Operational Plan 2014-16

Summary

Thurrock Clinical Commissioning Group

February Board

The health and care experience of the people of Thurrock will be improved as a result of our working effectively together

NHS Thurrock Clinical Commissioning Group

Thurrock Clinical Commissioning Group serves a population of 164,000 across 34 member GP practices. The CCG works closely with partners, notably Thurrock Council to deliver the following vision and objectives;

System Objective One
Reduce the number of people requiring a service response

Thurrock CCG will be led by its population by ensuring *"citizens are fully involved in service design and patients are given choice information and fully empowered in shared decision making"*.

System Objective Two
Empower communities to take responsibility for their own health and wellbeing

Working with the primary care community to federate in Thurrock Hubs that will define geographical areas for service provision across health and social care. This will include the wider provision of primary care (pharmacists, optometrists and dentists)

Resources will transfer from the acute setting into the primary and community care setting to ensure that there is the capacity outside of hospital to proactively manage need.

System Objective Three
Build a whole person approach to the health and care system

The **integration** of existing community, acute and specialist services to provide comprehensive pathways for designated indications. Such pathways will be evidence based and time limited.

System Objective Four
Bring health and care close to home

System wide **Urgent Care Working Group** and **Better Care Fund (BCF)**, both aimed at reducing unnecessary emergency admissions and developing fully integrated community alternatives across health and social care.

Proactive case finding, with reablement and rehabilitation as the default offer; more acute clinical and social care services moved to the communitv.

System Objective Five
Ensure people are able to live as independently as possible for as long as possible

BCF to include community nursing services, community beds and reablement in year 1 expanding to include social care funds for elderly care in following years.

Governance arrangements:

System wide arrangements including:

- Thurrock Council and Thurrock CCG overseeing the **BCF**
- **Strategic Leadership Group for Thurrock** (Social and Health Commissioners and Providers)
- **Thurrock Health and Wellbeing Board**.
- **Unplanned Care Working Group** and Access Group
- **BTUH** Executive Group with Basildon and Brentwood CCG
- **OIPP and OIPP Stakeholder**

Measured using the following success criteria

- All organisations within the health economy report a financial surplus in 2014/15 and beyond
- Delivery of the system objectives, inc those in BCF.
- Delivery of the outcome ambitions and constitution

Principles

1. Empowered citizens who have choice and independence and take personal responsibility for their health and wellbeing
2. Health and care solutions that can be accessed close to home
3. High quality services tailored around the outcomes the individual wishes to achieve
4. A focus on prevention and timely intervention that supports people to be healthy and live independently for as long as possible
5. Systems and structures that enable and deliver a co-ordinated and seamless response

Outcome Ambition 1: Securing additional years of life for the people of England with a treatable mental and physical health condition

Period	National	Median	75th Percentile	CCG	% Var (Nat.)	Rank (of 211)	Spine Chart (Diff from Median) [Limited to +/-100%]
CCGOF 1.1 | Potential years of life lost (PYLL) from causes considered amenable to healthcare							
Directly age and sex standardised potential years of life lost (PYLL) per 100,000							
2012	2060.8	2083.4	2390.1	2494.3	▲21%	170	

Performance against this standard has declined and is currently 21% higher than national average and currently in the highest 25% nationally. The CCG will look to reduce PYLL back down to below 75th Percentile.

Year	Target
2014/15	2430.2
2015/16	2366.4

Thurrock CCG remains significantly above the national average (21% above) for this outcome. Addressing this variation is a key priority for the CCG and our partners. The CCG has recently improved its performance on respiratory disease mortality and performs well on Alcohol and Liver disease outcomes. However, we are significantly poor performers for Cardiovascular and Cancer outcomes. The CCG is taking key measures to try and improve performance in these disease areas. We will also be working closely with both the local authority (in particular the public health team) and providers to try and jointly improve outcomes.

KEY WORK STREAMS: CARDIOLOGY SERVICES REVIEW, STROKE, HEART FAILURE, HAEMATOLOGY, RESPIRATORY, CANCER

The health and care experience of the people of Thurrock will be improved as a result of our working effectively together

Outcome Ambition 2: Improving the health related quality of life of the 15 million people with one or more long term condition, including mental health conditions

Period	National	Median	75th Percentile	CCG	% Var (Nat.)	Rank (of 211)	Spine Chart (Diff from Median) [Limited to +/-100%]
CCGOF 2.6 | Unplanned hospitalisation for chronic ambulatory care sensitive conditions							
July 2012 to June	795.1	802.2	970.6	779.1	▼2%	96	

Ambition: 658.8 or lower

CCG rate is 2% lower than national average. CCG is aiming to reduce the rate to below national average.

NHSOF 2 | Health related quality of life for people with long-term conditions (Local Authority Borough Level)							
2012/13	0.73	0.74	0.77	0.73	-	130	

Ambition: 73.7 or above

Thurrock score is the same as the national. In terms of total EQ-5D score per 100 people with LTC the CCG is within the average. Aiming to increase to 60th Percentile.

Year	Target
2014/15	73.6
2015/16	73.7

Total EQ-5D per 100 people with LTCs

Thurrock CCG is in line with national benchmarks for these indicators. However, there is further progress to be made to deliver good practice across all LTCs. In addition, significant progress is required to improve LTC management in patients with mental health problems

KEY WORK STREAMS: CARDIOLOGY SERVICES REVIEW, HEART FAILURE, HAEMATOLOGY, RESPIRATORY, DIABETES, CONTINENCE, PERSONAL HEALTH BUDGETS, HIGH IMPACT PATHWAYS FOR UNDER 19s, AMBULATORY EMERGENCY CARE, DEMENTIA SCREENING, IAPT

Outcome Ambition 3 : Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community outside of hospital

Period	National	Median	75th Percentile	CCG	% Var (Nat.)	Rank (of 211)	Spine Chart (Diff from Median) [Limited to +/-100%]
CCGOF 3.1 | Emergency admissions for acute conditions that should not usually require hospital admission							
Jul 12 to Jun 13	1184	1211.0	1456.5	881	▼26%	27	

CCG rate is 26% lower than national average. CCG is aiming to sustain low rate.

Year	Target
2014/15	TBC
2015/16	TBC

Thurrock CCG consistently performs well on this indicator. This is a demonstration of the close working between health and social services in primary and community care. However, the CCG recognise that there is still scope for improvement (both in terms of metrics and quality). A number of initiatives have been identified over the next 24 months that are underpinned by both the Better Care Fund and the Primary Care Strategy.

KEY WORK STREAMS: STROKE, HIGH IMPACT PATHWAYS FOR UNDER 19s, AMBULATORY EMERGENCY CARE, GERIATRICIAN MODEL, MSK PATHWAY, SRP REVIEW

Outcome Ambition 4: Increasing the proportion of older people living independently at home following discharge from hospital

Indicator	Period	National	Median	75th Percentile	CCG	% Var (Nat.)	Rank (of 211)	Spine Chart (Diff from Median) [Limited to +/-100%]
ASCOF 2B(1) | Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (effectiveness of the service) (Local Authority Council Level)								
ASCOF 2B(1)	2012/13	81.40	83.60	88.40	82.00	▲1%	63	

Thurrock's Vision for Integrated Health and Social Care services is of "resourceful and resilient people in resourceful and resilient communities". The delivery of our Vision through the Better Care Fund will support the achievement of this outcome. Significant progress has been made in delivering this outcome. In 2013/14 so far, 89.8% of those referred to reablement services were still living at home 91 days after discharge from hospital (ASCOF 2B). Together with Thurrock Council, we seek to improve upon this level of performance. We are also looking to improve reablement/rehabilitiation prior to being assessed for Continuing Health Care to ensure patients have achieved their maximum potential for the best long term outcomes. The vast majority of actions outlined within this section are being jointly delivered with Thurrock Council.

KEY WORK STREAMS: RRAS, CHC, COMMUNITY BED PROVISION REVIEW

Outcome Ambition 5: Increasing the number of people having a positive experience of hospital care

Basildon University Hospital - RDD

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Response Rate	8%	19%	13%	12%	10%	10%	12%	15%	16%
Net Promoter Score	**39**	**35**	**44**	**49**	**51**	**45**	**53**	**59**	**61**

Accident & Emergency (Types 1&2)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Response Rate	3%	11%	6%	6%	4%	4%	4%	5%	11%
Net Promoter Score	**-42**	**-13**	**16**	**21**	**9**	**6**	**-11**	**31**	**49**

The Friends and Family performance at our main provider (Basildon Hospital) remains poor (in particular A+E). A key part of low performance is the low response rate currently being achieved. A number of actions will be undertaken to redress response rates, identify issues with quality and agree and implement rectifying actions where required.

The actions on the following page will be supported by;

- Increased utilisation of patient engagement programmes
- Creation of a learning culture within all providers
- The establishment of the culture of the 6 Cs.

The CCG will lead on the roll out of the FFT to North East London Foundation Trust.

Supplementary data on the improvement areas can be found in Appendix XX

Outcome Ambition 6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community

Indicator	Period	National	10th Percentile	25th Percentile	Median	75th Percentile	90th Percentile	CCG	% Var (Nat.)	Rank (of 211)	Spine Chart (Diff from Median) [Limited to +/-100%]
CCGOF 4.1 | Patient experience of GP out of hours services											
Weighted percentage of respondents reporting a good experience											
CCG 4.1	011 to March	70.86	62.3	66.6	69.5	71.0	71.8	79.60	▲12%	205	
CCG 4.1	012 to March	70.21	62.3	66.1	69.5	70.4	71.0	71.00	▲1%	117	

The improvement of patient experience of general practice will be led by the Primary Care Strategy. Please see the Primary Care Strategy Action Plan for key milestones in relation to supporting improvements to this target.

In addition, to the Primary Care Strategy, the following actions will be undertaken across community care to improve patient experience. These actions are in addition to the pathway redesign work already outlined within this chapter.

KEY WORK STREAMS: PRIMARY CARE STRATEGY, ROLL OUT OF 5x5 NELFT

Outcome Ambition 7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

Thurrock CCG – C Diff	
Year	Target
2014/15	22 cases

BTUH – C Diff	
Year	Target
2014/15	18 cases

Thurrock CCG has a zero tolerance approach to MRSA (in line with guidelines). Thurrock CCG is currently less than the median for C Diff and therefore has a target of 1 case less than 2013/14

		2014/15				2015/16			
No.	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
G1.1	Reduce the number of avoidable deaths within the hospital • Care of deteriorating patient • Consultant review • 7 day working • Mechanisms used – contract and monitoring visits								
G1.2	MRSA Maintain zero tolerance for MRSA bacteremia cases								
G1.3	C-Diff Continue to drive down cases of Clostridium difficile								
G1.4	Monitor Monitor on-going arrangements within the main provider to prevent and control infection: • Via the contract • Via the Clinical Quality Review Group • Quality visit programme								

Constitution: Areas of Development

Metric	Target	Performance	Commentary
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E dept	95%	94.55% (as at 5th Jan 14)	With BB CCG, the CCG is working closely with Basildon Hospital on a number of key initiatives to improve flows both within the ED and inpatient capacity. The ED has an established primary care streaming pathway, ambulatory pathway and frail elderly pathway (please see the Urgent Care Working Group section for further information on the sustained delivery of these targets) Further initiatives will be identified through the BB CCG led Urgent Care Mobilisation event in February 2014.
No waits from decision to admit to admission (trolley waits) of over 12 hours	0	0	
Category A calls resulting in an emergency response arriving within 8 minutes (Red 1 and Red 2)	75% 75%	67% 65% (YTD Nov 13)	As part of the wider East of England Ambulance commissioners collaborative, the CCG is actively participating in the process for the recovery of this target. The CCG has provisionally committed to non recurrent monies that enable the ambulance service to commence the next phase of the recommendations that followed the Clinical Capacity Review.
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	95%	79% (YTD Nov 13)	

Constitution: Areas of Development

Metric	Target	Performance	Commentary
Maximum 62 day wait from urgent GP referral to first definitive treatment for cancer	85%	83.7% (YTD Nov 13)	The CCG is failing to achieve the 62 day wait from urgent GP referral to first definitive treatment. From analysis, it is identified that a key element of this poor performance is due to the delays in intra provider pathways. The CCG is committed to working with Southend Hospital, Basildon and Thurrock Hospital and Mid Essex Hospitals, to put in place a robust intra-provider policy for cancer pathways. .

Better Care Fund Metrics: Admissions

Target 1	Reducing inappropriate admissions of older people (65+) in to residential care
Definition	Rate of council-supported permanent admissions of older people to residential and nursing care.
Supporting Brief: Target based on reduction in placements from March 2013 baseline of 180 to 135 by March 2015. Factors in improvement trend and accurate reporting of CHC and full-cost payers through 2013-14 and would bring Thurrock in below 2012/13 national average of 708	

Year	Target
Baseline	899
2014/15	597
2015/16	

Target 4	Reduce emergency admissions which can be influenced by effective collaboration across the health and care system.
Definition	Composite measure of: • unplanned hospitalisation for ACS, asthma, diabetes, epilepsy, (children), acute conditions that should not require admission, children with LRTI
Supporting Brief; This trajectory will bring the CCG in line with the 20th percentile nationally by 2018/19.	

Year	Target
Baseline	1583.7
2014/15	1583.2
2015/16	1582.7

Better Care Fund Metrics: Reablement

Target 2	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation service
Definition	The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services.
Supporting Brief; Target based on a proposed ratio of 205 out of 220 people remaining settled and independent 91 days after discharge into reablement/rehab services.	

Year	Target
Baseline	89.8%
2014/15	93%
2015/16	

Better Care Fund Metrics: Transfers

Target 3	Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.
Definition	Average delayed transfers of care per 100,000 population (attributable to either NHS, social care or both) per month.
Supporting Brief; The BCF is being utilised to support a number of measures that reduced DTOCs. Additional resource is being put into the hospital social work team to improve flows. Capacity will be improved through Elizabeth House, Mountnessing Court and other initiatives. In addition, the CCG will participate in a review of the Acquired Brain Injury Pathway.	

Year	Target
Baseline	163.1
2014/15	156.6
2015/16	150.3

Better Care Fund Metrics: Patient/Service User Experience

Target 5	Co demonstrate local population/health data, patient/service user and carer feedback has been collated and used to improve patient experience.
Definition	To follow national guidance once released.
Supporting Brief	

Year	Target
Baseline	TBC
2014/15	TBC
2015/16	TBC

Better Care Fund Metrics: Local Metric

Target 6	TBC
Definition	TBC
Supporting Brief	

Year	Target
Baseline	TBC
2014/15	TBC
2015/16	TBC

Better Care Fund Metrics: Local Metric

Target 6	TBC
Definition	TBC
Supporting Brief	

Year	Target
Baseline	TBC
2014/15	TBC
2015/16	TBC

Delivery

- Engagement
- Contract Negotiations
- Primary Care Strategy
- 7 Day Working
- Urgent Care Working Group