deliver the planned trajectory in this area
Francis, Berwick & Winterbourne	We are strongly committed to embracing and acting upon the recommendations from Francis, Berwick and Winterbourne View. Examples include: • Joint work with Wiltshire Council ranging from better medicines management to revised clinical models, updated roles and responsibilities for staff and recommissioning LD services • Developing specific action plans in response to Francis encompassing culture, improved patient and public involvement and actively reviewing and valuating provider's responses • Enhanced quality monitoring of provider services	We expect a mix of positive outcomes for patients and services • Avoiding inpatient admissions and facilitating timely discharge where admissions are necessary through improved services for example the integrated CTLPD service to support patients with challenging behaviour • Reduce and where possible avoid crisis intervention with more emphasis on care at home and/or community settings to • Improvements in quality of care across providers which can be measured and assessed through our monthly quality reporting processes, for example 6Cs

Priority	What's included within our plans	Expected outcome
Achieving 5 of 10 standards for 7 day services	We are actively working with our principal providers to support and promote active delivery of 7 day services. We are explicitly linking 7 day working to initiatives to improve unplanned care by focusing on areas such as admission avoidance and discharge planning by: • Continuing to embed and enhance the Urgent Care at Home service 7 days a week. • Making step up care mainstream and available 7 days a week • Extending social care input to acute hospitals 7 days a week • Extending discharge to assess and discharge from A & E to a 7 day model and extending the concept to community hospitals • Mainstreaming Acute trust Liaison across all Acute trusts • Where possible funding GP input on weekends into assigned care homes to manage flow	We expect the outcomes to be: • Reduced peaks in workflow in unplanned care • Improved consistency of acute care whichever day of the week care is delivered • Better quality of non-elective care • Shorter lengths of stay in acute care through faster discharge • Greater focus on and delivery of Out Of Hospital services • Improved access to a wider range of effective services in primary and community settings • More home based care as an alternative to acute admission
Parity of esteem for mental health	We are making significant investment of £1.6m of ring fenced resources to improve Parity of Esteem for mental health. Practical actions include: • Early intervention services so mental health conditions are identified and addressed proactively as services do with physical health • Including mental health professionals within our Integrated Teams so mental illness is identified and proactively managed as part of an integrated package of care and support • Developing and offering real choice for mental health services	Our plans should deliver better outcomes for patients because: • Mental health conditions are identified and managed earlier, making them more amendable to successful intervention • Care is delivered in a more holistic way so the link between physical and mental health needs is explicitly identified and addressed through packages of integrated care
Prevention	We continue to work across the system through the Health and Wellbeing Board to pursue collaborative initiatives in areas including Preventing ill health, Taking care of your health, Regaining good health and Healthy communities We also collaborate around screening, which is a particular area of focus for planned care in 2015/16 to bring together clinicians across primary and acute care to effectively deliver new screening services	We anticipate the outcomes to be: • Improvements in people's health and wellbeing in Wiltshire • Reductions in preventable conditions, to improve the CCGs position in Domain 1 • Optimal delivery of screening for new campaigns in 2015/16

28. This summary demonstrates that we are planning to achieve the required outcome in each area and where there are risks or uncertainties, we have put in place remedial actions to address issues to bring performance into line with requirements.

Better Care Fund (ES8)

29. As one of only five health and social care systems with fast track status for BCF, we have worked in close partnership with Wiltshire Council to bring our plans to maturity. In 2014, the Wiltshire system initiated the 100 Day Challenge to improve cross system working and drive the development of BCF initiatives and generate an evidence base by which we can underpin our delivery assumptions for 2015/16.

Developing BCF plans across the health and social care system

30. The report on the 100 Day Challenge and the system wide feedback session on 6 January 2015 confirmed the actions that will be impactful in delivering to the overall admissions avoidance agenda by:

- Identifying a range of areas to manage better and reduce the level of non-elective admissions
- Generating an evidence base that has helped shape emerging priorities
- Showcasing tools and approaches developed to improve both management and delivery of urgent care outside hospital
- Setting out key themes to act as focal points for action in 2015/16.

31. The Wiltshire system has continued to support the implementation of BCF plans and to drive forward with positive actions through genuine whole system working:

- Formal meetings such as the Joint Commissioning Board have endorsed the results and plans for 2015/16 that have the full support of the Wiltshire HWB who will receive an updated plan for 2015/16 and are expected to sign this plan off at the HWB in March 2015
- A meeting of system leaders on 14 January 2015 not only affirmed their support for BCF, but committed to accelerate working on plans to improve discharge planning (single pathway, community support, response to crises at home) and contribute to improved admission avoidance across the system
- The 5 February 2015 system workshop's Unplanned Care Group agreed to focus on a small number of impactful areas to accelerate work on improving discharge

Key BCF actions for 2015/16

32. The table below summarises the key actions that will be implemented in 2015/16, grouped in three thematic areas, which should result in a reduction of 1,541 non elective admissions. This is an ambitious target, but the BCF team are confident that the 100 Day Challenge and other development work has generated robust actions that will deliver this reduction.

Key BCF actions and their planned impact for 2015/16

Area	Actions and initiatives	Impact
Community alternatives	• Step up intermediate care • Access to Care and Urgent Care at Home – *includes rapid response nursing, non-community hospital step up, enhanced care at home and tele health* • IV antibiotics in the community • Enhanced end of life 72 hour pathway - *across three hospices, each facing one of the CCGs primary acute providers*	*Reduction of 1,241 admissions*
Interface care	• Community geriatrics and interface geriatrics - *includes care at home, multiple morbidity reviews across Wiltshire, strengthening input into A&E assessment models, reducing readmissions from intermediate care and developing a Frailty Unit approach across community hospitals* • Developing and rolling out the concept of Discharge to Assess	*Reduction of 300 admissions*

Area	Actions and initiatives	Impact
Reductions in acute length of stay	• Bed based discharge to assess in Sarum • Non bed based discharge to assess • Trusted assessment • Improvements in intermediate care provision • DTOC recovery plans	*Contribute to an overall reduction of length of stay of two days per episode*

Linking BCF to other key CCG initiatives

33. There has also been engagement and close working between BCF and the CCG team implementing TCOP (Transforming Care for Older People); a series of locality based initiatives to reduce non elective admissions for over 75s. The key benefit of this co-ordination is a clear understanding of how the different initiatives will interrelate and to ensure there is no duplication or crossover in planned reductions in non-elective care.

Wiltshire's whole system approach (ES5)

34. To ensure there is a whole system approach to plans for delivering care and ownership of those plans, we built on our close relationship with provider colleagues across the system as well as commissioners and Wiltshire Council. Our objective was to make sure that the system developed a shared picture of the requirements for 2015/16 and able to align approaches and plans, with a particular emphasis on transformational change.

System working

35. Highlights of the system working together since 2014 included the following:

- Over autumn and winter 2014 we held and chaired two meetings with Chief Executives and Finance Directors from our major providers to share perspectives, confirm our joint commitment to the strategy and achieve a common approach to what we should do next. Their feedback confirmed sign up to the strategy and the need for transformational change, which was agreed to be included our proposed approach
- We also hosted two meetings with Provider Strategy Directors, to ensure that the level of resources we were proposing to deploy was shared and understood. This also helped to cascade information further into provider organisations to be included in their planning
- In early February 2015 as our plans reached greater maturity, we hosted an operational level workshop to galvanise action and line up support for implementation. This was well supported by our clinical leadership, with good attendance from all our system partners, which helped confirm the scale of change proposed as well as the anticipated financial and activity impact of our plans
- We have regularly briefed our Council partners at our monthly Joint Commissioning Board about our developing plans
- Using a series of updates and meetings we have also kept neighbouring CCGs BaNES and Swindon updated about the direction of travel of our plans so that any misalignment was identified

Operational alignment

36. At a more operational level we have worked closely with colleagues across the system to align our plans. This has been particularly important since the announcement of the results of the consultation on the 2015/16 tariff, where we communicated with provider colleague to outline:

- Our recurrent financial position in the light of the 2015/16 allocation and current financial performance

- The impact of the tariff consultation on resources available for provider services
- The CCGs approach to managing the financial risk

Aligning contracts

37. Through our contracting process we have worked with provider colleagues to
    - Share and agree activity and financial baselines
    - Map through the impact of QIPP schemes
    - Understand the impact of any other service proposals
38. The process has been understandably slower than expected because of the instability arising from the tariff consultation. We continue to work closely with colleagues across the system to ensure that there is a reasonable alignment in the financial and activity elements of plans and that any material misalignment is clear, explained and where necessary, mitigated.

Our capacity and demand model (ES6)

How we developed our demand and capacity plans

39. We have a robust capacity and demand model, which is refreshed annually, taking into account changes that would impact on projected levels of demand. In 2015/16 we:
    - Identified the most appropriate baseline position, making this robust by accounting for factors such a non-elective growth in 2014/15, to give us a realistic start point and one that would be supported by providers
    - Used weighted list size to determine population growth; this is more accurate than ONS in reflecting Wiltshire's local population changes and additional demand we should expect because of local population changes
    - Factored in other demand increases for example from changes in waiting lists and estimates of the impact of health awareness campaigns to build a true picture of increases in demand, whether recurrent or non-recurrent
    - Focused on non acute pressure areas such as prescribing, CHC and FNC to establish realistic growth assumptions and understand impact of issues such as high cost drugs and the in year impact of changes in policy
    - Included QIPP plans for reductions in non elective activity through BCF and TCOP, as well as initiatives around planned care
    - Started to review the impact of demographic changes in one of our Groups, as initial analysis indicated that demographics could generate higher demand for services. Work continues in this area to assess whether this represents a material risk that we need to incorporate into our plans

Understanding our comparative performance

40. As part of the modelling we reviewed our picture of performance and the comparative position of providers to identify potential QIPP actions. We analysed and evaluated:
    - The CSUs horizon scanning which benchmarked provider and service performance
    - Wiltshire Council's JSA including a locality level breakdown
    - CCG analysis that examined in detail provider performance in a range of operational areas
    - Commissioning for Value packs which indicated pathways that may merit attention

41. None of these assessments drew out or highlighted areas that demonstrated major difference between Wiltshire and its peers, whether locally or nationally, which would suggest major or material adverse comparative performance. This reflected our analysis during the previous planning round which included a comprehensive review of comparative information and found a similar position.

42. This exercise therefore confirmed our previous assessment that Wiltshire is a lean commissioner, there were no "easy wins" and that the direction of travel set out in the strategy of shifting care into out of hospital settings remained valid.

Aligning our plans with the local system

43. By bringing together these different factors that reflect the local position in Wiltshire, the plan has given us a clear projection of demand in 2015/16. We worked closely with providers through the contracting process to share information and get buy in to our activity plans, particularly:

    - Our activity assumptions
    - Baselines
    - Activity projections

44. This process has ensured:

    - We have robust plans that reflect the CCGs comparative performance position
    - That plans have been openly shared with providers
    - Our plans align across the system.

Our internal assurance processes (ES9)

45. Our Governing Body and Clinical Executive form an integral element of our internal assurance process for operational plans. An important focus has been on addressing the lessons learned from 2014/15 to ensure that plans for 2015/16 are realistic and deliverable.

46. The key elements of our planning process and assurance are set out below, showing how the Governing Body and Clinical Executive have reviewed and assured our plans.

The Governing Body and Clinical Executive have actively assured all stages of planning

Planning stage	Actions and initiatives
Understanding our financial position	• Our Chief Financial Officer has produced a monthly report since November 2014, summarising the CCGs current financial position and forward projections for 2015/16 to demonstrate the scale of available resources and the CCGs financial challenge during 2014/15 and projected into 2015/16 • This has provided a clear statement of our financial position, the extent of the QIPP challenge facing the CCG and plans being developed to address these issues • This has been supported by detailed monthly reporting of progress and achievement of each of our key programmes of work via our Monthly Integrated Performance Report to the Governing Body.
Formulating our approach	• With a clear understanding of the financial challenge, we developed a twin track approach to developing our 2015/16 plans • We worked with Localities and Groups to formulate initiatives and plans at locality level. • Alongside this we developed system level plans to address broader system level issues across providers. • Our Clinical leaders strongly support this approach, which built on previous process and ensures both local clinical input and central direction from the Governing Body to drive delivery of our strategy.

Planning stage	Actions and initiatives
Lessons learned from 2014/15	• We also undertook a critical review of 2014/15 to identify key lessons learned, which included an independent review of our programme management methodology • Key learning points taken on board were: a) **Capacity and capability** – ensuring sound leadership, project management skills, specialist skills and sufficient time dedicated to delivery for each project; we have both central OD and individual Personal Training and Development plans to address this b) **Quantification** - Ensuring plans are not over optimistic, duplication/overlap is identified and eliminated at the planning stage, lead times are built in and phasing is realistic c) **Programme management** – additional training to better utilise the CCGs programme management methodology and realise the benefits of the approach. PWC Internal Auditors have strongly endorsed our established structure and processes; we need to improve the application of the toolkit. d) **System approach** – getting active buy in and agreement and support for our plans from providers – we have done this in a systematic way for 2015/16 with a combination of system wide meetings and workshops e) **Appropriate governance** – emphasis on authorising robust plans then applying governance appropriate to the size and risk of the project, not "one size fits all". Reducing duplication of reporting to free up scarce staff time – we have streamlined our approach without diluting the richness of monthly reporting via our Integrated Performance Report to the Governing Body • Appendix A shows our assessment of the 2014/15 Delivery Plan and the key learning points for each programme area
Developing the longlist of initiatives	• We consolidated suggestions and proposals from Localities, Groups and CCG staff into a longlist of initiatives which showed a wide range of possible actions across both planned and unplanned care in and out of hospital. This was discussed, shaped and agreed by the Clinical Executive and endorsed by Governing Body. • We developed and agreed a set of evaluation criteria to indicate the strategic and financial impact of proposals as well as the risks for each
Agreeing and developing the shortlist	• The longlist was evaluated against the criteria and risk assessed to develop a shortlist of initiatives that were identified as the most impactful in the context of the strategy and their financial impact • We developed scoping documents for each shortlisted scheme which set out the high level plan and timeline, to move the implementation process forward and assist the decision making of the Governing Body
Sharing our developing plans with partners	• We have shared both approaches and plans with partners at Chief Executive level down • We met with Directors of Strategy in November and December 2014 to explain our approach and the scale of the challenge; this was followed up in Feb 15 • We met with provider colleagues in January to set out high level parameters and in February for a workshop to participate in development of detailed plans • We have also worked closely with provider colleagues circulating our financial planning assumptions, then sharing and agreeing financial and activity baselines so contracts are aligned

47. This shows our planning process has involved a wide range of clinical colleagues throughout. Clearly setting and updating the financial context meant that the financial parameters and pressures were explicit so the Governing Body and Clinical Executive's review and assurance of both the planning process and the content of plans was properly contextualised and therefore valuable at CCG well as individual project level.

Supporting material

48. The Excel file that accompanies this document provides additional supporting information:

- **Annex A** – shows how we have successfully addressed the 15 fundamental elements of operational plans
- **QIPP schedule** – sets out our list of QIPP plans with summary plans for material schemes (those over £0.5m)
- **FVIA** – confirms Wiltshire's position in 25 areas to show that we are putting the ideas set out in the Five Year Forward View into action

49. We have also included:

- **Summary plans for each of the material QIPP schemes** shown in the QIPP schedule. These are underpinned by more detailed Project Workbooks, which have not been included in our submission
- **Responses to NHS England's Key Lines of Enquiry** – our responses to NHS England's feedback on the CCGs initial draft of planning documents

Appendix A – Delivery Plan performance 2014/15

This appendix summarises the CCGs Delivery plan performance in 2014/15, using the latest data from the Integrated Performance Report to quantify the extent of achievement anticipated by the end of 2014/15.

We have also mapped the key learning points from the CCGs review of 2014/15 against each scheme. The five points were:

- **Capacity and capability** – ensuring sound leadership, project management skills, specialist skills and sufficient time dedicated to delivery for each project
- **Quantification** - Ensuring plans are not over optimistic, duplication/overlap is identified and eliminated at the planning stage, lead times are built in and phasing is realistic
- **Programme management** – additional training to better utilise the CCGs programme management methodology and realise the benefits of the approach
- **System approach** – getting active buy in and agreement and support for our plans from providers
- **Appropriate governance** – emphasis on authorising robust plans then applying governance appropriate to the size and risk of the project, not "one size fits all

The learning will be taken forward into 2015/16, with:

- An in depth and critical review of 2015/16 plans before they are authorised
- Assessment against predetermined criteria, with an emphasis on leadership, capacity/capability and sign up from providers as critical success factors
- Ensuring the right support is in place so plans are set up to succeed and not set up to fail

2014/15 Delivery Plan position	% delivery anticipated	£m planned savings	% forecast savings	Top lessons learned in priority order – maximum 3
<u>Urgent care</u> • Substantial work undertaken through Operational Resilience Capacity Planning Group • Community Urgent Care reviews to be rolled forward into 2015/16 • 7 day working to extend into 2015/16 • Mental health crisis concordat action plan agreed and submitted for approval	**85**	**3.6**	**40**	• Programme management • Capacity and capability • Appropriate governance

2014/15 Delivery Plan position	% delivery anticipated	£m planned savings	% forecast savings	Top lessons learned in priority order – maximum 3
<u>Planned care</u> • MSK transactional transferred to BAU • Referral Information System subject to business case and decision on whether this is rolled into 2015/16 • Shared decision making awaiting confirmation of pump priming and take up by early adopter sites • Ophthalmology will be rolled into 2015/16 subject to meeting with providers	**90**	**2.7**	**40**	• Capacity and capability • Quantification • System approach
<u>Optimising Community teams</u> • Roll out of social care and mental health still to complete • CCG facilitators in place but planned additional 20 staff in teams not yet in place • Reprocurement of community services underway with preferred bidder expecting to be identified in November 2015	**75**			• Appropriate governance • Capacity and capability • Programme management
<u>Intermediate Care (part of BCP)</u> • Preparation to handover community hospital step up beds to BAU • Discharge to Assess pilots underway and being evaluated • Help to Live at Home recruitment being managed by a task and finish group • Workforce development priorities identified and action plan being developed	**75**			• Quantification • Programme management • Appropriate governance
<u>Primary Care development</u> • Co-commissioning - CCG has expressed interest to jointly commission primary care from April 2015, formal ballots underway. • TCOP development at locality level with expected benefits to be delivered in 2015/16	**80**			• Appropriate governance • Quantification • Programme management

2014/15 Delivery Plan position	% delivery anticipated	£m planned savings	% forecast savings	Top lessons learned in priority order – maximum 3
Long term conditions • The diabetes programme is focusing on the main aspect of pathway redesign • The objective is to bring services closer to people's homes and out of hospital settings	**90**			• Quantification
End of Life Care • Electronic Patient care Co-ordination System support being identified as this transitions into BAU • Education programme continues to roll out and new TEP form in operational use with evaluation process being developed • Links to BCF pilots around 72 hour pathway and extension of Salisbury Hospice pilot	**70**			• Programme management • System approach

Wiltshire CCG
2 February Draft Operational Plans
Feedback and key lines of enquiry

Theme	Feedback and Key Line of Enquiry	CCG response
Documentation	The documents are not yet complete. To recap the requirement is: Executive summary Completed spreadsheet including: • Completed Annex A template • Completed Forward View into Action template • Completed QIPP template And additionally narrative supporting QIPP plans	We have completed all of these items: • Narrative summary • Excel Spreadsheet – all three elements • PowerPoint pack with summary QIPP plans
Executive summary	Please follow the content required on the 'ask' slide deck for the Executive summary	• All of this is included in the narrative – the NHS England template confirms the "section headings" which were used to develop the document outline. • Headings in the document are reference to the ES number for clarity
	Describe the benchmarking you have used as part of 15/16 planning process.	This is set out in the narrative document: • We used Horizon Scanning from the CSU • We provided CCG and locality level analysis in a number of key areas around non elective admissions and other aspects of care to encourage local ownership of activity • Relied on accumulated experience from last year's benchmarking which proved we're a lean commissioner and there is no "low hanging fruit", which confirms the direction of travel set out in the CCGs Five Year Strategy
	Describe how you have taken account of Commissioning for Value packs and LA profiles.	• CFV packs reviewed by Mark Harris to identify any key pathway areas and has helped in developing planned care projects • JSA at locality level used in locality planning that has supported development of QIPP longlist and locality plans, helping shape local services and initiatives
	It would be helpful if the key commissioning intentions were quantified e.g. increase IAPT by how much	• The initiatives in QIPP plans (PowerPoint deck) all set out the financial and activity impact plus the anticipated phasing of changes

Wiltshire CCG
2 February Draft Operational Plans
Feedback and key lines of enquiry

Theme	Feedback and Key Line of Enquiry	CCG response
QIPP	In line with the forward view, we would encourage all CCGs to aim for 3% QIPP even if this means generating higher surpluses which are not initially invested. Size of QIPP target compared to 14/15 needs to be tested.	• The 2015/16 QIPP requirement = £9.5m and we have plans to deliver the whole requirement. This represents 1.75% of available resources (excluding running costs) of £542m. 3% would be £16.4m • The QIPP position has been based on the assumption that the majority of providers elect to use the ETO tariff option. The final QIPP challenge may change depending on the outcome of provider contract agreements and other funding assumptions e.g. capital grants for community equipment services. • 2014/15 QIPP was £11.6m, which represented 2.2% of available resources (excluding running costs) of £523m
7 day service	CCG to summarise progress to be made **by provider** in 2015/16 re. implementation of at least 5 of the 10 clinical standards for 7DS, ie, update plan to describe 1. whether baseline assessment of 7DS has been undertaken (using NHSIQ template) 2. whether Service Development and Improvement Plans are in place 3. by provider, which 5 of the 10 clinical standards have been prioritised for implementation in 2015-16, and summarise key milestones 4. whether metrics have been developed/agreed to facilitate monitoring	• A detailed template is attached at the end of this document setting out the position for each of our three principal providers
Annex A	Not yet completed	• Annex A is complete – in Excel workbook
Francis, Berwick, Winterbourne		• No information requested. The narrative submission and our responses in Annex A demonstrate our commitment and actions in these areas
Patient experience	How will the CCG set measurable ambition?	• This has been put in place as part of the CQUIN and are included in the Quality Schedule of provider contracts • A9 shows CQUIN and Quality schedules

Wiltshire CCG
2 February Draft Operational Plans
Feedback and key lines of enquiry

Theme	Feedback and Key Line of Enquiry	CCG response
Reducing harm	Is the CCG clear on actions and outcomes?	• Yes, this is part of our approach to quality, where we have transferred measures to reduce harm that were part of our CQUIN into BAU – this is monitored through the quality schedule in contracts • See A9 for agenda and CQRM papers
Sepsis and acute kidney injury (patient safety Annex A) A8	**Sepsis** CCG plan to confirm that Hospital/Ambulance Trusts and GPs have action plans in place to achieve compliance with Patient Safety Alert (NHS/PSA/R/2014/01, 2 September 2014	• GWH – have confirmed plans are in place (email from Hilary Walker – A8) • RUH – have set out the plans they have put in place (email from Helen Blanchard – A8) • SFT – Sepsis 6 pathway in place (email from Lorna Wilkinson – A8) • SWAST – being progressed through CQUIN (email from Jane Andrews – A8) • CCG will be implementing this national CQUIN for 15/16
	Acute kidney injury CCG to confirm that the NHS nationally agreed algorithm, standardising the definition of AKI and providing the ability to ensure a timely and consistent approach to detection/diagnosis, is being implemented. CCG to report whether plans are in place to integrate the algorithm into a Laboratory Information Management System (LIMS).	• GWH – have confirmed plans are in place (email from Hilary Walker – A8) • RUH – algorithm purchased and being tested before going live (email from Helen Blanchard – A8) • SFT – in place since February 2015 (email from Lorna Wilkinson – A8) • SWAST – being progressed through CQUIN (email from Jane Andrews – A8) • CCG will be implementing this national CQUIN for 15/16
Antibiotic prescribing (patient safety Annex A) A8	Plans should confirm that CCG is monitoring usage at practice level and secondary care, and targeting support to outliers.	• Primary care antibiotic prescribing being actively monitored and action taken – see Area Team data antibiotic plot (A8) • Secondary Care antibiotic prescribing was an element of CQUIN for 14/15 and it is anticipated that this will be included in the 15/16 quality premium for CCG's.
NHS Constitutional standards	For standards that are currently failing what learning has the CCG identified during 2014/15 and how are you using this to develop more robust plans for 2015/16? Please append a recovery plan for all failing standards.	• Our narrative submission sets out all standards that require remedial action and summarises what action has been taken, which should confirm that plans have been put in place to address these issues. • Plans are in place although Wiltshire CCG is not lead commissioner for all aspects of services highlighted

Wiltshire CCG
2 February Draft Operational Plans
Feedback and key lines of enquiry

Theme	Feedback and Key Line of Enquiry	CCG response
Forward View into Action	Not yet completed	• This is complete and part of the Excel Workbook
Public Health England focus	Does the CCG have agreed, measurable and achievable ambitions on reducing obesity, alcohol harm and tobacco use? Does the CCG have plans to increase their work on diabetes prevention? Does the CCG have commissioning plans to ensure all NHS providers improve the health and wellbeing of their staff and MECC?	• Yes – we work closely with our partners through the Health and Wellbeing Board in these three areas. Plans are in place and are updated as part of a cycle of development. Examples include: a. Reducing obesity – Healthy Weight 4 Life and Eat Out Well b. Alcohol harm – alcohol misuse and services for young people (elements of Regaining good health programme) c. Tobacco use – Stop smoking service • Yes – we have already initiated joint work with the Council and in 2014/15 central aspects of our work were around prevention and self-management. We will continue this as part of our development of a common system wide diabetes pathway. There are also links to other prevention programmes around Healthy Eating, Obesity and exercise that will support the prevention of diabetes • Yes - We work through the Health and Wellbeing Board with other public sector partners including providers on workplace health and encouraging adoption of the Workplace Wellbeing Charter, to confirm provider organisation's commitment to the health of its staff

Wiltshire CCG
2 February Draft Operational Plans
Feedback and key lines of enquiry

Summary of responses from principal providers to 7 Day Working

- Responses provided by GWH and SFT. A more detailed document is available from GWH which sets out their planned milestones
- No response yet from RUH

NHS England requirements	GWH	SFT	RUH
Baseline assessment of 7DS has been undertaken using NHSIQ template	Yes Copy available	Yes	
Service Development and Improvement Plans are in place	No because national contract has not been provided, so this has not been agreed	No because national contract has not been provided, so this has not been agreed	
Which 5 of the 10 clinical standards below have been prioritised for implementation in 2015-16, and summarise key milestones			
1. Patients, and where appropriate, families and carers, must be actively involved in shared decision making and supported by clear information		Prioritised	
2. All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible (at the latest within 14 hours of arrival at hospital)	Prioritised Milestones available	Prioritised	
3. All emergency inpatients must be assessed within 14 hours by an MDT for complex or ongoing needs, with a care plan with estimated discharge date and criteria in place within 24 hours	Prioritised Milestones available		

Wiltshire CCG
2 February Draft Operational Plans
Feedback and key lines of enquiry

NHS England requirements	GWH	SFT	RUH
4. Handovers must be led by a competent senior decision maker and take place at a designated time and place, with MDT participation	Prioritised Milestones available We have included the requirement to be reviewed by a consultant within 14 hours in the proposed Quality Schedule	We have included the requirement to be reviewed by a consultant within 14 hours in the proposed Quality Schedule	We have included the requirement to be reviewed by a consultant within 14 hours in the proposed Quality Schedule
5. Hospital inpatients must have scheduled seven-day access to diagnostic services	Prioritised Milestones available	Prioritised	
6. Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions		Prioritised	
7. Where, following acute admission, a mental health need is identified, the patient must be assessed by psychiatric liaison within 1 hour for emergency care needs, and 14 hours for urgent care needs, 24 hours a day, 7 days a week			
8. All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily. Once transferred to a general ward patients should be reviewed at least once every 24 hours, 7 days a week			
9. Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week		Prioritised	
10. All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement	Prioritised Milestones available		

Wiltshire CCG
2 February Draft Operational Plans
Feedback and key lines of enquiry

NHS England requirements	GWH	SFT	RUH
Whether metrics have been developed/ agreed to facilitate monitoring	Yet to be developed as SDIPS not yet agreed	Yet to be developed as SDIPS not yet agreed	

(Detail held by Victoria Stanley)

2015/16 Planning round assurance: CCG template

Wiltshire CCG

Instructions for completion

This template is for completion by CCGs.
The CCG return will then be reviewed by NHSE sub regional teams as part of the 2015/16 planning round assurance process
There are three tabs to complete:

1. Assurance on Annex A - this tab is for the CCG to provide evidence that its 2015/16 plans reference to each 'ask' referenced in Annex A of the NHS England publication '*Supplementary information for commissioner planning, 2015/16'* which is available from NHS England's website.

2. QIPP - this tab is a simple list of all QIPP schemes and requires the CCG to define which schemes it considers 'material'. CCGs should also submit to their sub region supporting papers on each 'material' QIPP scheme.

3. FVIA - this tab is for the CCG to provide evidence that it has referenced additional 'asks' included in the NHS England publication '*The Forward View into Action, Planning for 2015/16'* .

The assurance on annex A and FVIA tabs require the user to select a response from a drop down list and then add additional comments to support the response.

Please save the file using the following file format, "xxxx CCG Narrative Op Plan Assurance Template" where 'xxxx' is the full name of the CCG

This template must be submitted to the Head of Assurance at your sub regional team by 27th February 2015 (draft plans) and again by 10th April 2015 (final plans)

Wiltshire CCG

Annex A: fundamental elements of operational plans			CCG to complete		
Ref	**Fundamental element**		**To what extent is this element**	**Please provide a short statement of assurance following from your response in column D, max 100 words. Please include within this cross references to relevant sections of main op plan narrative and/or other existing plans (e.g. ORCP, recovery plans etc.)**	**Evidence base**
	Outcomes				
A1	Delivery across the five domains and seven outcome measures	- Your understanding of your current position on outcomes as set out in the NHS outcomes framework - The actions you need to take to improve outcomes	Featured	Our position on outcome measures is better than the England position, with Domain 4 slipping slightly. A detailed analysis is available to show Wiltshire's position by domain Section ES2 in the narrative submission shows how key elements of our plans are linked to each of the domains showing that our plans and actions are designed to improve outcomes	Summary in narrative submission (ES2), plus detailed Excel Quality Dashboard file
A2	Improving health	Working with HWB partners, your planned outcomes from talking the five steps recommended in the "commissioning for prevention" report.	Featured	***HWB perspective on the Five Steps:*** **1. Analyse key health problems.** We collected and published data and analysis of the health and wellbeing in our County and community areas, sharing with over 2,000 people in 2014. The experts in our single intelligence, research and performance team provide analysis to define local priorities and decide the action required to improve local outcomes. **Outcome** - The breadth of our data collection means we have a comprehensive picture of the factors influencing health outcomes to address problems more effectively with our partners. **2. Prioritise and set common goals**. We are committed to developing service and action plans with our partners for all council services that affect all public services in Wiltshire, such as demographic changes and obesity. The Service Plans we are currently preparing for the year ahead will be influenced by the JSA, the business plan outcomes, priority actions and the goals set with our partners. **Outcome** - We will deliver the joint HWB strategy, working across organisational boundaries to deliver local priorities and plans, using pooled budgets and integrated services where this is appropriate and where it will improve outcomes. **3. Identify high-impact programmes.** We focus on prevention and helping vulnerable people and families with complex needs to manage their problems before these escalate and further intervention is needed. We have committed to continued investment in early intervention and commission preventative working with partners to reshape and redesign multi-agency services for families with complex needs. **Outcome** - our services enable early intervention and improve health and wellbeing to reduce risk factors and causes of premature mortality. **4. Plan resources.** We ensure our long-term strategy aligns resources with our commitment to deliver the vision set out in our Business Plan. We share buildings, facilities and resources, wherever this is possible and we support communities to be active and self-sufficient by helping people in communities connect with each other and make the best use of resources they already have. **Outcome** - providing resources and services for those most in need of them. **5. Measure and experiment.** We have a strong track record on innovation: with services nationally recognised at the cutting edge. Our innovative Community JSA, Help to Live at Home, Health Eating, Health Trainer, Stop Smoking and Active Health programmes are all improving health and wellbeing across our County and changing lives. **Outcome** - we measure success and performance through our service planning process which sets objectives, outcomes and priorities but also through the JSA and against the expectations and experience of their residents.	JSA, Joint action plans and Business Plan 2013-17, Investment plans for early intervention, schemes underway cited in narrative Summary Plan

A3	Reducing health inequalities	- Identification of the groups of people in your area that have a worse outcomes and experience of care, and your plans to close the gap. - Implementation of the five most cost effective high impact interventions recommended by the NAO report on health inequalities - Implementing EDS2 - Examination of how the organisation compares against the first NHS Workforce Race Equality Standard	Featured	To identify groups/areas of our County where health inequalities exist, we utilise the Wiltshire Joint Strategic Assessment (JSA) as part of our planning process. This is made up from a range of sources, and is supported by JSAs for each of our twenty local communities, which provides vital local insight for the local derivation and tailoring of plans. All our major decisions are supported by an Equality Impact Assessment. We have invested in the training of E&D Advisors in each of our service re-design areas, and have commissioned work from our CSU to implement EDS2 in a proportionate manner The Governing body receives a comprehensive quarterly report on workforce, which includes a diversity profile of the CCGs workforce. We are working with our HR partner in the CSU to develop tools for self assessing our equality performance	Locality planning packs include JSA summaries CCG work with CSU to implement EDS2 November 2014 Workforce report to Governing Body
A4	Parity of Esteem	- The resources you are allocating to mental health to achieve parity of esteem - Identification and support for young people with mental health problems - Plans to reduce 20 year gap in life expectancy for people with severe mental illness - The planned level of real terms increase in spending on mental health services	Featured	We are planning to invest £1.63m ring fenced allocation into Mental Health Services, which will contribute to establishing parity of esteem. Our plans include the development of early intervention services for people with emerging personality disorders, including young people. We already commission early intervention services for young people with psychosis. Through the development of integrated teams (Primary, community and social care, including Mental Health Community services) people with severe mental illness will be identified through risk stratification and be offered health checks and care co-ordination as specified in our imminent Community Services Procurement. We are applying the national CQUIN indicator 4 with the goal of ensuring that individuals with severe mental illness receive the comprehensive cardio metablic risk assessments and treatments required to prevent premature mortality. The second indicator we have identified from the national menu relating to urgent care and the improved recording of diagnosis in A&E with an aim to reduce the rate of mental health re-attendance at A&E. A community focussed intensive support service is being commissioned for 15/16 to support those individuals with a learning disability who require additional support and intervention when in crises and prevent an avoidable admission to an inpatient facility.	The specification for Community Services as part of the Integrated Community Team model includes specific reference to inclusion of physical health checks for people with severe mental illness being classified as with other long term conditions.
	Access				
A5	Convenient access for everyone	- How you will deliver good access to the full range of services, including general practice and community services, especially mental health services in a way which is timely, convenient and specifically tailored to minority groups. - Plans to improve early diagnosis for cancer and to track one-year cancer survival rates	Featured	The underlying philosophy and approach within our Five Year Strategy is to deliver access to services that is timely and convenient. Our capacity plan ensures we commission sufficient acute services to assure timely access - see A6. Initiatives outside hospital include deployment of Integrated teams, using MDT approaches to care and continued development of Out of Hospital care. For 2015/16, we have focused strongly on locality level planning, looking at ways that services can be tailored to local needs and local groups of patients. We have used locality level JSAs to identify and understand specific health and care issues and developed tailored actions within each locality We are working to bring together primary and acute clinicians to develop an integrated approach to Public Health campaigns. The objective is to ensure that referral protocols are developed and agreed across primary and secondary care so referrals are appropriate and resources are targeted to patients that are at risk	Locality plans QIPP Effective Planned Care plan

A6	Meeting the NHS Constitution standards	- That your plans include commissioning sufficient services to deliver the NHS Constitution rights and pledges for patients on access to treatment as set out in Annex B and how they will be maintained during busy periods. - How you will prepare for and implement the new mental health access standards.	Featured	**<u>Commissioning sufficient services</u>** - The CCGs capacity plan projects the level of activity required to deliver NHS constitution rights and pledges on access, so we know the volume of services required by Provider and POD. We work through the System Resilience Group to ensure that there is sufficient capacity at busy periods to deliver these standards. We will continue our whole systems approach from 2014/15 and target ORCP monies at schemes that meet specific needs and are shown to be impactful **<u>Mental Health access standards</u> -** Wiltshire currently invest £2.3m a year in Wiltshire LIFT (the local IAPT service) and the service is open access, with people able to book themselves onto courses on-line. Services are available at weekends and in the evenings and are available across Wiltshire. The service receives between 900 and 1,000 referrals a month and because it is an opt in service, there is no triage or discharge as part of the pathway. The service is therefore unusual compared to other IAPT services across the Country and as such data collection against the national KPIs is complicated but work is ongoing to develop systems to collect the new KPIs. At present the service does meet the 2014/15 national targets although it is believed that there is under reporting due to the way that the data is submitted through AWP. We will be working with AWP to prepare for the monitoring of early intervention for people with emerging psychosis, although nationally the indicator is still in development. We are currently reviewing the 3 acute psychiatric liaison services that we commission and are confident that the outcome of the review will prepare us for the indicator for access to acute liaison services when published.	CCG capacity plan SRG prioritisation paper Wiltshire LIFT service and IAPT KPIs
	Quality				
A7	Response to Francis, Berwick and Winterbourne View	- How your plans will reflect the key findings of the Francis, Berwick and Winterbourne View reports - including how your plans will make demonstrable progress in reducing the number of inpatients for people with learning disability and improve the availability of community services for people with a learning disability	Featured	The CCG's Five Year Strategic Plan 2014-2019 (5YSP) outlines our commitment to embracing the recommendations from Francis, Berwick and Winterbourne View. This is evidenced by the strengthening of quality and safety metrics through provider CQRM monitoring, the ongoing embedding of a complaints management process, the use of personal health budgets for Wiltshire residents with LD needs and the innovative commissioning of a Wiltshire unit which will provide flexible community accommodation for people with LD needs. In addition a community intensive LD team which will be integrated within the current CTPLD service to support patients who exhibit challenging behaviour. This should avoid admissions to an inpatient unit but in the event that an admission is clinically appropriate, our care model should assist with a timely discharge back home. Our approach of joint commissioning and provision of services explicitly designed to provide care at home and/or in community settings through an intensive community based team will reduce the level of unplanned crisis intervention and make a broader range of services more easily available	Frances and Berwick papers Winterbourne action plan Monthly quality report

A8	Patient Safety	- How you will address the need to understand and measure the harm that can occur in healthcare services, to support the development of capacity and capability in patient safety improvement - How you will increase the reporting of harm to patients, particularly in primary care and focused on learning and improvement - Your plans for tackling sepsis and acute kidney injury - How you will improve antibiotic prescribing in primary and secondary care	Featured	Our five year strategy sets out plans for driving improvement in patient safety through projects like Harm Free Care with focus on local priorities and clinical risks. The CCG participates in the National Patient Safety Learning "Collaborative" and intend to implement recommendations from National Advisory Group on safety of patients in England, a Promise to Learn – A Commitment to Act, Improving the Safety of Patients in England. The CCG monitors the safety thermometer and safer staffing data for providers, challenges are made at Clinical Quality Review meetings. This triangulated data is discussed bi monthly at the Quality and Clinical Governance committee to identify trends, themes and outliers. Any non mitigated concerns are escalated to the Governing Body for discussion in public. An example of this was at the November 2014 Governing Body meeting, which was widely reported in then local press The plans for tackling Sepsis and Acute Kidney Injury are linked to the CQUINs for 2015/16 and associated stretch targets. The Commissioning Intentions for 2015/16 set out how GPs will be supported to raise standards and quality (clinical effectiveness, patient experience and patient safety) within GP services, reduce unwarranted variations in quality, and, where appropriate provide targeted support for practices. The CCG has a dedicated Infection Prevention & Control function which is providing advice and guidance to the community for primary care and care homes. This team works closely with the CCGs medicines management team to actively monitor antimicrobial prescribing in primary care, the primary care pharmacist discusses outlying practices with the relevant gap lead Antibiotic prescribing in primary care is monitored and action taken on outliers. Plans for improvement are also in our CQUIN for secondary care	Monthly quality report Governing body papers/minutes Quality and Clinical Governance committee minutes
A9	Patient Experience	- How you will set measureable ambitions to reduce poor experience of inpatients care and poor experience in general practice - How you will assess the quality of care experienced by vulnerable groups of patients and how and where experiences will be improved for those patients - How you will demonstrate improvements from FFT complaints and other feedback - How you will ensure that all the NHS Constitution patient rights and commitments given to patients are met - How you will ensure you meet the recommendations of the Caldicott Review that are relevant to the patient experience	Featured	We have set ambitions for the Friends and Family Test for inpatient's and maternity. There is an FFT CQUIN for these groups and a Quality Schedule for providers to report against. The level of complaints and PALS activity will reflect the scale of improvement Since the 1st December 2014 there has been requirement for primary care to implement the Friends and Family Test. Plans for future co-commissioning of primary care would mean that the CCG would measure this as a quality indicator and monitor any required improvement in response rates and feedback. The quality of care to vulnerable groups of patients will be assessed through strengthened links with patient groups/forums and Healthwatch. Complaints made directly to the CCG regarding sub optimal care will be monitored and analysis of any themes and trends highlighted to inform closer scrutiny. We also work collaboratively with Wiltshire Parent Carers and have developed new services in response to their concerns for example overnight short breaks The anticipated introduction of the 2015/16 FFT which requires providers to report on actions taken in response to feedback will be incorporated into the reporting requirements of the Quality Standards and will be monitored through CQRM and contract route. Caldicott guardian in post will have the responsibility to implement recommendations of review NHS constitution rights – The Governing Body reviews and signs of each organisations quality account in May, which are then published in May. This review process helps hold all organisations to account for meting NHS constitutional rights to patients Caldicott – The CCG does not access patient identifiable data. All staff are trained to appreciate and keep confidential any patient information that they might handle in the course of their work.	CQUINS and quality schedules Overnight short breaks paper LD forum

A10	Compassion in practice	- How your plans will ensure that local provider plans are delivering against the six action areas of Compassion in Practice implementation plans - How the 6Cs are being rolled out across all staff	Featured	Our five year strategic plan sets out how the six areas of action will be delivered as one programme to achieve the values and behaviours of the 6Cs. The 6Cs are set out in provider's quality schedules so the requirement is clear and the CCG will ensure that local provider plans are delivering against the six action areas by monitoring provider's action plan. Providers will also be reporting their position against 6Cs to their own Boards The CCGs Quality Team have primary responsibility for 6Cs and have already received training relating to 6Cs, with these skills now part of the team's core competencies We are committed to supporting ongoing rollout the 6Cs out across the health and social care system and have obtained national funding to support Help to Live at Home Providers in Wiltshire to deliver compassionate care to those individuals in receipt of care at home.	See Compassion section
A11	Staff satisfaction	- An in-depth understanding of the factors affecting staff satisfaction in the local health economy and how staff satisfaction locally benchmarks against others - How your plans will ensure measureable improvements in staff experience in order to improve patient experience	Featured	Staff satisfaction is monitored through CQRMs as part of the Local QS. The quality schedule requires providers to submit an annual staff /workforce report which includes retention rates, appraisals and training, which helps us understand the factors that affect staff satisfaction in the local health economy. Workforce reports indicate that our turnover and absence rates are very low. We believe one of the key factors that drives these trends is our continuous investment in education and training for our staff. By professionally up skilling we seek to create an environment where new ideas can flourish. We have also made a strong commitment to leadership training and development of our people to give them the vision and confidence to be leaders of change. Our appraisal system is based on a cascade of corporate objectives to help coherence of effort, and every member of staff has a personal development plan. Our recent staff survey indicated clear enthusiasm for this process. Providers are required to provide Patient Experience reports to identify areas of improvement based on themes and trends, which can also inform future re-design of services, which include a focus ion improving patient experience	CQRMs Quarterly workforce report to Governing body Provider patient experience reports
A12	Seven Day Services	- How you will make significant further progress in 2015/16 to implement at least 5 of the 10 clinical standards for seven day working	Featured	7 day working is a priority programme for Wiltshire with key areas of focus on extending 7 day provision in areas such as admission avoidance and discharge planning by: • Continuing to embed and enhance the Urgent Care at Home service 7 days a week. • Step up making this mainstream and 7 days a week • Extending social care input to acute hospitals 7 days a week • Extending discharge to assess and discharge from A & E to a 7 day and extending the concept to community hospitals • Look to mainstream Acute trust Liaison across all Acute trusts • Look at funding GP input on weekends into assigned care homes to manage flow We will build on commissioning principles and existing relationships including: • The intermediate care commissioning principles that reflect the need for 7 day working in identified care homes as part of core contracts • PTS contracts which reflect 7 day principles • Extending care package and care home brokerage / resource team to 7 days • Equipment access - making sure that equipment availability on weekend is the norm • A number of TCOP schemes provide support and input on weekends so we need to link this to an enhanced model of primary care, interfacing with 111 and OOH across 7 days.	**The KLOE submission contains a detailed breakdown of the 7 Day working position by our three principal providers**

A13	Safeguarding	- How your plans will meet the requirements of the accountability and assurance framework for protecting vulnerable people - The support for quality improvement in application of the Mental Capacity Act - How you will measure the requirement set out in your plans in order to meet the standards in the prevent agenda	Featured	Governance arrangements are in place to ensure that the organisations from which we commission services provide a safe system that safeguards children and adults at risk of abuse or neglect. There are Safeguarding Children and Safeguarding Adults schedules in the quality schedules for all provider contracts. These Safeguarding schedules are monitored quarterly and reported to the CCGs Quality and Clinical Governance committee The CCG also has senior representation at LSCH and SAB, working in partnership with local authorities and contributing to Serious Case Reviews. The CCG employs a Mental Capacity Act Lead to oversee service quality when the Mental Health Capacity Act is applied. The required Prevent standards are set out in the adult safeguarding schedule of contracts, which are monitored and reported on. The CCG is also a member of the Prevent Board, which provides a forum for broader understanding of how standards are being achieved and action required to ensure standards are met Safeguarding arrangements for Primary Care will be determined during 2015/16.	Children and Adult Safeguarding schedules Capacity act paper
	Innovation				
A14	Research and innovation	- How your plans fulfil your statutory responsibilities to support research - How you will use Academic Health Science Networks to promote research - How you will adopt innovative approaches using the delivery agenda set out in Innovation Health and Wealth: accelerating adoption and diffusion in the NHS	Featured	We fulfil our statutory responsibilities through our involvement in the local Academic Health Sciences Network We are committed to using innovation and research to drive the transformation we aspire to. By virtue of geography, we are fortunate to be represented on two Academic Health Science Networks (West of England and Wessex). This enables us to share information across a wide network to focus on improving the identification, adoption and spread of innovative health care across our County. We have received support from a local; GP that works part time for the AHSN to help develop some of our QIPP initiatives - Prescribing and Planned care We also draw on the collective experience in linking clinical service and research networks to improve clinical outcomes and utilise the network to translate discoveries into clinical care rapidly	AHSN meting agenda and attendance - example January 2015 Dr Julian Treadwell involvement in QIPP - Planned Care and Prescribing
	Delivery Value				

A15	Financial resilience; delivery value for money for taxpayers and patients and procurement	- Meeting the business rules on financial plans including surplus, contingency and non-recurrent expenditure - Clear and credible plans that meet the efficiency challenge and are evidence based, including reference to benchmarks - The clear link between service plans, financial and activity plans	Featured	Our financial planning has been completed in line with business rules such as the requirement to generate a 1% surplus and provide for 1% headroom. We developed our activity plans based on a capacity and demand model that was comprehensively updated for 2015/16 by confirming baselines, accounting for population growth (not ONS but list sizes which are more accurate), increases in non elective activity and other factors such as the impact of public health campaigns on planned care volumes and waiting lists . We reviewed CSU comprehensive benchmarking (Horizon Scanning), CFV packs and other local analysis which confirmed that the CCG is a lean commissioner, and that there were no areas of obvious poor performance compared to peers that we needed to address. QIPP plans were developed bottom up through a longlist - shortlist - deep dive planning approach, with evaluation criteria used to develop the shortlist and critical review of the activity projections within proposed plans to avoid duplication and confirm their robustness. A detailed assessment of available resources has been updated monthly since October 2014. As a part of the planning process resources are compared to priced up activity plans to confirm that resources available match the projected cost of activity plans. Where plans exceed available resources additional QIPP and/or contractual measures will need to be identified to bridge the gap The finanial, and associated QIPP, plan has been created on the basis of providers opting to choose the ETO tariff. A small number of providers have opted for the DTR tariff which has an immaterial impact on the QIPP challenge.	Monthly reports to Governing body QIPP plans, work on eliminating duplication, benchmarking analysis completed during planning stage Work to match quantum of activity plans to available resources

Note: Please submit detailed QIPP plans for all material schemes to supplement the information you have provided within this template

QIPP plan title	QIPP plan value (£000's)	Material scheme Y/N
Non elective reductions via TCOP and BCF	5,544	**Y**
Prescribing	1,500	**Y**
Effective planned care	615	**Y**
Unplanned to planned	500	**Y**
CHC	869	**Y**
Outpatients	299	N
Day cases to RDA	200	N
Total value	**9,527**	

Forward View into Action		To what extent is this element featured in your plans? - CCG to select response from	Please provide a short statement of assurance following from your response in column C, max 100 words. Please include within this cross references to relevant sections of main op plan narrative and/or other existing plans (e.g. ORCP, recovery plans etc.)
FV1	Confirmation that the CCG recognises that winter pressure funds are within the 2015/16 baseline	Featured	Our plans recognise that Winter Pressures funding is now included in the financial baseline and is recurrently ring fenced. Our approach to allocating these funds is through the System Resilience Group which will prioritise and agree to fund initiatives that are judged to be the most impactful in dealing with winter pressures.
FV2	Confirmation that plans reflect the local impact of national investment in primary care (the £250m)	Featured	The CCG has an application for Vanguard status and if successful, the financial implications will be reflected in plans If this question relates to infrastructure, see answer to FV10 below

FV3	Confirmation that plans reflect the six approaches to prevention	Featured	Our plans, as mapped out in the Council's Business Plan and the Public Health Annual Report, support the six different approaches to improving health and wellbeing for 2015/16 as advocated by the NHS: • We have a Joint Health and Wellbeing Strategy that sets out how we will enable people to live healthily and to be independent, how we will work to meet their needs met and to keep people safe. Our commitment is to work with public sector partners to deliver these aims. The strategy is currently being refreshed and is underpinned by both the CCG's Five Year Plan and our own Business Plan and Service Plans, priorities and goals. • We have collected and published data on countywide and community health outcomes, against national comparators, and are focused on implementing initiatives and programmes that tackle health risks from alcohol, fast food, tobacco and other issues as they specifically affect our communities. • We are committed to improving early and timely diagnosis of high impact diseases including diabetes and renal conditions. This year we ran a diabetes roadshow, with experts going out to our Market Towns and talking to over 750 people. An annual diabetes summit started in 2012 to improve healthcare for people with diabetes and we work with NHS colleagues to improve the care of people with diabetes and to reduce the number of people with Type 2 diabetes by increasing the population's awareness of the disease. • We prioritise creating and supporting inclusive communities where everyone can achieve their potential. • Our Workplace Health Charter initiative and the integration of public protection and occupational health and safety with public health has allowed us to look at how we can more effectively support local business improve health in Wiltshire's workplaces and at the Council.

FV4	Confirmation of plans to expand the offer & delivery of personal health budgets	Featured	Wiltshire CCG is a part of the successful South West Integrated Personal Commissioning Pilot bid to NHS England, working together with Wiltshire Council to further develop the personalisation agenda in Wiltshire. The two organisations are working with third sector organisations to deliver personal care planning for people with long term conditions and there are plans to develop joint care planning, piloting processes in the Wiltshire integrated team programme demonstrator sites. The Council are looking at personal healthcare budgets for children with high levels of need and we are also considering people with learning disabilities. Commissioning intentions for Mental Health include exploring the implementation of integrated personal health budgets The CCGs has implemented personal health budgets for CHC, although this has been limited because there is no dedicated infrastructure to manage this. There are currently 71 eligible patients of which 20 have registered interest in a PHB and a further five now have PHBs. A business case is being developed for additional staff dedicated to rolling out PHBs to all eligible patients who express an interest.
FV5	Confirmation that the CCG has plans to ensure MH patients are offered choice	Featured	Wiltshire CCG is part of a commissioning collaborative of 6 CCGs that co-commission Mental Health services from AWP Mental Health Trust. All six CCGs are working together, with AWP to establish how to offer meaningful choice for MH patients.
FV6	Confirmation that the CCG will review locally available maternity choices	Featured	Wiltshire CCG has reviewed its service specification for the 2015/16 community contract including maternity choices. This is being done in conjunction with co-commissioners and public health. We are also adding to the acute contract SDIP a separate line around maternity provision.

FV7	Confirmation that the CCG is working with local authorities to identify carers, particularly young carers & carers aged over 85.	Featured	The CCG contributes to a carers pooled budget, formalised in a section 256 agreement, which details the pooled funding arrangements for the commissioning of carers services, including those for young carers, in Wiltshire. The budget is managed by Wiltshire Council on half of the Council and the Wiltshire CCG. The commissioned provider works closely with the local authority to identify young carers. In addition, a task and finish group is in place to implement an action plan which focuses our efforts on ensuring we meet the changes required by the Children and Families Act and Care Act. A major part of our action plan is to work with partners to identify who our young carers are in Wiltshire. This will be led by the joint CCG and Wiltshire Council children's commissioning team and will involve GPs, Schools, Colleges, children's services, Health Visitors, School Nurses, Voluntary and Community Sector organisations.
FV8	Confirmation that the CCG will review its own policy towards staff who are carers	Featured	There is currently no specific carer's policy, although there are provisions for supporting carers through policies such as adoption leave, parental leave and flexible working The CCG will review the policy for staff who are carers during 2015/16
FV9	Confirmation that the CCG has plans to bid for a share of the Prime Minister's Challenge Fund	Featured	The CCG are supporting a submission to the PMCF by five practices in Devizes to transform same day primary care access by developing an urgent primary care centre in the town
FV10	Confirmation that the CCG has plans to bid for a share of the £250m premises & infrastructure fund	Featured	The CCG are supporting the Primary Care Integration Project - a group of GPs in Salisbury who are bidding for funds to develop an integrated primary care centre to replace their current premises which are not fit for purpose The Primary Care Programme Board has discussed other practices submitting applications under the Infrastructure Fund

FV11	Confirmation that the CCG will use CQUINs to implement the findings of the urgent and emergency care review	Featured	The approach to CQUINS will be to incentivise the health system to deliver greater effectiveness, as well as supporting the delivery of the QIPP initiatives. Initial plans include aligning the CQUINS's to the aims and aspirations of the CCG and ensure that they contribute to improving the pathways for patients between secondary care and community. A focus will be on improving the communication between secondary care and the community to ensure that safe and timely discharges are achieved. Wiltshire CCG plan to promote collaborative working between secondary care and community to ensure that there is a reduction in avoidable admissions to secondary care.
FV12	Confirmation that the CCG will participate in the new urgent & emergency care network from April 2015	Featured	The CCG will participate in the new Urgent and Emergency Care Networks that will build upon the existing System Resilience Groups. The CCG will participate in the first meeting to initiate the network in March 2015 and it is anticipated that the network should be established by April 2015 to oversee the planning and delivery of a regional or sub-regional urgent care system. This will include designating and then assuring the quality of urgent care facilities, in line with guidance planned for summer 2015
FV13	Confirmation that the CCG plans to use CQC inspection reports in its work to assure quality of care	Featured	The CCG will ensure that it liaises closely with CQC regarding the outcome of inspections and meets regularly with CQC representatives from CQC through the regional Quality Surveillance Group chaired by NHS England. The CCG has also set up a local QSG which will be attended by CQC and at which concerns regarding any care provision can be raised and discussed with both CQC and Local Authority colleagues in a confidential forum. CQC action plans will also be monitored through the CQRM route to gain assurance regarding provider compliance.

FV14	Confirmation that the CCG will work with providers to embed the practice of clear clinical accountability	Featured	The CCG will work with providers to: • focus on improving patient safety, patient experience and clinical effectiveness. • embed learning from incidents, safeguarding, complaints and clinical reviews into contractual processes • seek assurance from site visits and working with providers to enhance services to patients. • continue with projects such as Harm Free Care and the National safety thermometer. • implement personalised care, anticipatory care plans and review priorities for the frail elderly. • place emphasise on monitoring nursing and clinical skill mix and the impact that staff shortages have on patient experience and outcomes. Quality assurance is gained through a systematic four stage methodology: Stage 1: Quality Data Analysis Stage 2: Triangulation Stage 3: Clinical Quality Review Meetings Stage 4: Support Improvement
FV15	Confirmation that plans address the need to have adequate & effect liaison psychiatry services in place	Featured	The CCG currently invests £1.058m in liaison psychiatry services across all 3 acute hospitals that serve the population. The work programme for 2015/16 includes a service review of all 3 services to ensure that services are effective and efficient and meet the needs of people with a mental health problem that are attending ED departments or receiving treatment in an acute hospital.
FV16	Confirmation plans are in place to prevent young people or vulnerable adults undergoing MH assessment in police cells.	Featured	Wiltshire CCG lead the Wiltshire Crisis Care Concordat which has an action plan. Individuals in mental health crisis are taken to a health based place of safety rather than a police station. No patient (adult or child) is taken to a police cell unless there is significant violence or a crime has been committed.

FV17	Confirmation that the CCG will work with other commissioners to invest in children & young people's MH	Featured	There are a wide range of services in Wiltshire that contribute towards promoting children and young people's wellbeing and ensuring they have good mental health. Specific counselling services and mental health services are funded from a number of different commissioners: • Time to Talk counselling service in primary schools in funded from Wiltshire Council – additional funding is provided by schools / local charitable trusts and the Reaching Communities fund. • The TalkZone counselling service for young people is funded by NHS Wiltshire CCG. External funding is also received by the provider. Many secondary schools in Wiltshire also purchase counselling services directly and / or employ their own counsellors. • The Primary Child and Adolescent Mental Health Service is funded by Wiltshire Council. • The Specialist Child and Adolescent Mental Health Service is funded by NHS Wiltshire CCG. The CCG will continue to work closely with Wiltshire Council to improve access to support for children and young people with emotional and mental health difficulties. There is a joint Emotional Wellbeing and Mental Health Strategy for Children and Young People with an Implementation Plan that is overseen by a sub group of the multi-agency Children's Trust Commissioning Executive.
FV18	Confirmation plans are in place to use the contract to enforce use of the NHS number as the primary identifier	Featured	Under Schedule 4 (Quality Requirements) Part B National Quality Requirements of the 15-16 National Standard Contract there are two mandatory KPI's requiring Providers to complete a valid NHS number field in: 1) both Acute and Mental Health contracts submitted via SUS; and 2) in A & E commissioning data sets submitted via SUS These are included in all our quality schedules with our main providers.
FV19	Confirmation plans target 60% of GP prescriptions to be sent electronically to pharmacies by 31st March 2016	Featured	The CCG is currently close to the 60% target with 50 out of 58 practices live and using EPSr2. Our target is for all practices to use electronic prescribing by the end of April 2015. 100% usage is not currently possible because of the restrictions on controlled drugs (change anticipated in October 2015) and because EPSr2 does not currently work for dispensed patients so usage at dispensing surgeries appears lower.
FV20	Confirmation plans to ensure electronic discharge summaries are in place by October 2015	Featured	Wiltshire is working with providers to deliver electronic discharge summaries from acute hospitals. Remedial plan required with GWH and work is underway to deliver an improved performance from this Trust

FV21	Confirmation plans target 80% of GP referrals to be sent electronically to providers by 31st March 2016	Featured	The CCG are working with an IT provider that supports the electronic referral from GP practices. GPs in the south of the County are referring electronically to the acute hospital and plans are moving forward to expand this functionality to other areas of Wiltshire
FV22	Confirmation that a roadmap for fully interoperable digital records will be in place by March 2016	Featured	The CCG is working with Wiltshire Council under the Single View of the Client programme to establish fully interoperable digital records across all parts of the health and social care system. The cost implications of this are currently being assessed and the process for making a system selection is underway. Funding for this programme is a risk as there is no clear funding sources at this point in time.
FV23	Confirmation plans to work with the LETB on workforce planning	Please select	Wiltshire CCG plans to continue to work with the South West Local Education and Training Board through our representative to understand, identify and address workforce planning issues. This includes subjects like the GP Workforce Action Plan, using toolkits such as the LETB dashboards and charts as well as using LETB information on developments such as Integrated Personal Care Budgets
FV24	Confirmation the CCG has plans in place on how to invest the 30% balance from margin tariffs on investment to reduce non-elective admissions	Featured	The CCGs plans are to invest in a range of admissions avoidance services and community services which would be alternatives to non elective admissions. These investments will be either with Providers affected by marginal rates or services affected by this activity and investments agreed by SRG Investments will be made upto the level of marginal rate threshold funding that is held by the CCG.
FV25	Confirmation whether the BCF non-elective reduction trajectory has been revisited	Featured	BCF plans were reviewed as part of the 100 Day Challenge and the evidence base from the challenge shaped the key overarching BCF themes for 2015/16 of admissions avoidance and improving discharge. The reduction trajectory was revisited following the 100 Day Challenge. The original reduction figure was set at 3.75% (which now includes assumed growth of 2%) . We have amended admission avoidance volume by 200 units in 2015/16 (decreased ambition by 200 units) and incorporated this into our plans
FV26	Confirmation that CQUINs are in place for up to 2.5% of annual contract values	Featured	The majority of providers have opted for Enhanced Tarriff Option which will attract a CQUIN scheme. The negotiation and agreement of these schemes has commenced and is intended to reflect the commissioning priorities of the CCG. Initial discussions with providers of acute services have focussed on the adoption of all national CQUINS whihc are relevant and apply them in order to maximise the benefits of the urgent care menu across the system.

Excellent
Good
Acceptable
Under development
Not yet developed

Please select
Yes in 2014/2015 Plans
No - to be added to 15/16 Plans

Director of Finance
Director of Commissioning
Director of Assurance and Delivery
Director of Nursing and Quality

Please select
Featured
Partially featured
Not featured

Please select
Assured
Assured with support
Not Assured

NHS
Wiltshire
Clinical Commissioning Group

2015/16 Delivery Plan

Summary of QIPP Projects to support NHS England Submission

27 February 2015

Contents

Purpose & Development Process

NHS Wiltshire Clinical Commissioning Group

Purpose

- The purpose of this pack is to demonstrate the depth of development of QIPP projects by providing a detailed overview of how they were formulated
- Each project has been scoped and sized, and the QIPP saving included in our financial plans
- The following slides provide a comprehensive synopsis of material schemes (those defined by NHS England as being greater than £0.5m in value). More detailed plans have been set out internally in project workbooks.

Development Process

- We used a structured process to develop the schemes, engaging with clinicians, groups and localities-
  - We developed a 'longlist' of possible opportunities
  - We refined the 'longlist' into a 'shortlist' using pre-determined financial and strategic criteria as part of an engagement exercise with stakeholders
  - We performed detailed scoping work to confirm objectives, understand constraints and plan for delivery
  - We developed activity and financial assumptions to assess the level of savings
  - We identified and eliminated duplication between schemes as part of quantifying schemes
  - We assessed the point at which benefits would be delivered for each scheme
  - We held an engagement workshop with providers to test and reach agreement about schemes and delivery
  - The CSU sized each scheme to confirm financial impact by POD and provider.

Overview of Schemes

NHS Wiltshire Clinical Commissioning Group

QIPP Scheme Title	QIPP Scheme Value (£000's)	Material Scheme Y/N
Non elective reductions via TCOP and BCF	5,544	Y
Prescribing	1,500	Y
CHC	869	Y
Effective planned care	615	Y
Unplanned to planned	500	Y
Outpatients	299	N
Day cases to RDA	200	N
Total value	**9,527**	

Profiling –

TCOP/BCF – we expect benefits to be delivered evenly across the financial year from April 2015 as a result of significant development work that occurred on both schemes throughout 2014/15.

Other schemes – we have confirmed the lead time and point of savings delivery on a scheme by scheme basis.

TCOP - Project Highlights

NHS Wiltshire Clinical Commissioning Group

Identified Cohort -	A&E attendances and non-elective admissions	**Scheme Owner -**	Jo Cullen

Current position and rationale	In 2014 the CCG invited proposals for schemes at locality level to deliver outcomes based on transforming care for older people. We assessed proposals against the following criteria: • The CCG's strategic vision • Improved care for vulnerable older people • Reduced avoidable admissions • Continuity of care for older people • Improved overall quality and productivity of services • Greater integration of health & care services, in particular out of hospital care 13 schemes were supported and are funded on an on-going basis subject to successful delivery of the outcomes (predominantly admissions avoidance).

Intended outcomes

A programme of proactive measures targeted at over 75s at locality level, tailored to local needs will result in :

- A reduction in emergency admissions
- A reduction in A&E attendances
- A reduction in re-admissions
- A reduction in admissions from Care Homes
- Improved access to primary care
- Improved access to integrated care
- Enhanced care closer to the patient's home

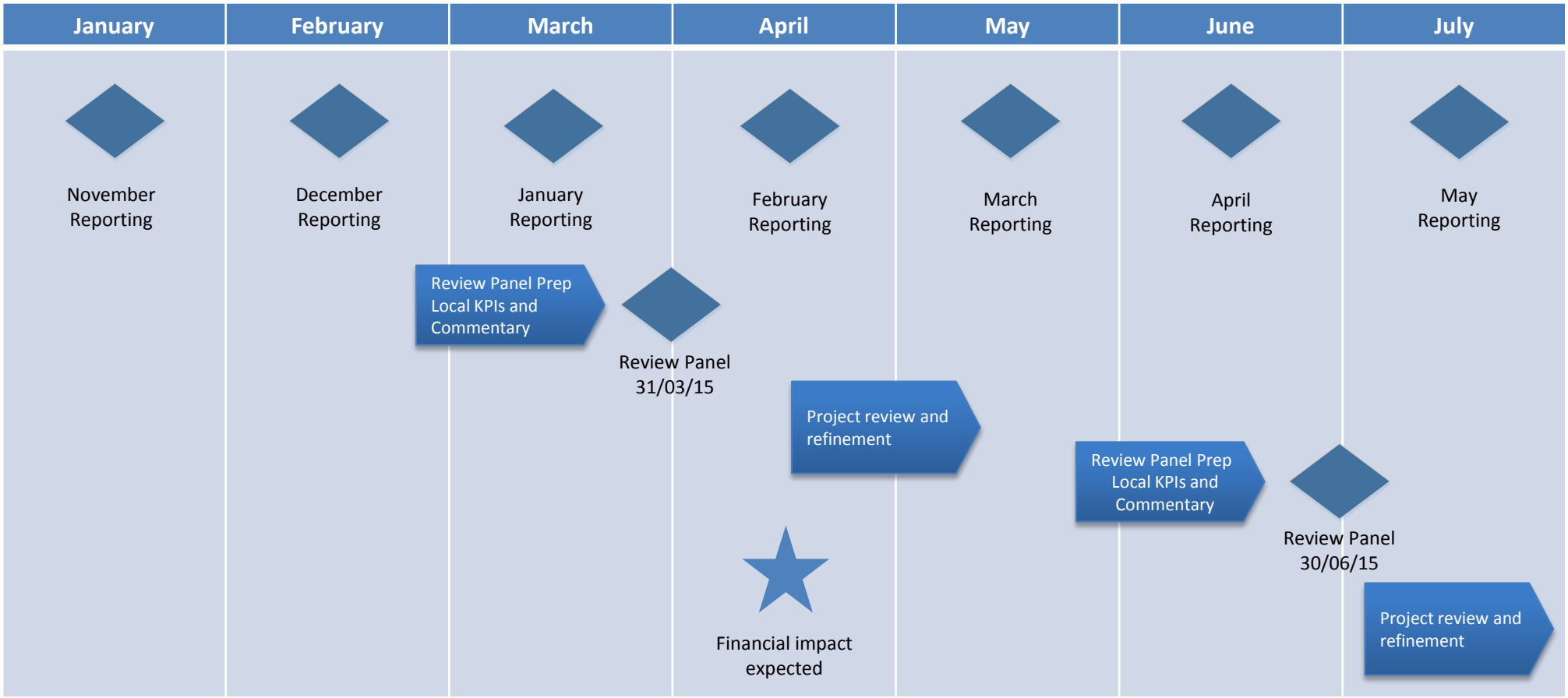
Financial and activity impact

Benefits are expected to accrue in twelfths from April 2015.

Area	Activity Reduction	Financial Impact (£000s)
Emergency Attendances	646	£74
Admissions	1,046	£2,531
	Total -	**£2,605**

TCOP – Milestones and Requirements

NHS Wiltshire Clinical Commissioning Group



Project manager and staff	Communications/engagement	Duplication and interdependencies
• Locality support for review panel preparation, project review/refinement • Programme manager to oversee process, collate reporting • Information/analytical support • Review panel membership	• Local engagement and communication through link to Locality Plans • Shared learning across/between localities	• BCF – identified and eliminated duplication for double counting over 75s NEL • Interdependencies with Locality Planning process

BCF - Project Highlights

NHS Wiltshire Clinical Commissioning Group

Identified Cohort -	Non-elective admissions	Scheme Owner -	James Roach

Current position and rationale

- A range of integrated schemes established across health and social care aimed at managing crisis, reducing admissions and reducing bedded length of stay
- Admissions avoidance and crisis management – the aim is to deliver proactive care and intervention in the community instead of defaulting to an acute admission through a range of intermediate care and community schemes
- Reducing length of stay – they key focus is to get the patient home through one discharge pathway, and to get them home as soon as they are medically fit
- These have been confirmed as key scheme priorities jointly by the CCG and Local Authority, and were launched and piloted during the Wiltshire 100 Day Challenge.

Intended outcomes

Avoid emergency admissions through -

- Step up intermediate care
- Urgent care at home
- Community geriatrics
- Crisis at front door pathway

Reduce bedded length of stay/volume of delayed transfers of care through -

- Roll out of discharge to assess at scale
- Enhanced intermediate care and care at home
- Integrated discharge processes in place at each of the 3 acute hospitals

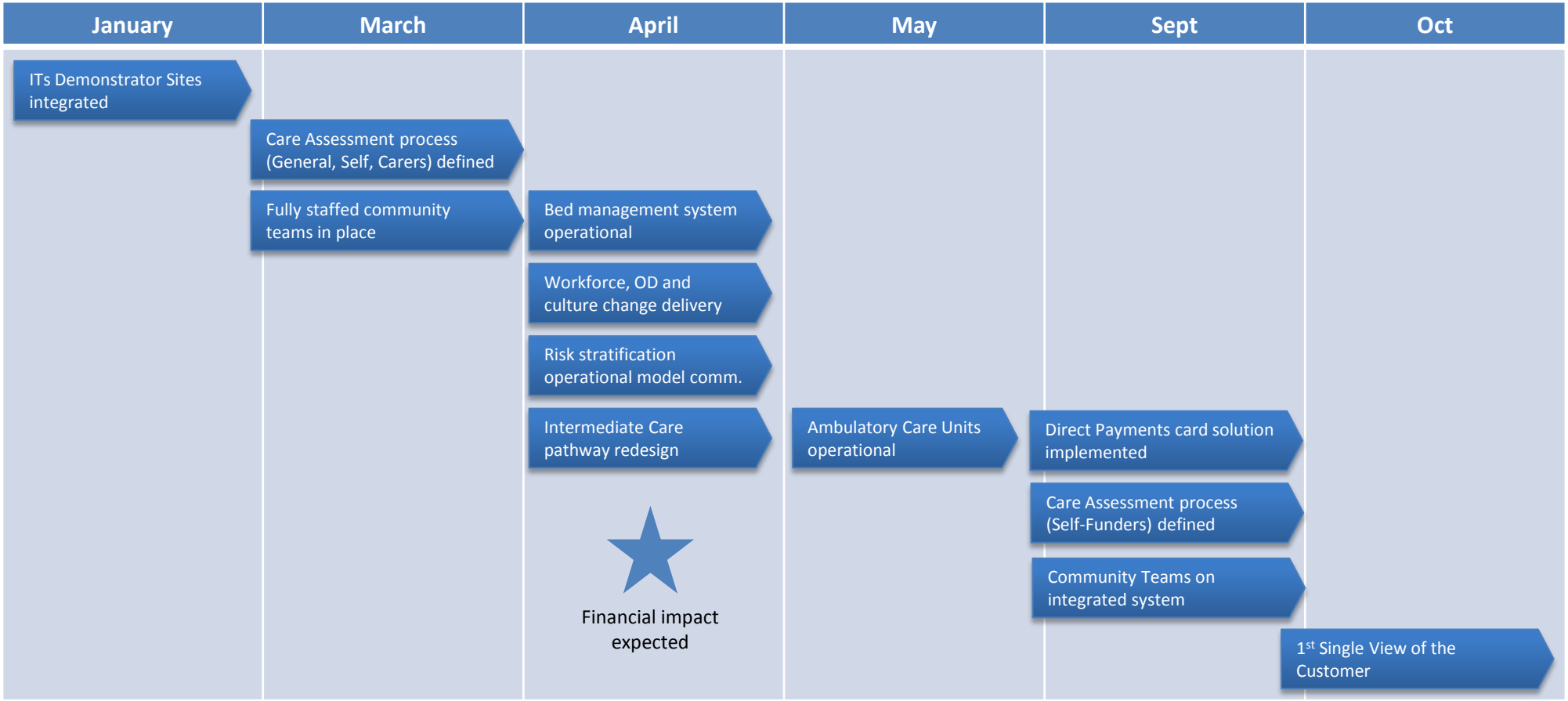
Financial and activity impact

Benefits are expected to accrue in twelfths from April 2015. Figures assume 2% growth within the 3.75% reduction. There is also a further aim through the discharge planning work stream to reduce non-elective length of stay by 2 days.

Area	Activity Reduction	Financial Impact (£000s)
Admissions	978	£2,785
Enhanced End of Life	53	£153
	Total -	**£2,939**

BCF – Milestones and Requirements

NHS Wiltshire Clinical Commissioning Group



Project manager and staff	Communications/engagement	Duplication and interdependencies
• Jointly appointed Programme Director • Organisational leads in CCG and Local Authority	• Membership of workstreams is whole-system • Acute trusts and other providers fully engaged • Focused patient engagement strategy led by Healthwatch Wiltshire	• TCOP – identified and eliminated duplication for double counting over 75s NEL

Medicines Management - Project Highlights

NHS Wiltshire Clinical Commissioning Group

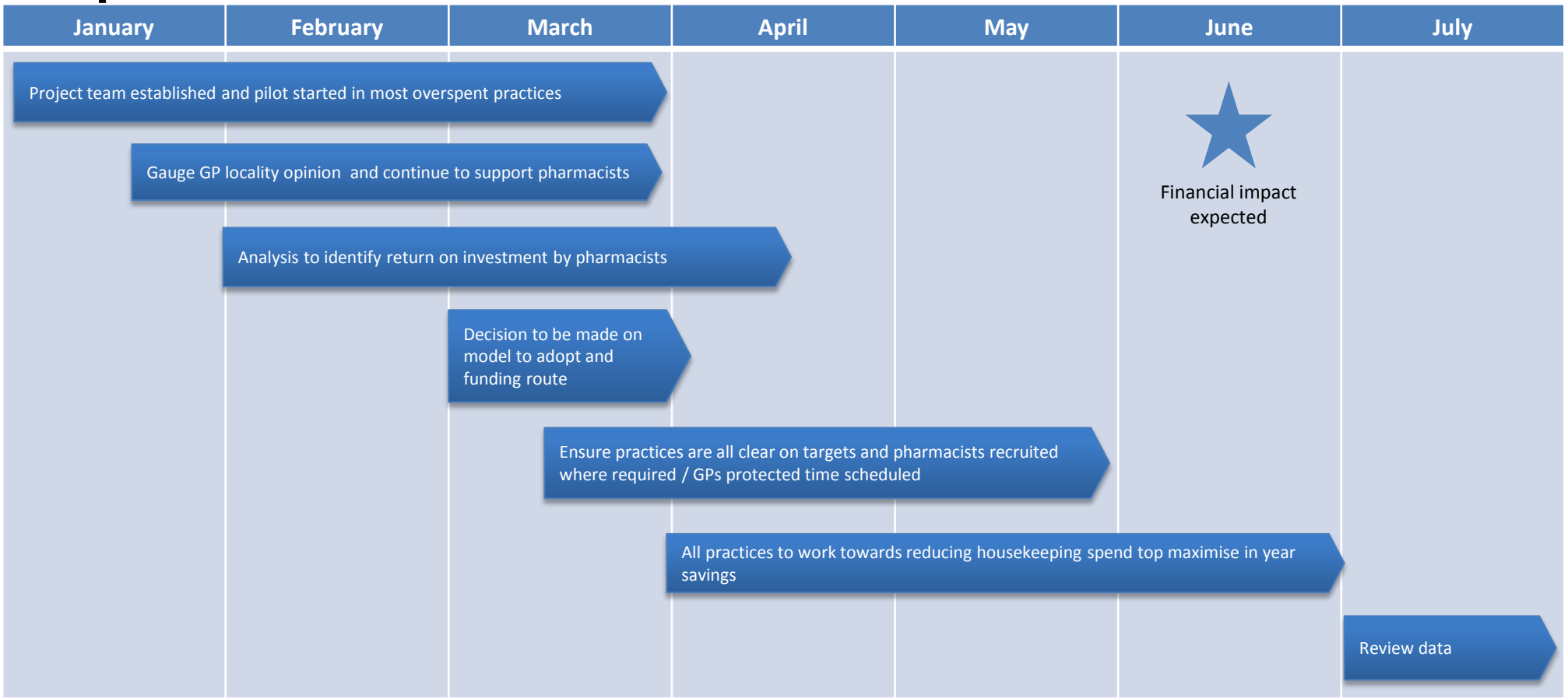
Identified Cohort -	Prescribing savings via housekeeping	Scheme Owner -	Alex Goddard

Current position and rationale	
	• The objective of the project is to realise the identified 'housekeeping' savings by increasing engagement with prescribing leads and other staff in GP practices • During 2014/15, £1.7m of potential savings were identified throughout Wiltshire across 13 different clinical areas. It is our intention for 2015/16 to apply a reduction for each practice in their SLA, taking into account investment costs to assist with capacity issues • This could require a change in process by both GP practices and the Medicines Management Team • We are also engaging with one of the GP Fellows for Evidence Based Commissioning (an initiative of Health Education South West under the Department of Primary Care at Bristol University) on this project, as this forms his area of special interest.

Intended outcomes	Financial and activity impact			
• Reduction of overall spend on prescribing where more clinical and cost effective options are available • Utilisation of existing technology within GP clinical system TPP SystmOne (shared searches and formulary)	Benefits are expected to accrue in twelfths from April 2015. Investment costs will depend on the model adopted by Group. Information is already available for all TPP sites (non-TPP will require additional information).			
	Savings Identified (£000s)		**Investment Required (£000s) – two options**	
	£1,700		£150 (1 WTE Band 7 Pharmacist per locality) OR £240 (Protected time for GP leads)	
	Total – **Total net investment -**	**£1,700** **£1,500**	**Total investment (average between options) -**	**£195**

Medicines Management – Milestones and Requirements

NHS Wiltshire Clinical Commissioning Group



Project manager and staff	Communications/engagement	Duplication and interdependencies
• Alex Goddard • Sessional practice pharmacists • Group leads • Prescribing lead GPs	• Discussions with all group execs • Expressions of interests from community pharmacists • Dissemination via medicines management website and newsletter	• Funding required (invest to save/group SLA) - identified • Practice funding may have already been allocated • Pharmacists need to be supervised and managed by MMT

CHC - Project Highlights

NHS Wiltshire Clinical Commissioning Group

Identified Cohort -	FastTrack patients and LD patients	Scheme Owner -	Theresa Blay/Karen Littlewood

Current position and rationale

FastTrack patients –

- A clinical audit identified that approximately one-third of patients had been inappropriately referred, with subsequent impact on resources and capacity to manage cases and appeals. To address this we are recruiting two members of staff to review referrals for appropriateness, and to filter what is received for approval
- The current case load is 76 patients, costing an average of £750 weekly each. We expect to reduce referrals by around one-third, with an offset built in for recruitment of one nurse and one social worker.

Learning Disabilities patients –

- A mini review conducted within the 2014/15 financial year highlighted that there were a number of patients receiving funding who required a full review of needs. The core team will review these active cases to reach decision.
- The current case load is 11 patients, costing an average of £3000 weekly each. We anticipate a reduction of two-thirds achieved within existing staffing capacity.

Intended outcomes

Outcomes expected are –

- Reduced activity through better management of referrals
- Increased appropriateness of referrals
- Maintained quality of care

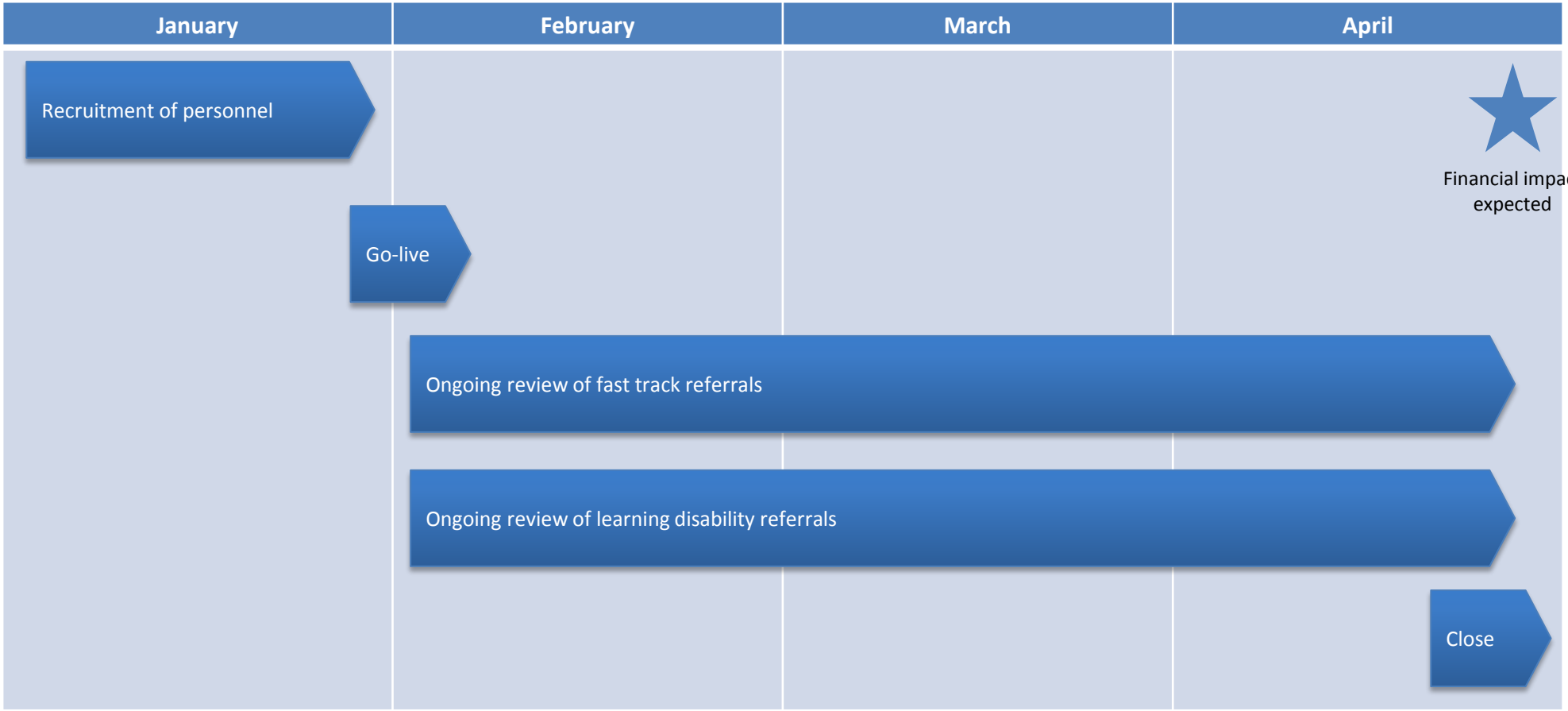
Financial and activity impact

Reviews began in January with the intention of realising a full year effect in twelfths from April. Patients are given 28 days notice of cease of funding thus effect should be felt from May 2015 onwards. The figures below are net of investment costs.

Area	Activity Reduction	Financial Impact (£000s)
FastTrack	20	£453
Learning Disabilities	5	£416
Total -	**25**	**£869**

CHC– Milestones and Requirements

NHS Wiltshire Clinical Commissioning Group



Project manager and staff	Communications/engagement	Duplication and interdependencies
• Theresa Blay (until April 2015) • Karen Littlewood (April 2015 onwards)	• Dialogue with stakeholders and providers as part of End of Life Programme Board and project development	• None identified – standalone project

Effective Planned Care - Project Highlights

NHS Wiltshire Clinical Commissioning Group

Identified Cohort -	Elective Care	Scheme Owner -	Mark Harris

Current position and rationale	We are reviewing effectiveness of clinical procedures to consider whether to commission those classed as having little or no clinical effectiveness. Our approach will include: • Reviewing practice across commissioners • Discussions with clinical colleagues in primary and secondary care • Identifying volumes of procedures Once the list of procedures is agreed, we will look to confirm the administrative processes to put in place an approvals process that is effective but not unnecessarily bureaucratic. We are working with one of the GP Fellows for Evidence Based Commissioning (an initiative of Health Education South West under the Department of Primary Care at Bristol University) on this project.

Intended outcomes

- Reduced interventions
- Treatment aligned to evidence around efficacy
- Reduced risk associated with avoided interventions
- Streamlined process to reduce bureaucracy and decision making for patients

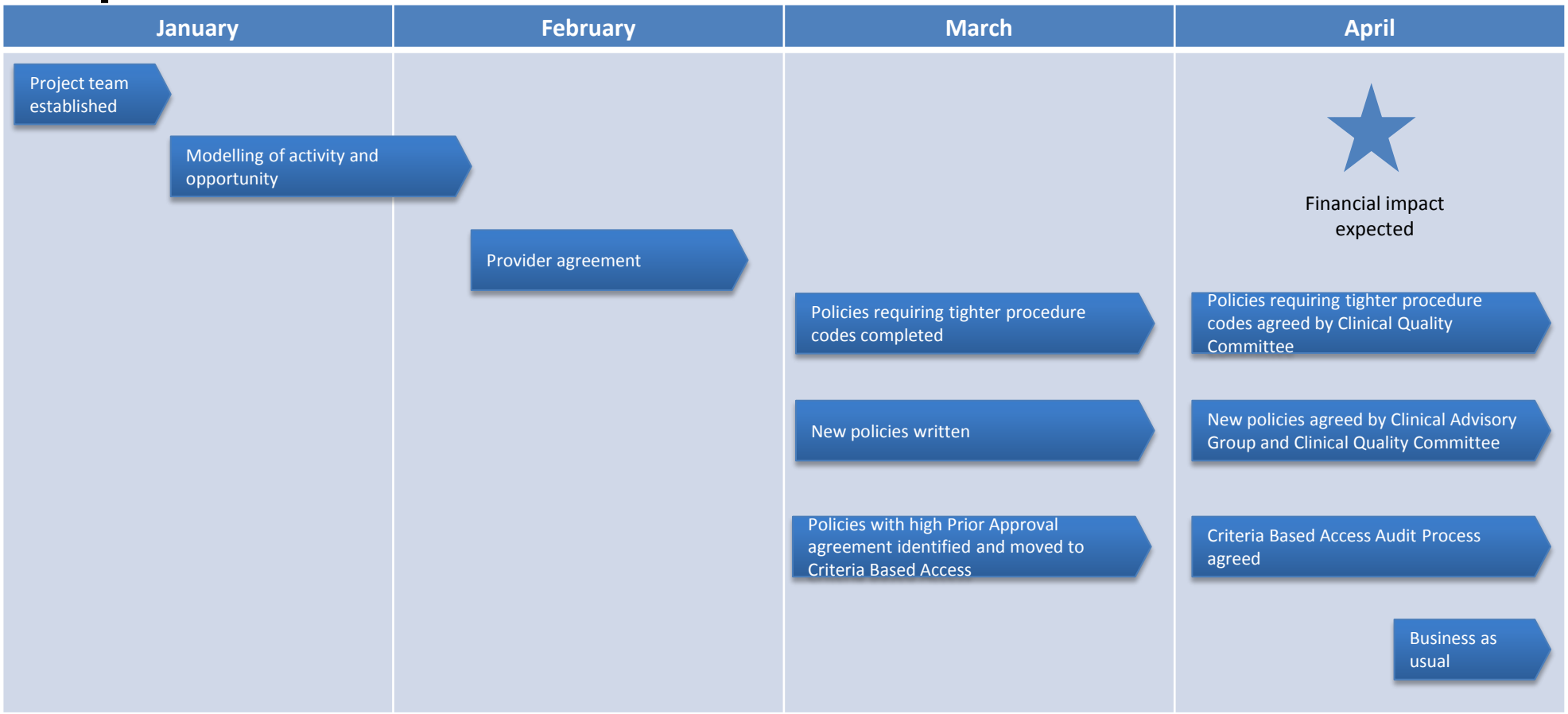
Financial and activity impact

Benefits are expected to accrue in twelfths from April 2015.

Procedure Type	Activity Reduction	Financial Impact (£000s)
Elective	110	£129
Day Case	404	£485
Total -	**514**	**£615**

Effective Planned Care – Milestones and Requirements

NHS Wiltshire Clinical Commissioning Group



Project manager and staff	Communications/engagement	Duplication and interdependencies
• Lucy Baker	• Providers have been involved in developing activity assumptions to support reduction • Workshop in early February tested and confirmed scale and ambition with providers	• None identified – standalone project

Unplanned to Planned - Project Highlights

NHS Wiltshire Clinical Commissioning Group

Identified Cohort -	Non-elective admissions	Scheme Owner -	Mark Harris

Current position and rationale	This proposal focuses on a number of identified ambulatory care pathways to reduce emergency admissions and improve planning around care and conditions. Medical patients: • 30% of the medical take will be treated as ambulatory care, with the charge reflecting this • For an identified cohort within the medical assessment unit, 20% of activity will shift to a 'hot' clinic, with 80% being seen and charged as ambulatory care Surgical patients: • For an identified cohort within the surgical assessment unit, all activity will be managed as an ambulatory assessment from 5pm-9am, or through a hot clinic during working hours • Urology pathways will also be re-engineered to run through 'hot' clinics Implementation will be phased and delivered as BAU during 2015/16 with the initial focus on delivering consistent five day cover

Intended outcomes	Financial and activity impact	
Outcomes are focussed around patient experience and continued quality of care, and include – • Reduced inpatient stays • Maintained patient quality • Improved patient flow and less requirement for escalation • Improved access to secondary care for GPs	Due to the phased implementation there will be a lead in time with savings accrued in equal phases from May, August and November across the financial year to realise a full year effect.	
	Activity Reduction	**Financial Impact (£000s)**
	1690	£500

Unplanned to Planned – Milestones and Requirements

NHS Wiltshire Clinical Commissioning Group

Project manager and staff	Communications/engagement	Duplication and interdependencies
• Lucy Baker	• Providers have been involved in developing activity assumptions to support reduction • Workshop in early February tested and confirmed scale and ambition with providers	• TCOP/BCF – agreed that targeted patients represent a separate cohort of NEL.

Further Details – Project Workbooks

NHS Wiltshire Clinical Commissioning Group

We have developed detailed plans to support the delivery of each scheme. These are an integral element of the CCGs internal PMO processes. The information captured in each project workbook is summarised below. We have evaluated each project to ensure they are sufficiently developed to provide assurance of delivery in 2015/16.

Information Captured	Detail Included
Overview	• Capacity, including programme and project managers, clinical lead and accountable director • Current and future position (including rationale) • Measures of success and organisational strategic alignment • Milestones, target dates and dependencies • In scope/out of scope
Quality Impact Assessment	• Assessment of project across key domains of – duty of quality; patient experience; patient safety; clinical effectiveness; responsiveness; productivity and innovation

Finance Summary	• Project savings and investment costs covering –
	  • Measurement YTD
	  • Variance
	  • KPI tracker

Risk Register	• Risk scoring template and mitigating actions to manage

NHS Wiltshire Clinical Commissioning Group

Equality Impact Analysis – the EIA form

Title of the paper or Scheme: **2015/16 Delivery Plan**

For the record	
Name of person leading this EIA: **Louise Warren**	Date completed
Names of people involved in consideration of impact:	
Name of director signing EIA: **David Noyes**	Date signed

What is the proposal? What outcomes/benefits are you hoping to achieve?
The purpose of this delivery plan is to continue the direction of travel for the CCG 5 year Strategy which has a strong correlation with the themes set out in NHS England's 5 year view. The outcome/benefit will be transformation to an out of hospital care model.

Who's it for?
All Wiltshire residents.

How will this proposal meet the equality duties?
This plan is aimed at all individuals, the CCG will ensure that all appropriate documentation can be made available in a range of alternative languages or formats for the visually impaired are considered.

What are the barriers to meeting this potential?
None identified.

2 Whose 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)?
None identified

How can you involve your customers in developing the proposal?
Builds on the engagement conducted last year in formulating the strategy.

Who is missing? Do you need to fill any gaps in your data? (pause EIA if necessary)
There are no current gaps at this stage of the plan.

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 identified

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?
None identified.

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?

No changes have been made as no adverse impacts have been identified.

What will you do now and what will be included in future planning?

Focus on three principles (as part of 2015/16 Commissioning intentions:

- People 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

When will this be reviewed?

The delivery plan will be reviewed monthly via the IPR

How will success be measured?

Once plans are being practically applied and achieving what the plans have set out, this will amount to the success of the Delivery Plan for 2015/16.