Brighton and Hove CCG

Strategic Commissioning Plan

2012-2017

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1 Foreword

This inaugural Strategic Commissioning Plan demonstrates how Brighton and Hove Clinical Commissioning Group (CCG) will harness its clinical and managerial skills, expertise and energy to improve the quality and outcomes of healthcare for our population at a time of tight budgetary constraint.

Our plan is built on firm foundations: clear statements of our vision and values; strong working relationships with primary care clinicians, provider organisations, and other partners and stakeholders; national directives and guidance; a good understanding of local needs and priorities; and an absolute commitment to engage and listen to the people we serve.

Our aim is to develop a local health system which is radically different, clinically led, and co-designed by patients and the public.

We recognise that achieving this aim during a period of tight controls on public spending will require greater productivity, more emphasis on prevention rather than cure, innovation and, above all, change.

We are committed to working with neighbouring CCGs, local councils and other partners to develop and deliver financially sustainable healthcare services for Sussex as a whole, breaking down old geographical and professional boundaries to provide a seamless, integrated approach to care.

To give just one practical example, our CCG will be the lead commissioner of services provided by Brighton and Sussex University Hospital NHS Trust to all Sussex CCGs. We believe that this unified approach will improve both quality and value.

Other changes will see more services provided away from hospitals in settings closer to where people live, and new initiatives to reduce variations in primary care services and make them easier to access.

The remainder of this document provides more information about how we will approach our work. Further details are available in the appendices, and by following up the references in the text to other documents and sources.

1.1 Introduction and context

This strategic commissioning plan describes how we intend to achieve our ambitions as a CCG. It sets out our composition and leadership; what drives us and where we want to be; the national context; and how we will address the priority areas for our population and the wider health economy.

It will be reviewed regularly and updated as necessary to reflect changing local, regional and national circumstances.

It has been developed from, and influenced by, many different sources but at its core are the NHS Constitution, and our commitment to promoting equality and reducing health inequality.

1.2 The NHS constitution

The NHS Constitution establishes the principles and values of the NHS in England; sets out the legal rights of patients, public and staff, and the further pledges which the NHS is committed to achieve; and sets out the responsibilities of public, patients and staff.

We are committed to meeting the obligations and expectations placed upon the CCG by the NHS Constitution. We will also do all we can to promote patient rights, address concerns where these are brought to our attention, and support our providers in doing the same.

1.3 Our commitment to equality

We are committed to meeting our legal and moral responsibilities in relation to promoting equality, eliminating discrimination and promoting good relations between individuals and communities[1].

We will make sure that our commissioning meets our obligations under the Public Sector Equality Duty ands the objectives in the CCG Equality and Diversity Strategy by:

- Engaging and involving our population, specific communities of interest and other stakeholders;
- Reviewing the provision of, and access to, services; and
- Undertaking Equality Assessments to ensure the services we commission are accessible, effective and appropriate for our diverse communities

Progress against our 2012-13 equality objectives is currently being reviewed and will be published in due course.

1.4 The new NHS

Brighton and Hove CCG becomes a statutory organisation, with wide-ranging duties, from 1 April 2013 after successfully completing a rigorous authorisation process that tested its capacity and capabilities.

At the same time Primary Care Trusts and Strategic Health Authorities will be abolished and the NHS Commissioning Board will formally come into being. The diagram below illustrates the new NHS and the place of CCGs in the overall structure.

[1] Equality Act 2010: Public Sector Equality Duty, a Quick Start Guide for Public Sector Organisations

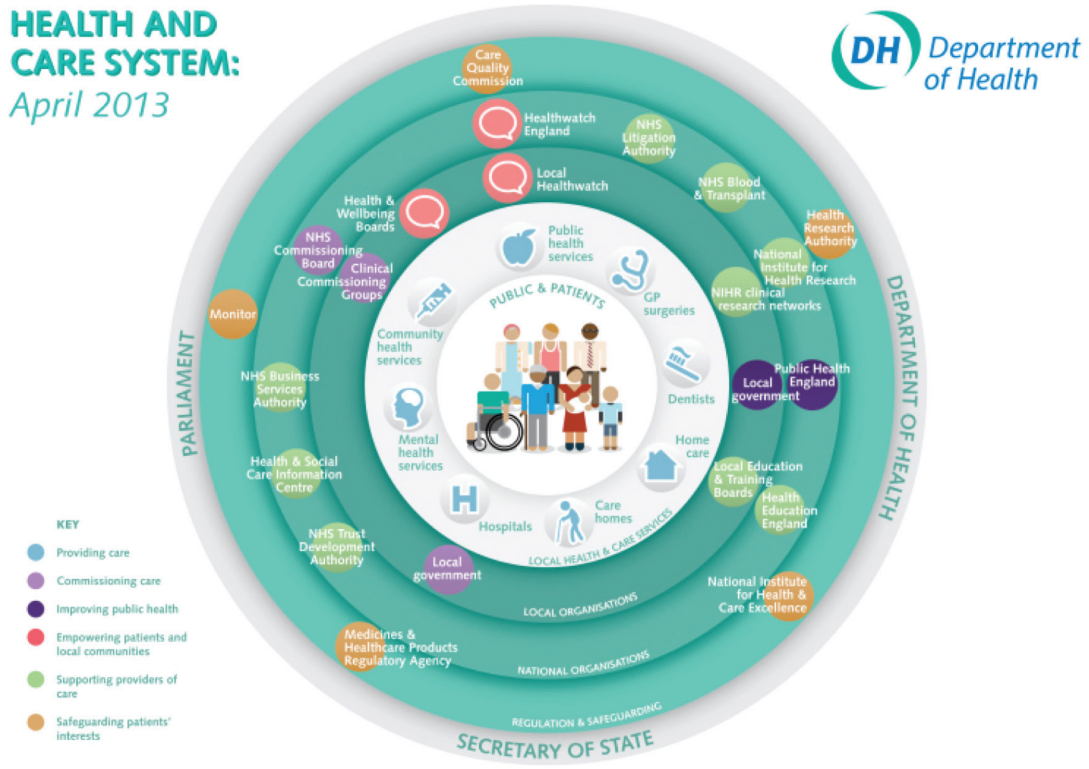


Figure 1: Health and care system April 2013

1.5 Brighton and Hove CCG - a membership organisation

Our members

The CCG comprises all the general practitioners working within the Brighton and Hove city boundary (around 170 GPs from 47 practices in 55 surgery buildings). Between them they serve around 300,000 patients, with individual practices varying from less than 1,000 patients to more than 16,000. Each practice sits in one of three local member groups (West, Central and East).

Our constitution

Our 2012 Constitution sets out how the CCG will meet its commissioning responsibilities. It describes the CCG's governing principles plus rules and procedures to ensure probity and accountability, open and transparent decision-making, and the central place of the interests of patients and the public.

Member accountability

The diagram below (figure 2) shows lines of engagement, support and accountability between GPs, practices, local member groups and the CCG as a corporate body.

Each Local Member Group will elect a GP to lead the group, represent its views on the CCG's Governing Board and Clinical Strategy Group, and ensure in turn that practices are fully engaged in delivering the CCG's duties and plans.

Each lead GP will be supported by a team comprising a practice manager, practice nurse and a patient representative, with further support coming from CCG managers and administrative staff.

Each practice will also nominate a GP, practice nurse or practice manager as its Practice Clinical Commissioning Lead (PCCL) to represent their practice to the Local Member

Group (e.g. by attending meetings, giving practice responses to CCG documents, and attending planning workshops).

Member Accountability

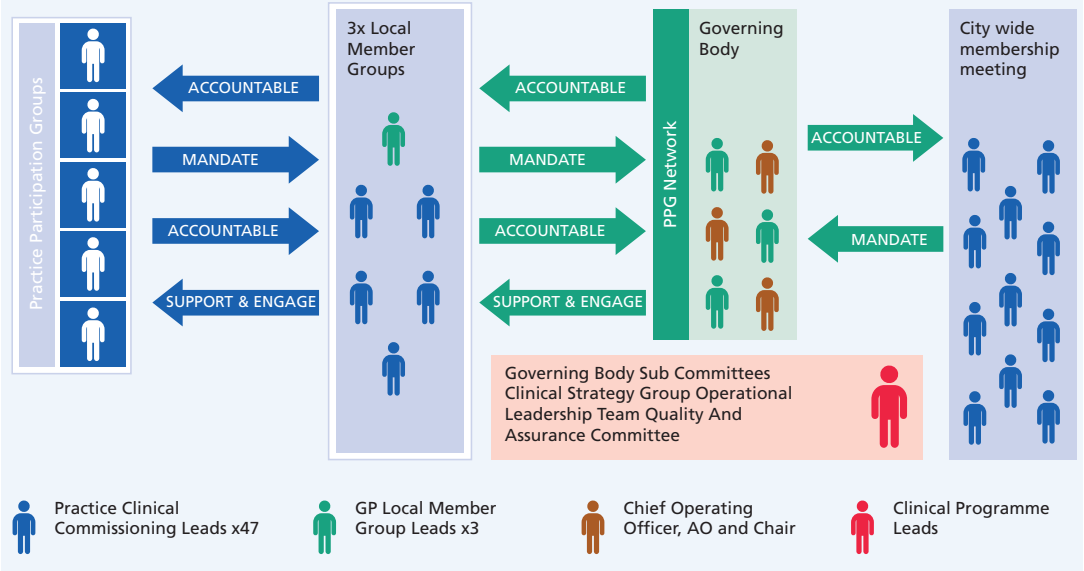


Figure 2: Brighton and Hove CCG member accountability

Clinical leadership

CCG governing bodies must fulfil the functions placed on them by the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and any other functions conferred on them via their members.

Our governing body (see figure 3 below) has four main tasks:

- ensuring effective delivery of strategy and planning;
- accountability;
- systems of control; and
- establishing and promoting public sector values and high standards of conduct.

Each member of the governing body shares responsibility for delivering these functions effectively, efficiently and economically in line with our governance framework[2].

[2] Governance Arrangements for Authorisation and Beyond, Brighton and Hove CCG

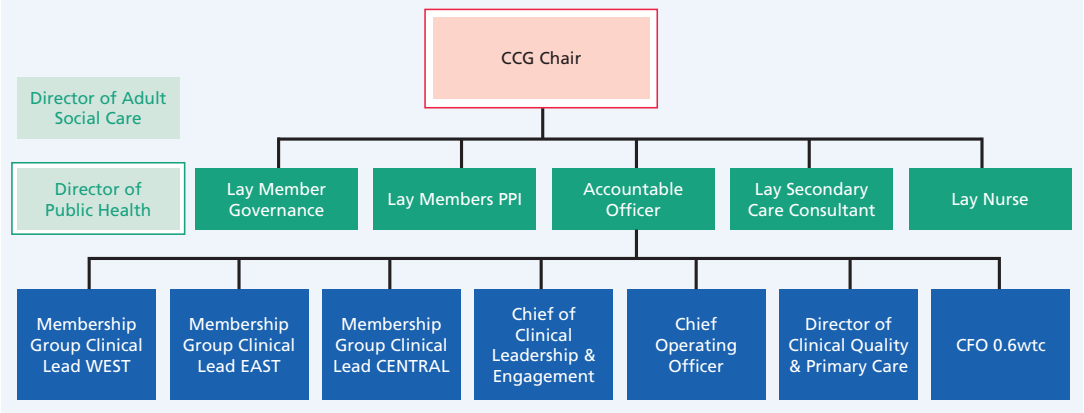


Figure 3: Brighton and Hove CCG Governing Body

1.6 Clinical management structure

Clinical leaders are at the heart of the CCG's structure and have a crucial role in setting the organisational direction, commissioning, decision making and delivery.

They include eight clinical programme leads for the following areas:

- **Primary care -** supporting member practices to improve the quality of primary care and commission health services at a practice and strategic level more effectively.
- **Integrated community care -** commissioning proactive care that helps people who are frail or who have complex/long term needs (including dementia) to live as independently as possible. This includes rapid support and intervention when people become unwell suddenly to prevent avoidable hospital admissions and/or reduce length of stay in acute care.
- **Acute/secondary care -** to commission effective care pathways for diagnosis, treatment and care when people need health service support. This will include close working with neighbouring CCGs, public health staff, specialist commissioning teams, and the emerging local and national networks.
- **Mental health -** to commission mental health care across the full range of care pathways from early diagnosis to specialist treatment.

Our vision, mission, values and aims

Strong clinical engagement within the CCG needs to be mirrored by strong patient and public engagement. The following vision and mission statements were discussed at a series of engagement events in 2012 so that we could reach collective agreement on the way forward before enshrining final versions in our constitution.

Our vision

To be an excellent clinical commissioning group, bringing clinicians, local people and managers together, to ensure that there is help to stay healthy as well as high quality, easy to use comprehensive health care for those who are unwell.

Our mission

The CCG is driven by the desire to improve the health of all the people in Brighton and Hove. We are proud to live and work in such a vibrant and diverse city and we will strive to ensure that the needs of all our communities are well served.

The vision and mission are supported by a set of aims and values which will further shape the way we work and clearly articulate what we plan to do over the next five years.

Our values

- We are accountable to the people of Brighton and Hove as well as our member practices.
- We are committed to making decisions openly in a way that is easily understood.
- We place patients, their families and the public at the centre of everything we do.
- We value innovation and will create an environment that supports good ideas.
- We take time to celebrate achievements.
- We listen to and respect patients, the public, staff and clinicians.
- We value the highest standards of excellence and professionalism in the provision of health care that is safe, effective and focused on patient experience.
- We value and uphold the NHS constitution in all that we do.

Our aims

- We will clinically lead our local healthcare system to improve the quality, effectiveness and outcomes of NHS health care.
- We will ensure the best possible stewardship of NHS funds.
- We will promote equality through the services we commission and pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population. We will work to reduce health inequalities and seek to identify and eliminate discrimination.
- We will involve patients, their families and the public in all decisions about their care and treatment and the design of NHS services in our City.
- We will support the education, training and development that the staff of the CCG and member practices to improve the current and future healthcare of the population.
- We will bring our member practices together to work effectively for the benefit of the whole population.
- We will work across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population, to create a happier healthier City.
- We will minimise waste and bureaucracy.

1.7 Our strategic objectives

We have used our vision and mission statements to help us identify four over-arching strategic objectives for the CCG:

1. Keeping our local population healthy. We will achieve a measurable reduction in health inequalities and a measurable improvement in NHS Outcomes Framework results
2. Providing accessible care. Patients will record greater satisfaction with the accessibility of services.
3. Providing high quality care. We will improve performance in NHS Outcomes Framework results and Patient Reported Outcome Measures.
4. Involving patients and the public. –We will listen and respond to feedback from patients, and co-design services with patients and the public.

We aim to achieve year on year improvements against each of these objectives. To help us do this we have identified key criteria for each objective and a number of cross cutting themes (see figure 4 below).

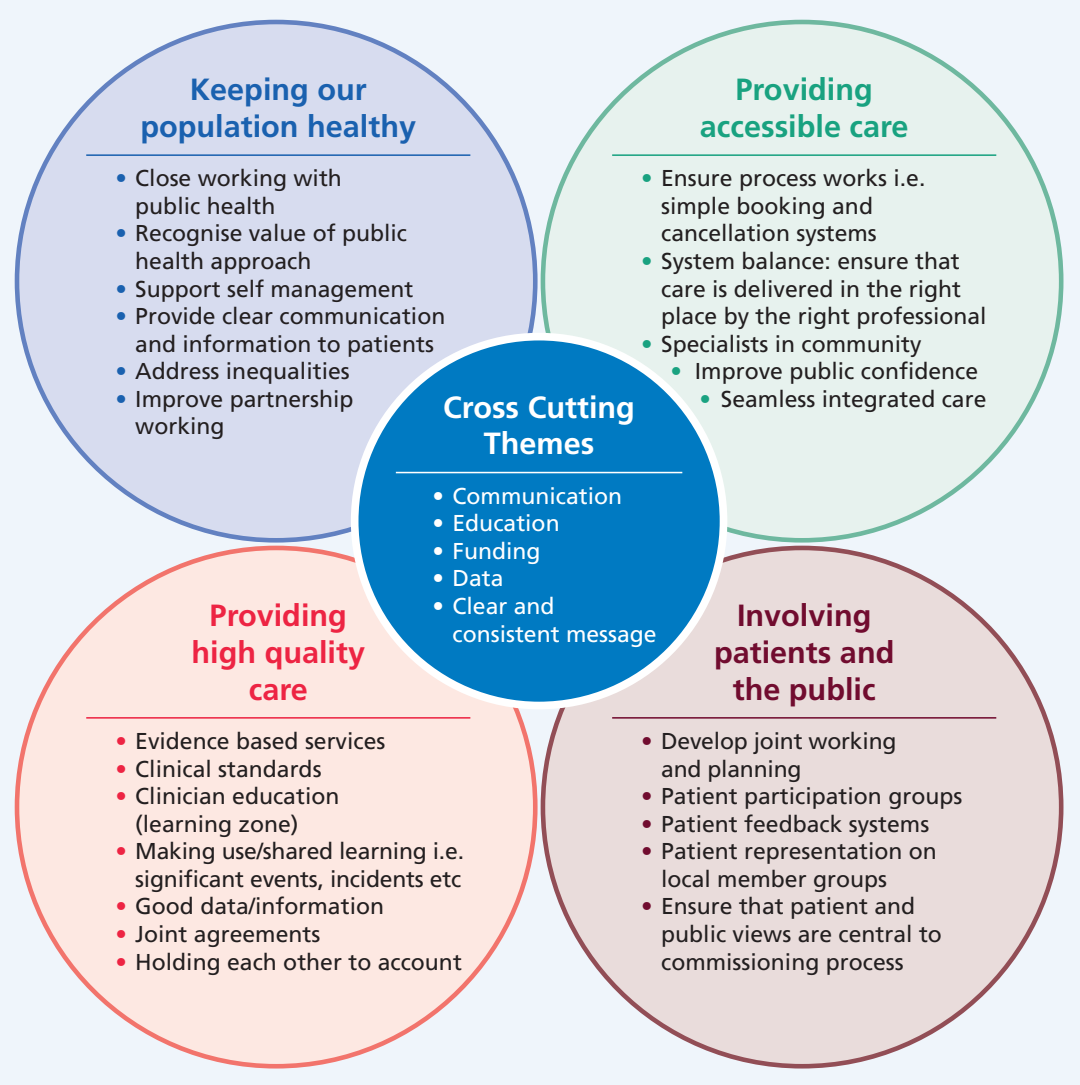


Figure 4: Key Criteria for achieving strategic objectives

Details of how we plan to achieve our objective of providing accessible care are given in section 3 (see page 29). Sections 1.8 to 1.10 (below) outline the main ways in which we intend to deliver the other three objectives.

1.8 Keeping our population healthy

See Joint Health and Wellbeing Strategy[3].

[3] We are currently developing a detailed work plan with Public Health which will be published on our web site in late Spring 2013.

1.9 Patient safety and quality

Clinical quality and patient safety are key elements of the Government's mandate to the NHS Commissioning Board and the NHS Outcomes Framework, in which they are most overtly stated in domain 4 (ensuring that people have a positive experience of care) and domain 5 (treating and caring for people in a safe environment and protecting them from avoidable harm).

Governance and assurance

The CCG has a range of processes and mechanisms to promote clinical quality and patient safety, and be assured that they are being delivered. These include clinical engagement, quality and risk management, and hard and soft reporting mechanisms.

Figure 5 (below) demonstrates how clinical engagement, quality management and risk management feed into our governance structure so that we can account to patients, the public, member practices and the NHS Commissioning Board for service quality, service improvement and risk management.

Overview

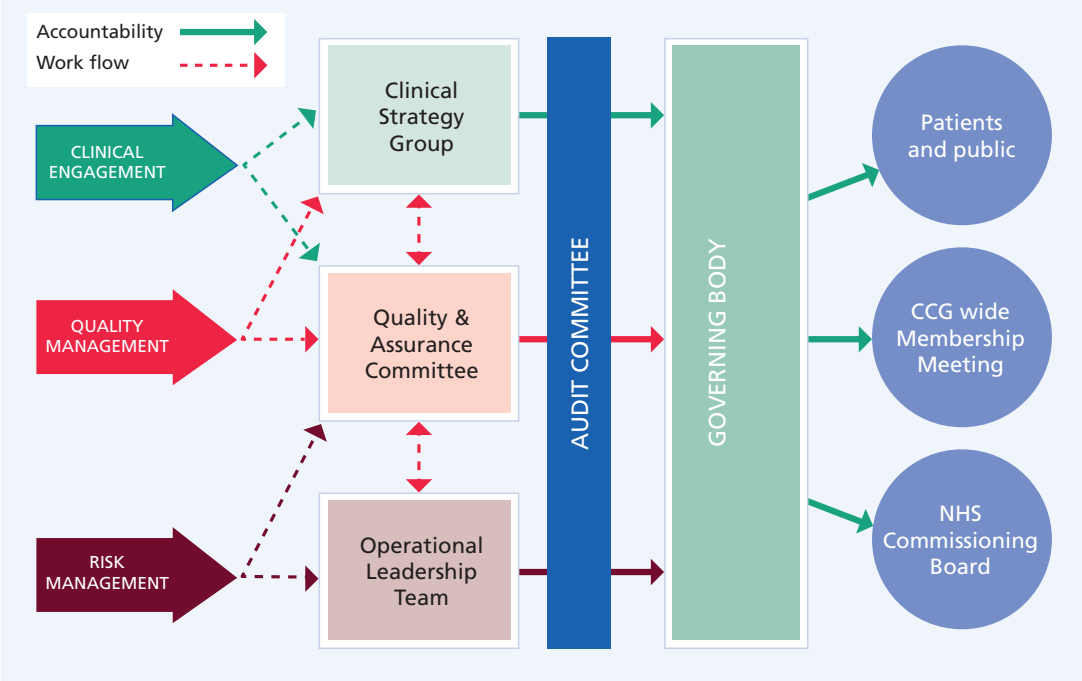


Figure 5: Overview of clinical engagement, quality and risk management

Member awareness and reporting

As clinicians with direct links to patients and the services we commission, CCG members are in a position to understand and report on quality and any concerns they may have. CCG members can raise issues at Local Member Group meetings or directly with the governing body through their Practice Clinical Commissioning Lead or the Local Member Group lead GP. Primary care practitioners and staff can also raise concerns via our incident reporting or complaints procedures.

Quality management

The Director of Clinical Quality and Primary Care leads the CCG Quality Team draws together data and information from various sources including patients, public and partner organisations, provider contracts, primary care and data analysis (see figure 6 below).

The data and information is used to ensure that we meet formal reporting responsibilities (e.g. the National Reporting and Learning System for patient safety issues), follow through and escalate critical quality issues (e.g. safeguarding, complaints) appropriately, and to support the Quality and Assurance Committee's work programme.

Figure 6: Quality management information sources

The newly established Primary Care Development Team has a substantial role in supporting delivery of the quality agenda in general practice, e.g. by supporting quality improvement in medicines management, benchmarking outcome indicators across member practices' and supporting quality improvements programmes.

The quality and assurance committee

The Quality and Assurance Committee is responsible for establishing the quality framework of national standards and outcome targets, and local priorities, through which providers are held to account for the quality and safety of their services. Its remit includes systems and processes to safeguard children and vulnerable adults, equality and diversity monitoring, information governance, and reviewing serious incidents and Never Events on behalf of the Governing Body.

Its overview of quality standards and improvement will also include reviewing performance against Commissioning for Quality and Innovation (CQUIN) targets, patient experience indicators (including complaints and compliments), and clinical performance indicators.

Governing body

The CCG's Governing Body bears ultimate responsibility for quality, safety and the systems and processes which ensure continuous improvement and the active management of safety concerns (although it delegates many of the detailed assurance tasks to the Audit Committee).

The Governing Body will publish an annual quality report as part of its accountability to member practices and the public, and formally receive and consider in public the annual reports of the Safeguarding Vulnerable Adults and Safeguarding Children Boards.

Brighton and Hove City Council Overview and Scrutiny Committee can formally call the Governing Body to account for the quality and safety of care it commissions on behalf of Brighton and Hove residents.

Risk management

Risk management is a fundamental part of quality and safety assurance and the CCG has an integrated Risk Management Framework covering clinical, financial and corporate risks.

A corporate risk register is updated monthly. Relevant information is presented to the Quality Assurance Committee, Operational Leadership Team (OLT) and governing body, and there are clear mechanisms through which quality and patient safety risks are escalated and resolved. The clinical risk manager ensures that Serious Untoward Incidents are reported to the National Reporting and Learning System.

Project management office

CCG-commissioned projects are reviewed fortnightly by the project management office to ensure they are being delivered correctly and on time. A fortnightly report goes directly to the OLT and provides a further conduit for raising and escalating quality concerns relating to commissioned services.

NICE quality standards

The CCG will further ensure and demonstrate quality and outcome improvements through adherence to existing and future NICE Quality Guidelines[4].

These guidelines and their supporting resources (e.g. specific markers to clearly measure outcomes as set out in Every Patient Counts technical specifications[5]) will enable us to demonstrate improvements in quality and outcomes in the coming years.

Friends and family test[6]

In 2012 the Prime Minister announced the introduction of the "The NHS Friends and Family Test".

Starting from April 2013, patients will be asked whether they would recommend hospital wards and A&E departments to friends or family members if they needed similar care or treatment.

It is intended as a simple, easily collated quality indicator for providers and commissioners of services. It will give patients another source of information when making choices about where to receive care, and encourage them to challenge providers and commissioners about any perceived shortfall in standards of care.

Brighton and Sussex University Hospitals NHS Trust and other Sussex providers are using this test already. The results will be collected from April 2013 and reviewed regularly by the CCG alongside other patient feedback to inform quality, outcome and contract discussions.

[4] NICE Quality Standards

[5] Every Patient Counts Technical Definitions

[6] The NHS Friends and Family Test: Publication Guidance, DoH, February 2013

1.10 Working with patients and the public

We are determined to put patients at the heart of what we do as a CCG and see shared ownership of the commissioning agenda and shared responsibilities for health as a key priority.

We will ensure the CCG has the capacity and skills required to actively strengthen our patient and public relationships, especially in relation to our communications and engagement function.

Our patient and public engagement plan builds on existing good practice across the City and has been informed by a review of engagement mechanisms conducted in partnership with Brighton and Hove City Council.

Full details of this review and the resulting proposals can be found in the CCG Engagement and Communications Strategy but the key engagement mechanisms are:

- Individual Patient Participation Groups, many of which exist already;
- A network of Patient Participation Groups members from across the city;
- Public and patient representatives on our three Local Member Groups;
- CCG funding of mechanisms to reach seldom heard/chronically excluded groups;

and

- A city-wide participation forum that brings together members of the third sector, neighbourhood and community groups, patient participation groups and Healthwatch.

Another important part of our engagement and communication strategy is to raise our profile with patients and the public. We held at least fifteen public events across the City during our 'shadow' development phase including three very successful public events in November 2011. We are keen to build on this good start and create an ongoing dialogue with patients and the public around the CCG, health priorities for the city, and how they might become involved.

1.11 Our provider landscape

The CCG develops and supports services in five provider sectors:

- Primary Care
- Community Care
- Secondary Care
- Tertiary and Specialist Care
- Mental Health Services.

The provider organisations with which we contract offer services across and sometimes beyond Sussex. Our commissioning arrangements extend between providers and beyond the city limits so that patients receive seamless, high quality services along the whole care pathway, and we are committed to strengthening the links between providers to better deliver the NHS National Outcomes Framework.

CCGs in Sussex have agreed to co-ordinating their commissioning with the main health providers in the county. The full terms of the arrangement are described in the consortium agreement signed by Accountable Officers in December 2012, and an associated Sussex Collaborative agreement outlines the delivery and governance arrangements for the wider collaborative agenda in Sussex.

The roles and responsibilities of a co-ordinating organisation are:

- Day to day management of the main contract on behalf of all participating CCGs. This includes (but is not limited to):
  1. Reviewing delivery of all key performance indicators;
  2. Ensuring delivery of critical service efficiencies;
  3. Performance management of national access targets and waiting times;
  4. Robust capacity planning; and
  5. Reviewing and managing the demand and capacity interface across the local health community.
- Agreeing to commission new services or decommission existing services.
- Maintaining a log/minutes of actions arising from all meetings and negotiations with the provider, and circulating these to all participating CCGs within an agreed timeframe
- Monitoring activity and performance including key performance indicators, CQUIN and other national quality standards, and financial performance.
- Establishing clear lines of communication, including regular meetings of participating CCGs.
- Overseeing monthly activity, finance and performance reporting by the provider to all participating CCGs.
- Having due regard to information provided and opinions expressed about any aspect of the main contract by participating CCGs. This includes:
  1. Any requirement for an audit of the provider's calculations or prices charged under clause 19.6.1 of the main contract; and
  2. Any query raised by a participating CCG in connection with the provider's performance under the main contract.

Co-ordinating commissioners will also oversee:

- On-going negotiation and management of the contract;
- Service reviews and their outcomes;
- The introduction of agreed new services, drugs and technologies; and
- The implementation of NICE and/or other national guidance.

Figure 7 (below) outlines the co-ordinating commissioners for each provider Trust:

PROVIDER	CO-ORDINATING COMMISSIONER
Brighton and Sussex University Hospitals	Brighton and Hove CCG
East Sussex Healthcare Trust	Eastbourne, Hailsham and Seaford CCG
Maidstone and Tunbridge Wells Trust	High Weald, Lewes and Havens CCG
Queen Victoria Hospitals	Horsham and Mid Sussex CCG
Surrey and Sussex Hospitals Trust	Crawley CCG
Sussex Community Trust	Horsham and Mid Sussex CCG
Sussex Partnership Trust	Coastal West Sussex CCG
SEC Ambulance	High Weald, Lewes and Havens CCG
Western Sussex Hospitals Trust	Coastal West Sussex CCG

Figure 7: Sussex Collaborative coordinating commissioners

Brighton and Hove CCG is committed to this consortium agreement and will negotiate a contract with Brighton and Sussex University Hospitals NHS Trust that represents the wishes of Sussex CCGs and aligns with the Trust's plans for Foundation Trust status and its 3T (Teaching, Trauma and Tertiary care) programme. We will rigorously monitor performance against this contract and use contract levers to their full extent to ensure delivery.

The following sections give a brief description of each provider and its associated services.

Primary care

General practice is both a major provider of and gateway to health services for the city's population, with some 170 GPs in 47 practices supporting a population of approximately 300,000.

The CCG will support primary care practitioners in their efforts to improve quality and outcomes for patients. Local Enhanced Services (LES) schemes will continue as a means through which we invest in community based services to meet local needs[7]. Further support will come through national Directed Enhanced Services (DES) linked to national priorities; these will be commissioned through the NHS Commissioning Board[8].

Quality Outcome Framework (QOF) mechanisms have been used for some years to encourage a more systematic approach to improved patient, condition and illness management. Evidence from the QOF benchmarks in Brighton and Hove[9] suggests that:

- There remains a wide variation in the quality and performance of primary care services in Brighton and Hove.
- On average local practice QOF scores are lower than the national average
- Prevalence of the conditions measured by the QOF registers (including CHD, diabetes, COPD and hypertension) is lower than expected. This indicates that there may be significant undiagnosed conditions in our population which impacts on the potential to save lives, reduce the burden of ill-health and improve patient outcomes.
- Brighton and Hove has higher than average exception reporting, suggesting the need for more creative approaches to optimise patient engagement.

We therefore believe there is scope to improve primary care quality and outcomes in the city, and have created a dedicated Primary Care Directorate to lead this work.

Community care

Sussex Community NHS Trust was established in October 2010 and provides a wide range of health and social care services for children and adults across Sussex[10]. The CCG commissions a number of Trust services for Brighton and Hove residents including falls prevention, stroke rehabilitation, end of life care and integrated primary care teams.

Sussex Community NHS Trust also supports elderly people in the city through its provision of community beds, and is currently working with the CCG to improve community care teams and services so that more local people can be treated at home.

The Trust had a successful 2011-2012 (e.g. eliminating single sex accommodation, reducing C. Difficile infection, doing well in Care Quality Commission inspections, and delivering its financial targets[11]) and now wishes to make further progress.

The next steps in driving up the quality of service, patient outcomes and patient experience are detailed in the Trust's Quality Account 2011-2012[12] and form its priorities for 2013-2014. The Trust aims to achieve NHS Trust Foundation status by April 2014.

[7] www.brightonandhove.nhs.uk/healthprofessionals/generalpractice/enhancedservices/index.asp

[8] Enhanced Services Commissioning Factsheet, NHS Commissioning Board, July 2012

[9] Improving Patient Outcomes, Terry Blair Stevens

[10] A full list of services can be found at the link below http://www.sussexcommunity.nhs.uk/services/all_services.htm

[11] "Our achievements 2011/2012, Our Priorities 2012/2013" Sussex Community NHS Trust

[12] "Quality Account 2011/2012", Sussex Community NHS Trust

Secondary care

Secondary care comprises a range of services including emergency and urgent care, district general hospital services and maternity facilities.

Our main contract for secondary care services is with Brighton and Sussex University Hospitals NHS Trust (BSUH).

BSUH is a teaching Trust based across two sites -the Royal Sussex County Hospital (RSCH) in Brighton, which includes the Royal Alexandra Children's Hospital and the Sussex Eye Hospital, and the Princess Royal Hospital (PRH) in Haywards Heath.

Both sites provide acute and general hospital services for their local populations and specialised services for patients across Sussex and South of England. RSCH is the major trauma centre for Sussex and the South East, whilst PRH is the centre for planned care[13].

BSUH has demonstrated its commitment to high standards of performance. It has set itself further quality challenges – e.g. providing more single sex accommodation, improving, privacy and dignity, and reducing Never Events - and has the CCG's support in delivering these.

BSUH has an ambitious development programme that will see it grow into a centre of teaching excellence in collaboration with local academia, progress and mature as the region's major trauma centre, and further develop its expertise in tertiary services such as neurology and cancer. Redevelopment of aging buildings on the RSCH site will improve the patient experience significantly. BSUH seeks to obtain NHS Foundation Trust status in April 2013.

Planned care

Speedy access to planned care for routine treatments is a CCG priority and we will maintain our work with providers to meet the 18-weeks referral to treatment target for planned care. Work to date has focused on performance managing acute hospitals to achieve this and associated national targets (including outpatient and day case targets), and developing new local care pathways. We will continue to commission these local pathways - which provide high quality care in GP surgeries and other community settings - to increase access to diagnostic tests and treatments in the pre-hospital phase of the patient journey.

Maternity services

The CCG is supporting the development of maternity services across Sussex and specifically at the Royal Sussex County Hospital where a planned midwife-led unit and additional midwives will improve services. Our focus on quality improvement has already led to restructuring of the community midwife service, an increase in midwifery resources, and national funding for en suite facilities in the maternity unit.

Emergency and urgent care

Emergency department and urgent care services for Brighton and Hove patients centre on the Royal Sussex County Hospital. RSCH currently provides major trauma services via consultant- led trauma teams and wishes to strengthen services further with additional polytrauma theatre capacity, and more ward and intensive care beds.

[13] Brighton and Sussex University Hospitals Annual Report 2011-2012

Cancer services

The Sussex Cancer Network is the network for Brighton and Hove and is the main network in Sussex.

Brighton and Sussex University Hospitals NHS Trust is the largest provider of cancer services for Sussex. It works collaboratively with other Trusts through the Sussex Cancer Network, which is one of a number of managed clinical networks in the South East coast region.

The CCG will engage with BSUH and the Cancer Network to address chemotherapy and radiotherapy capacity issues and the expansion needed to meet significant growth in demand.

Neurosciences

BSUH is a regional treatment centre for specialist neurosciences services. These are currently located in Haywards Heath in unsuitable accommodation and the service is to move to a purpose built unit at the RSCH. This new unit will remove the need for some patients to be treated in London.

Ambulance services

Brighton and Hove residents receive their service from South East Coast Ambulance Service NHS Foundation Trust which manages 999 calls from the public, urgent calls from healthcare professionals and non-emergency patient transport for Sussex and Kent.

Mental health services

Brighton and Hove City has issues relating to homelessness, substance misuse and mental health, the latter of these can be high in volume and complex in nature.

The CCG intends to move more mental health services into community settings and increase the focus on prevention. We commission a range of services from the community and voluntary sectors, and also commission specialist mental health services from Sussex Partnership Foundation Trust (SPFT) including community and in-patient services, assertive outreach, support for people with learning disabilities, and services for older people.

CCG support is helping SPFT to improve access to talking therapies, care for those in crisis, and support for people with both substance abuse and mental health problems.

1.12 Our population

Brighton and Hove CCG covers a geographical area of approximately thirty four square miles and shares the same boundaries as Brighton and Hove City Council.

Brighton and Hove has an unusual population distribution with relatively large numbers of people aged 20 to 44 years, relatively fewer children and older people, and relatively more people (particularly women) aged 85 years or over who are likely to need more services.

The resident population rose from 248,400 people in 2002 to 258,800 in 2010 (an increase of 3.2%) according to Office for National Statistics (ONS) mid-year estimates, although there is a large difference between ONS estimates and numbers of people on local GP registers.

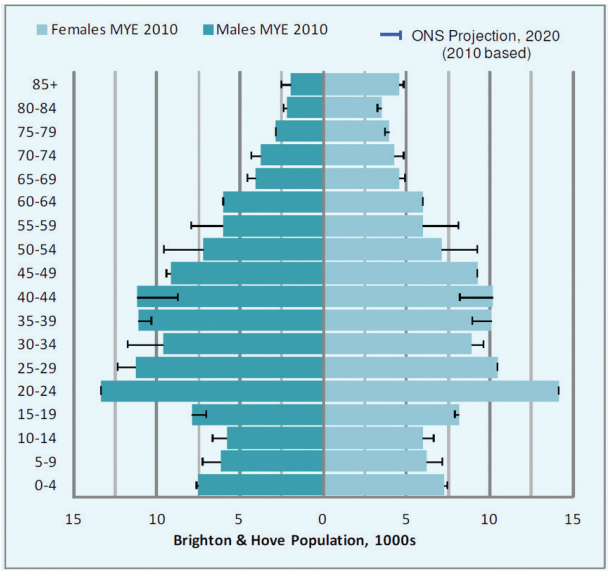


Figure 8: Bright & Hove population

There are two universities in the city and a student population of approx 34,000. There has been a sustained increase in the numbers of students from almost 26,000 in 1995/96 to almost 33,400 in 2010/11.

The city is a destination for migrants from outside the UK with 15.1% of the city's population born outside the UK, higher than the South East (11.0%) and England (12.8%).

For the year ending June 2010 there were estimated to be 4,000 migrants to the city from outside of the UK, and 2,400 people leaving the city to outside of the UK – a net inward migration of 1,600 people.

Whilst lots of people move into the city from other parts of the UK each year (17,600 in the year ending June 2010), a similar number move out of the city (18,100) and so the net effect of internal migration is very small (500 fewer people). The largest numbers move from and to London.

Predicted future need

Changes in the population age structure affect the need for health and social care services. Population projections therefore have an essential role in assessing the future need for services. Current trends in births, deaths and migration are projected forwards and used to produce population projections.

Brighton and Hove resident population is predicted to increase to 269,400 by 2020 (a 4.1% increase from the current 2010 mid year estimate) and to 291,000 by 2030. The greatest projected increase will be seen in the 25-34 and 50-59 year age group. There will also be increased numbers of children under 15 years old. The number of people aged 75 years or over is expected to increase very slightly.

As in the recent past, the main determinants of future changes in the total population of the city are house building, international migration, and the number of university students.

Life expectancy

Life expectancy in Brighton and Hove is 77.7 years for males and 83.2 for females (2008-2010). Whilst females in the city can expect to live on average six months longer than nationally, life expectancy for males is almost a year lower than in England (78.6 years for males and 82.6 years for females).

Life expectancy at age 65 years is 18.0 years for males and 21.6 years for females in the city compared to 18.3 and 20.9 respectively for England.

Life expectancy in the city is higher than it has ever been, and is continuing to increase by around four months each year for both males and females.

Local inequalities

Despite the narrowing gap in life expectancy between men and women, men tend to develop and die from many conditions earlier than women.

The slope index of inequality in life expectancy gives a measure of the hypothetical difference in life expectancy between the most deprived and least deprived individuals. It is a more sensitive measure than the difference in mortality between the most deprived and least deprived quintiles of population as it looks at differences in life expectancy across the whole population.

In 2006-2010 the slope index was 10.6 years for males and 6.6 years for females in Brighton and Hove. For females in the most deprived 10% of Lower Super Output Areas (LSOAs) in the city, life expectancy is 80.0 years compared with 84.4 years in the least deprived 10% of LSOAs. The equivalent figures for males are 71.7 and 81.7 years respectively.

For males this gap is almost two years wider than nationally. Whilst mortality rates in the city are falling in all groups in line with national trends, they are falling at a faster rate in the least deprived quintile and so inequalities are widening.

In 2001 those living in the most deprived quintile of the city had a mortality rate 1.5 times higher than the least deprived quintile. By 2009 this gap had widened to 1.9 times.

1.13 Joint strategic needs assessment

"Joint Strategic Needs Assessment describes a process that identifies current and future health and wellbeing needs in light of existing services and informs future service planning taking into account evidence of effectiveness. Joint Strategic Needs Assessment identifies 'the big picture', in terms of the health and wellbeing needs and inequalities of a local population" JSNA Guidance, Department of Health.

The Joint Strategic Needs Assessment (JSNA) for Brighton and Hove (www.bhlis.org) provides an overview of city residents' health needs and the range of healthcare services provided for them. It is derived from the NHS Atlas of Variations 2011 and CCG data profiles produced by the NHS Commissioning Board.

JSNA outcomes have been used to inform commissioning priorities. All CCG member practices were invited to workshops where the JSNA findings were discussed; the results of these discussions were fed into the CCG commissioning plans.

The CCG has used the JSNA to identify service areas that are working successfully, and those areas which need improvement, so that we can set appropriate priorities for future service provision and development.

Services working successfully

The JSNA outcomes suggest that the following areas of provision are working well:

- Reproductive health, maternity and neonatal care
- End of life care
- Audiology services
- Dental services
- Stroke services
- Cataract services
- Breast screening
- Primary care mental health service development

Areas for further development

Diabetes

A number of indicators, when taken together, suggest unwarranted variation in the care of people with diabetes. There may be substantial scope for improving the quality of local diabetes care for some patients and using resources more effectively.

Cancers and tumours

Early detection and surgical intervention are considered to be factors in survival. We have a high rate of GP referrals for suspected cancer but less successful outcomes and a low rate of lung cancer cases receiving surgery. This suggests that work could be done to improve care pathways and specifically early detection in the community.

Dementia

Brighton and Hove has

- A lower than expected number of patients identified with dementia
- Low expenditure on dementia drugs
- Low rates of hospital admissions in patients with dementia

These findings suggest we need to significantly improve the identification and treatment of dementia.

Mental health

Brighton and Hove has high death rates from substance misuse and suicide, and high rates of hospital admission for people with mental health issues. We are continuing to work with providers to improve identification, management and services for people with mental health issues.

Circulatory illnesses

We need to improve identification in primary care of people at risk of heart disease and stroke. Our area's results are amongst the worst in the country; better preventative diagnosis should results in more health benefits to patients.

Emergency care

Brighton and Hove has a high rate of Accident and Emergency attendances but relatively few need emergency admission, suggesting that many attendances were for conditions that could have been managed elsewhere. Hospitals also admit many patients whose condition could be managed elsewhere. We need to review the links between hospital and community services, and care management for chronic conditions.

Care pathways

A number of local indicators associated with cancer, diabetes, coronary heart disease and respiratory disease are cause for concern and suggest that a renewed focus on the care pathways for these diseases and conditions would improve the quality of treatment and health outcomes, and reduce health inequalities across the city.

1.14 The wider strategic context

The NHS mandate

The NHS Mandate[14], published in November 2012 and effective from April 2013, outlines objectives and goals for the NHS in delivering sustainable improvements in care, outcomes quality and equity of access for patients. Patients and the public should expect to see discernable improvements across the NHS by March 2015.

The NHS Commissioning Board will ensure that local NHS commissioners and providers deliver the objectives in the 2013-2014 Mandate, which mirror the NHS Outcomes Framework and focus on those healthcare areas the public deemed of most importance. The Commissioning Board will in turn be held to account by the Department of Health for delivery of the Mandate.

There are approximately 20 objectives. The key ones are:

- Improving standards of care and not just treatment, especially for the elderly
- Better diagnosis, treatment and care for people with dementia
- Better care for women during pregnancy, including a named midwife responsible for ensuring personalised, one-to-one care throughout pregnancy, childbirth and the postnatal period
- Every patient will be able to give feedback on the quality of their care through the Friends and Family Test starting from April 2013 – so patients will be able to tell which wards, A&E departments, maternity units and hospitals are providing the best care
- By 2015 everyone will be able to book their GP appointments online, order a repeat prescription online and talk to their GP online
- Putting mental health on an equal footing with physical health – this means everyone who needs mental health services having timely access to the best available treatment
- Preventing premature deaths from the biggest killers
- By 2015, everyone should be able to find out how well their local NHS is providing the care they need, with the publication of the results it achieves for all major services.[15]"

The CCG and its partners are committed to delivering the objectives in the NHS Mandate and thereby improving quality and outcomes for city residents. Our success will be clearly measured and demonstrated through the NHS Outcomes Framework (see below).

[14] www.dh.gov.uk/health/2012/11/nhs-mandate/

[15] www.dh.gov.uk/health/2012/11/nhs-mandate/

The NHS outcomes framework

NHS Outcomes Frameworks were introduced in December 2010 to provide indicators of improved health outcomes and quality based Lord Darzi's[16] principles of effectiveness, patient experience and safety. The indicators for 2013-2014[17] focus on five domains (see figure 9 below):

- Preventing people dying premature by improved early diagnosis of potentially terminal conditions and preventing ill health
- Enhancing the quality of life for people with long term physical and mental health conditions including dementia
- Helping people recover from periods of ill health or following injury
- Ensuring people have a positive experience of care across all areas and in all sectors
- Treating and caring for people in a safe environment and protecting them from harm

Figure 9: NHS Outcome Framework domains

The CCG uses the outcomes in the national framework to measure the success of our strategic objectives and annual plans. All plans are mapped to the outcomes framework domains and are designed to deliver demonstrable improvements in patient outcomes.

Partnership working and the outcome frameworks

The three national outcomes frameworks covering the NHS, public health and social care have been aligned to maximise progress against NHS Mandate goals and objectives, and were released concurrently in November 2012.

Each has high level domains (areas of focus) supported by detailed indicators. The domains overlap in some area (see figure 10 below) and may also have common or corresponding indicators.

[16] High Quality Care for All: NHS Next Stage Review http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

[17] http://www.dh.gov.uk/health/2012/11/nhs-outcomes-framework/

This alignment will stimulate shared improvement through partnership working across the three sectors. For the CCG it will be a further stimulus to the strong organisational working partnerships already in place across the city and deepen our commitment to integrated planning.

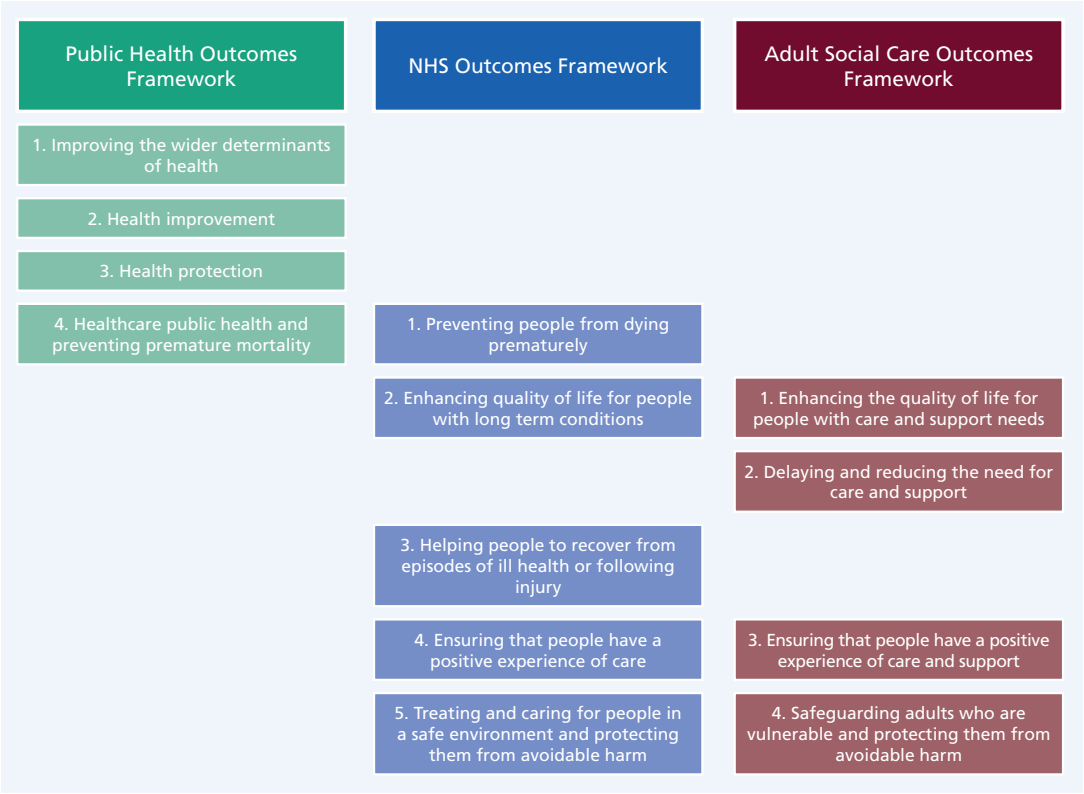


Figure 10: Alignment of the three outcomes frameworks

Everyone counts: planning for patients 2013/14

The NHS Commissioning Board published a suite of planning guidance documents for CCGs in December 2012.

The core document - Everyone Counts: Planning for Patients 2013/14 - replaces the previous year's National Operating Framework and sets a number of objectives for NHS Commissioners. Supporting documents provide technical detail regarding outcomes, quality premium, CQUINS, financial planning assumptions and the planning timetable.

Everyone Counts describes 'assumed liberty' for local commissioners, i.e. CCGs and local communities are given the power to prioritise on the basis of local needs and community preferences. The guidance goes on to outline five 'offers' to NHS commissioners to give them the evidence and insight they need to produce better outcomes:

Offer 1: NHS services, seven days a week – initially for urgent and emergency services only

Offer 2: More transparency, more choice – publish activity and quality measures

Offer 3: Listening to patients and increasing their participation – introduction of family and friends test

Offer 4: Better data, informed commissioning, driving improved outcomes – timely accurate data

Offer 5: Higher standards, safer care – Implementing Transforming Care recommendations

The guidance also requires CCGs to work with Health and Wellbeing Boards to oversee the delivery of plans which improve outcomes for patients, deliver the NHS Constitution rights and pledges, and strengthen local QIPP programmes. It specifies tools and levers to support commissioning including mandatory use of the NHS Standard Contract (including financial consequences for underperformance) and CQUIN.

CCG quality premium

The NHS Commissioning Board can reward CCGs with a Quality Premium (currently up to £5 per head of population) for improvements in the quality of commissioned services, associated improvements in patient outcomes, and reductions in healthcare inequalities. CCGs are free to decide how this premium is spent so long as it improves either quality or outcomes.

The 2013/14 quality premium is based on improvements against four national measures and three local measures.

The four national measures align with the NHS Outcomes Framework and are:

- Reduce premature mortality
- Prevent/reduce avoidable emergency admissions
- Roll out Friends and Family Test and demonstrate improved patient experience as measured by this test
- Reduce incidence of healthcare associated infections (MRSA/Clostridum difficile).

Definitions and details of the measures, values and thresholds are given in Quality Premium: 2013/14, NHS Commissioning Board, December 2012 - draft.

The three local measures are expected to be in line with priorities contained in local health and well being strategies and agreed with NHS Commissioning Board Area Teams.

Commissioning for quality and innovation (CQUIN)

CQUIN was introduced in 2009 as a way for commissioners to drive and reward quality improvements and uptake of innovation by NHS service providers. In 2013/2014 the value of these incentives is up to 2.5% over the standard provider contract according to how fully a provider meets nationally and locally set goals and targets.

Providers must now demonstrate that they meet CQUIN prequalification requirements relating to six high impact innovations which have been identified as 'game changing improvements'[18]. They are fully described in 'Innovation, Health and Wealth, Accelerating Adoption and Diffusion in the NHS'[19]

Providers should have measures in place by March 2013 to meet these prequalification requirements for services commissioned by CCG or the NHS Commissioning Board in order to be eligible for CQUIN payments[20]. We will seek assurance about compliance on a provider by provider basis.

[18] "Innovation, Health and Well, Accelerating Adoption and Diffusion in The NHS", December 2011

[19] "Innovation, Health and Well, Accelerating Adoption and Diffusion in The NHS", December 2011

[20] "Commissioning for Quality and Innovation (CQUIN), 2013/14 Guidance" NHS Commissioning Board, draft- December 2012

Innovation, health and wealth

In December 2011 the Department of Health published 'Innovation, Health and Wealth: Accelerated Adoption and Diffusion in the NHS' - a review, strategic overview, agenda and implementation programme to drive forward the use of innovation in the NHS. The paper is the culmination of work by a group drawn from many sectors including the NHS, industry, academic and scientific bodies, and voluntary organisations.

CCGs and the NHS Commissioning Board have a legal duty to promote, adopt and diffuse innovation in line with the eight keys themes (below) which emerged in the paper:

- **Reducing Variation and Strengthening Compliance -** Reduce variation in health care and increase compliance with NICE Guidance across the NHS.
- **Metrics and Information -** Improve measures for innovation adoption and diffusion and create information focus points to aid dissemination and uptake of new ideas throughout the NHS.
- **Creating a System to Deliver Innovation -** Strengthen NHS networks to drive methodical delivery, implementation and sharing of innovation
- **Incentives and Investment -** Develop incentives and investments, both personal and organisational which recognise, reward and encourage beneficial innovations while disengaging dated and less effective processes and procedures.
- **Procurement -** Modernise, develop and implement an efficient procurement strategy to deliver value for money, optimise the benefits of the NHS' large purchasing base, foster links with industries and small and medium sized businesses and ensure patients have access to "best services, technologies and medicines"[21].
- **Developing Our People -** Actively develop staff and clinicians' competencies at all levels to ensure an innovative culture is "hardwired" from the outset of training and induction and perpetuated and sustained throughout the individuals' career in the NHS. This will be supported by educational and industry leadership training programmes and an NHS Innovation Fellowship Scheme.
- **Leadership for Innovation -** NHS Boards and leaders at all levels have a legal duty to promote, recognise and adopt innovation as a core element in the current and future development of the NHS. Clear direction and priorities have and continue to be set and developed to ensure commissioners, providers and staff are strongly led and supported in the core integration of innovation and subsequent best practice at all levels.
- **Spreading Best Practice and Adoption -** High Impact Innovations - These are recognised as six elements of substantial but achievable change which are being implemented at pace and have direct, immediate impact on the way the NHS operates; improving outcomes and optimising the use of resources. They are described in detail in the CQUIN section below.

A review of the progress published in December 2012 reports the varying levels of advancements against this agenda. It provides detailed information on the measures and actions already implemented, movement towards the stated goals, and further legislative, organisational and fiscal imperatives needed to support and encourage further progress.

[21] "Creating Change, IHW One Year On" Department of Health December 2012

2 Managing resources

Brighton and Hove CCG has an underlying surplus and a history of assisting other parts of the local health system where there are underlying deficits.

Our main acute provider (BSUH) continues to have an underlying deficit which we estimate at £10m to £15m. Although savings within the city's NHS system can contribute to reducing this deficit, the ultimate resolution must come from reconfiguring acute services across the wider health system.

High Weald Lewes and Haven CCG and Horsham and Mid Sussex CCG, the other main customers of BSUHT, have underlying deficits. We believe these can in part be resolved through our collaborative commissioning plans which will address some long standing issues around hospital over-performance.

Ensuring an appropriate level of spending on acute services across the health economy will greatly assist our ability to invest in community and mental health services.

As a CCG we inherited QIPP plans for 2012/13. During that year there was no major over-performance on the BSUH contract overall but the level of urgent care activity across the system remains a concern.

If we are to maintain a sustainable position the CCG, like the PCT before it, must set plans that keep us 'ahead of the curve'.

The CCG initially set a very stretching savings target for 2013-2014 but has since reviewed the position and set a target of 4%. This is purposely above the nationally expected 3% and we have also extended the planned surplus to 1.5%, thereby storing up benefits for future years. We have concerns over the impact of the removal of specialist commissioning funds which we believe will erode the underlying surplus as the percentage of specialist work at BSUHT is above average (representing more than 30% of their overall income).

We assess our risk at this level of savings at around £2 million. The calls on the 2.5% contingency from schemes agreed in 2012/13 are being reviewed but the main one - supporting trauma - is now a specialist/direct commissioning issue for which no allowance needs to be made in our plans. We therefore believe there is sufficient coverage for risks around our stretch savings target and the move to straight Payment by Results contracts with Sussex providers in 2013/14. We would also seek to fund investments needed to release QIPP savings this year or next from this reserve.

2.1 Key modelling assumptions

We anticipate moderate service pressures, due in part to demographic changes. More adults and children will require NHS funded continuing care, and we will have to fund an increase in specialist mental health treatment packages. Drugs expenditure costs are likely to increase as in previous years.

We have used locally agreed assumptions of annual population-related growth in acute services. Our model reflects demand management initiatives within urgent care and planned care plans that will ensure demand is both realistic and affordable.

Our modelling also includes the effect of a number of existing plans and the full year effect of similar in-year investments.

Our key assumptions are shown in the figure 11 below:

Figure 11: QIPP planning assumptions

NOTE:	PLANNING ASSUMPTION	2013 /14	2014/ 15	2015 /16	2016 /17	2017 /18
A	Growth on notified opening allocations	2.30%	2.00%	2.00%	2.00%	2.00%
B	Tariff (Mandatory)	-1.10%	-1.30%	-1.30%	-1.30%	-1.30%
B	Non Mandatory (Non-PbR, Tariff)	-1.30%	-1.30%	-1.30%	-1.30%	-1.30%
C	CQUIN	2.50%	2.50%	2.50%	2.50%	2.50%
D	Prescribing Inflation (before new drugs)	5.00%	5.00%	5.00%	5.00%	5.00%
D	Growth	1.00%	2.34%	2.34%	2.34%	2.34%
E	Ringfence - Non-recurrent Funds	2.00%	2.00%	2.00%	2.00%	2.00%
E	Contingency	0.50%	0.50%	0.50%	0.50%	0.50%
E	Surplus	1.50%	1.00%	1.00%	1.00%	1.00%

Notes:

A - Allocations

An allocation to CCGs to cover the local services they will commission on behalf of their populations representing 2.3% nominal growth or 0.3% real terms growth.

B - Tariff Deflator

The national provider efficiency requirement for 2013/14 tariff setting is 4 per cent. This will be offset against estimated provider cost inflation of 2.7 percent. This gives a net tariff adjustment of -1.3 per cent, which will also be the base assumption for discussions on price for services outside the scope of the mandatory tariff.

C - CQUIN

CQUIN presents an opportunity for commissioners to secure local quality improvements over and above the norm by agreeing priorities with their providers. It is set at a level of 2.5 per cent of the value of all services commissioned through the NHS Standard Contract. Locally we have used CQUIN to incentivise whole system working by making CQUINS across a number of providers interdependent.

D – Growth and cost pressures

We have allocated 1% for growth and cost pressures in 2013/14.

E - Contingency

Clinical commissioning groups are asked to hold a contingency of at least 0.5 per cent of revenue within their plans to determine locally the contingency required to mitigate risks within the local health economy. This is in addition to 2 per cent ringfenced non-recurrent funds. Our own direct commissioners will also hold a minimum 0.5 per cent contingency.

E - Surplus

Each commissioning organisation should plan to make a cumulative surplus at the end of 2013/14 of at least 1 per cent of revenue, including any historic surplus not drawn down. This will be carried forward into 2014/15.

2.2 QIPP savings challenge

These assumptions allow us to model our medium term financial plan and identify the scale of the financial challenge. The table below shows that our QIPP challenge is £8 million in 2013-2014 and £6m in the following four years:

Figure 12: QIPP savings challenge

SUMMARY	£M	£M	£M	£M	£M
MTFP (Medium Term Financial Plan)	2013/14	2014/15	2015/16	2016/17	2017/18
Allocation increase / growth	7.8	7.0	7.1	7.3	7.4
Return of prior year surplus	0.5	3.4	3.7	3.8	3.9
Source of Funds	**8.4**	**10.4**	**10.8**	**11.1**	**11.3**
Cost Pressures and Service Pressures	(4.5)	(3.6)	(3.5)	(3.3)	(3.2)
2% Ringfenced Non-recurrent Reserve	(6.8)	(7.5)	(7.7)	(7.9)	(8.1)
0.5% Contingency	(1.7)	(1.9)	(1.9)	(2.0)	(2.0)
Application of Funds	(15.2)	(12.9)	(13.0)	(13.1)	(13.3)
Plus - QIPP and Efficiency Savings	8.0	6.3	6.0	6.0	6.0
Stretch target	2.0				
Surplus (1.5%)	**5.2**	**3.7**	**3.8**	**3.9**	**4.0**

Our annual operating plan describes saving schemes sufficient to meet our QIPP challenge for 2013/14.

2.3 Future-proof finances

In 2013/14 we will stretch our surplus from the 1% mandated in national guidance to 1.5%. This will help future-proof our finances against additional cost pressures forecast in 2014/15 and beyond. In addition we have set ourselves a QIPP stretch target of £2m. Throughout 2013/14 we will work to develop and deliver additional works streams to achieve this.

Each year we will produce an Annual Operating Plan that clearly articulates how we will meet the QIPP financial challenge whilst improving quality and patient outcomes.

2.4 Planning principles

The QIPP (Quality, Innovation, Productivity and Prevention) programme launched in 2010 by the Department of Health is a large scale transformational programme intended to improve quality of care delivers while making up to £20 billion in efficiency savings by 2014-15 for reinvestment in frontline care.

The CCG uses QIPP to guide its commissioning and planning, recognizing that:

- There is no additional money; cost pressures must be funded through improved quality and productivity, innovation, and by preventing ill health and promoting wellbeing
- Commissioned services must meet internal cost pressures within existing financial envelope by redesigning services, not reducing them
- All invest to save projects must be evidenced based, have a robust business case and be subject to rigorous internal challenge and testing
- Primary care and public health must be involved to ensure a focus on prevention, not just treatment
- Innovative solutions should be developed through workshops at the beginning of the planning cycle
- Telehealth and telecare should be implemented across a range of providers through HII CQUINS
- Year round planning must be led by clinicians and guided by QIPP principles

3 Transformational change areas

This section describes five key areas for transformational change.

3.1 Optimising the quality and sustainability of health services across Sussex

The NHS in Sussex spends some £2.6 billion a year. The Sussex Together project, which brought together all parts of the NHS and partner organisations in the county, identified that the Sussex health economy could only meet future health needs within the funding likely to be available by changing the way in which services are provided, ensuring widespread adoption of best practice, and reducing duplication.

In addition Sussex provider trusts will only achieve NHS Foundation Trust status, in line with Department of Health requirements, if there is a clinically and financially sustainable NHS across the county.

Sussex CCGs have undertaken to work collaboratively to oversee the development and delivery of high quality, sustainable services across Sussex whilst maintaining individual accountability to the population they serve.

The Sussex Collaborative will build upon the Sussex Together plan developed by NHS Sussex by designing a clear strategy for the county and aligning commissioning plans at all levels to help deliver the changes needed. Decisions will be made by the Sussex Collaborative executive which is accountable to the CCG governing bodies.

By working on a pan-Sussex basis, services can be aligned and organised in a way that reduces cost. Analysis shows that CCGs could save between 14.2% to 19.2% of current planned care contract costs by organising work differently.

The clinical leaders of Sussex CCGs support the radical approach to service redesign that will be required to deliver a clinically and financially sustainable NHS, and work will begin in 2013-2014 on developing new service models for paediatrics, maternity, imaging and ophthalmology services.

3.2 Improving community care and urgent care services

The care we commission should be of the highest quality, responsive to patient needs, and delivered in the most appropriate setting.

Community services - whether day to day care, enhanced support during periods of crisis, or specialist provision – should be delivered seamlessly across primary and social care and physical and mental health. We have already developed eleven Integrated Primary Care Teams, focused around clusters of GP practices, which provide better co-ordinated and more consistent care, improve the patient experience, deliver better health outcomes, reduce health inequalities and make better use of health resources.

We will now review the impact of these teams, take any further action needed to fully embed the service improvements, and then progress with plans to achieve greater integration of teams working across urgent care, general care, mental health and specialist pathways.

We know that hospital is not the ideal place for frail elderly patients in particular, and, hope , that more responsive and proactive community services can reduce the need for people to attend the emergency department or be admitted as an emergency.

Urgent care was a key focus of our commissioning plans in 2012/13. We strengthened community alternatives to hospital and saw emergency admissions fall by 5% from the previous year, and adult emergency department attendances fall by 8%. Our aim in 2013-2014 is to build on this progress by:

- Creating a single Integrated Rapid Response Service for the city;
- Simplifying access to services and maximising alternatives to hospital treatment or admission.
- Increasing the options for ambulances to see and treat patients rather than simply convey them to hospital.

We hope that consolidating and building on last year's achievements will see overall emergency department attendances reduce by 3% and emergency admissions decrease by another 10%.

New programmes in development include the clarification of future commissioning and provision of ICES service and the scoping and review of diabetes services to inform development of future diabetes provision

3.3 Integrating physical and mental health services

The overall system of care in Brighton and Hove for people with physical and mental health needs is fragmented into largely separate care pathways. One of our key priorities is to achieve better integration to improve health outcomes and make better use of resources.

There inter-relationship between physical and mental health is complex but we know that having a long term physical condition increases the likelihood of having a mental health problem, whilst having a mental health condition can increase risk for a range of physical illnesses:

- People with a long term condition such as diabetes are 2-3 times more likely to experience mental health problems such as depression. People with diabetes and a mental health condition experience more hospital admission and more GP consultations for physical complaints. This translates into increased costs of about 45%.
- Brighton and Hove has a comparatively high proportion of our population with mental health conditions and we know they tend to have comparatively worse overall health outcomes. This is particularly the case for people with serious mental health problems where life expectancy is considerably less than the overall population as a whole.

We wish to transform the way care is delivered by pursuing those care pathways which deliver most benefit for our population. In choosing these we will consider national evidence as well the demographics of Brighton and Hove and local service usage (e.g. diabetes affects a large proportion of our population so transforming the care pathway for this single condition will yield significant health benefits).

In many instances we will need to change the culture of service delivery. Workforce training and development will be fundamental to this, e.g. training and equipping generalist practitioners such as hospital and community nurses to use psychological assessment and other tools in a more structured way in care planning and treatment, and enabling mental health staff to incorporate physical health assessments into care planning for people with mental health conditions.

Specific objectives will include:

- Ensuring that all pathway redesign specifically address better integration of physical and mental health care;
- Developing standard psychological and assessment tools (e.g. for use by hospital and community nurses);
- Improving links between services and professions, and particularly between mental health and generalist services such as primary care; and
- Expanding our psychological therapy service to support people with long term conditions and medically unexplained symptoms.

3.4 Improving the quality of primary care

Primary care already counts for about 9 out of 10 patient contacts, and achieves high levels of patient satisfaction, but there is scope to provide even more care in primary care settings.

We wish to achieve a strategic shift of services from secondary to primary care where this will improve outcomes, reduce inequalities and improve use of resources, and are establishing a clinically-led primary care team to strengthen and develop the primary care system in Brighton and Hove.

We have many excellent local examples of high quality primary care but recognise that (in common with most other CCG areas) there are wide variations in the quality of care between practices. Within Brighton and Hove:

- QOF scores at an individual practice level ranged from 783 to 998 points in 2011-2012
- The average 2011-2012 QOF score for city practices (952 points) was slightly lower than the national average (969 points)
- Practice registers record lower than expected prevalence for several disease areas including CHD, diabetes and hypertension. Better risk identification and diagnosis would improve health outcomes for our population.

As key elements of our approach to ensuring that high quality care is a consistent factor of people's primary care experience the CCG will:

- Actively support peer review as a systematic way of enabling member practices to share best practice and drive quality improvement;
- Support member practices to consider the benefits of working in larger teams (e.g. in federations) if this improves quality of care;
- Consider the context in which each member practice operates but challenge any unwarranted variation in quality and provision of primary care; and
- Ensure that appropriate resources follow the patient when services move to primary care settings.

4 Enablers

This section describes the system enablers currently in place.

4.1 Health and well being boards

Health and Wellbeing Boards are fully functioning legal bodies from 1 April 2013 tasked with ensuring fully integrated health and social care commissioning strategies for their area. These strategies should reflect both the Joint Strategic Needs Assessment for the area and an agreed Joint Health and Well Being Strategy[22].

Their membership includes CCG representatives, councillors, local authority directors for adult social services, children's services and public health, and representatives from Healthwatch and the third sector. They are expected to ensure that the needs and views of the local population are fully recognised in health and social care planning.

Brighton and Hove City health and well being board

Brighton and Hove is covered by one City Council and one Clinical Commissioning Group, making the relationship between these two organisations rather more straightforward than in some other areas. Brighton and Hove City Council and local NHS commissioners and providers have a long and successful history of partnership working reflected in formally shared services and informal partnership working,

[22] http://healthandcare.dh.gov.uk/hwb-guide/

complemented by a well-established and thriving strategic partnership structure across city organisations including the police, fire service, academic institutions, local businesses and third sector organisations.

Brighton and Hove joint health and well being strategy

Given the well established and successful commissioning structures and partnerships already operating locally, Brighton and Hove Well Being Board intends to focus its Joint Health and Well Being Strategy on a few high priority areas where more effective partnership delivery will provide significant health and social gains. This is not intended to downgrade the importance of other areas/services, but simply reflects that these may be better dealt with through other forums.

These high priority areas were identified through the Joint Strategic Needs Assessment; scored for their likely impact on a range of criteria relating to health, quality of life and equality; and further refined to focus on core health, public health and social care issues.

The five priority areas selected at the conclusion of this process are:

- Cancer and access to cancer screening
- Dementia
- Emotional health and wellbeing-including mental health
- Smoking
- Healthy weight and good nutrition

Detailed summaries of each area, and the approach being taken, are included in annual operating plans.

4.2 Workforce planning

Our commissioning intentions and plans will give due consideration to their implications for provider workforces to that proposals are adequately and appropriately resourced and supported.

The CCG has made a commitment to engage and work with providers to develop and agree workforce plans which are appropriate to, and aligned with, commissioning plans. Workforce plans will be included in main contracts and be covered by CQUINs for staffing ratios as recommended by the Royal Colleges where appropriate. They will be further reviewed in light of recommendations made by the 2013 Francis Report into Mid Staffordshire Hospital.

4.3 Delivering change

"The NHS Change model has been developed to support the NHS adopt a shared approach to leading change and transformation…The model brings together collective improvement knowledge and experience from across the NHS into eight key components. Through applying all eight components change can happen. This means no matter whom or wherever you are in the NHS you can use the approach to fit your own context as a way of making sense at every level of the 'how and why' for delivering improvement, to consistently make a bigger difference." NHS Change Model[23]

The NHS is undergoing huge change at a rapid pace and with restricted resources. The NHS Change Model has been developed to support organisations and individuals in delivering this change[24].

The elements that form the NHS Change Model hexagon are outlined below together with details of their integration into the CCG's operation and leadership.

[23] http://www.changemodel.nhs.uk/pg/dashboard

[24] http://www.changemodel.nhs.uk/pg/groups/12195/Leadership+for+change/689?community=Leadership+for+change

Leadership for change

The complexity of healthcare delivery often necessitates shared or distributed leadership where people across an organisation share responsibility for driving forward and delivering change and improvement. Leadership for Change is key to this success, with leaders acting as exemplars and conduits for all parties to realise the ambition for change.

As a new organisation the CCG has been able to ensure from the outset that its clinical leaders, managers and staff have a shared committed to the changes required to establish the organisation and achieve its goals. They are open to challenge, responsive to feedback from a variety of sources, and have the practical and theoretical expertise to guide the CCG through to accomplished maturity.

Spread of innovation

Delivering change and achieving savings will require innovation. We are committed to working in new and innovative ways, as evidenced in the way we are commissioning and/or redesigning services so that they incorporate new ways to access or deliver care. Clinical leads and commissioners research and adopt successful practice from elsewhere and ensure that lessons learned from less successful practice are shared with others.

CCG member practices have been involved in priority planning workshops which actively encouraged innovative approaches to future service provision, e.g. combining outreach services for testing for conditions and the promotion of healthy lifestyles, or approaching smokers outside pubs and restaurants.

Improvement methodology

We are committed to using national improvement methodologies such as the Six Sigma and LEAN as well as many others recommended by the NHS Change Mode (e.g. the clear benefits management method). To this end our organisational development plan includes dedicated resources to ensure such methodologies are developed and embedded at all levels.

Rigorous delivery

We have a core of experienced managers and commissioners whose knowledge of how best to deliver programmes and projects is underpinned by accepted methodology such as Prince2 and P3M. We also research, adapt and adopt new delivery mechanisms to suit our needs; regular monitor all programmes and projects implemented or commissioned by the CCG through our project management office; and report regularly on delivery to the CCG governing body and Area Team.

Transparent measurement

We collect evidence of service quality and improvement by analysing performance data from a number of sources, and where necessary use this data to challenge assumptions about the quality of services being delivered.

We acknowledge that a large number of complex variables can impact on outcomes and will build lessons learnt from this into our measurement reports. As part of our commitment to the NHS Change Management Model we will continually evaluate and update our measurement methodologies, variables and metrics to ensure they are best matched for purpose. We need to focus on why we are measuring as well as what we are measuring, and always keep the sights on outcome.

System drivers

NHS system drivers are forces for change which come from a multitude of directions, on a macro and micro level, and may be intra- or inter- organisational in origin. In order to provide the most effective environment for change individuals, teams and organisations should share the change framework and collaboratively develop solutions to meet the common needs[25].

Our system drivers are aligned to our strategic direction and strategic objectives which in turn are the outcome and drivers for the collaborative working with other CCGs and LHE organisations.

Engagement to mobilise

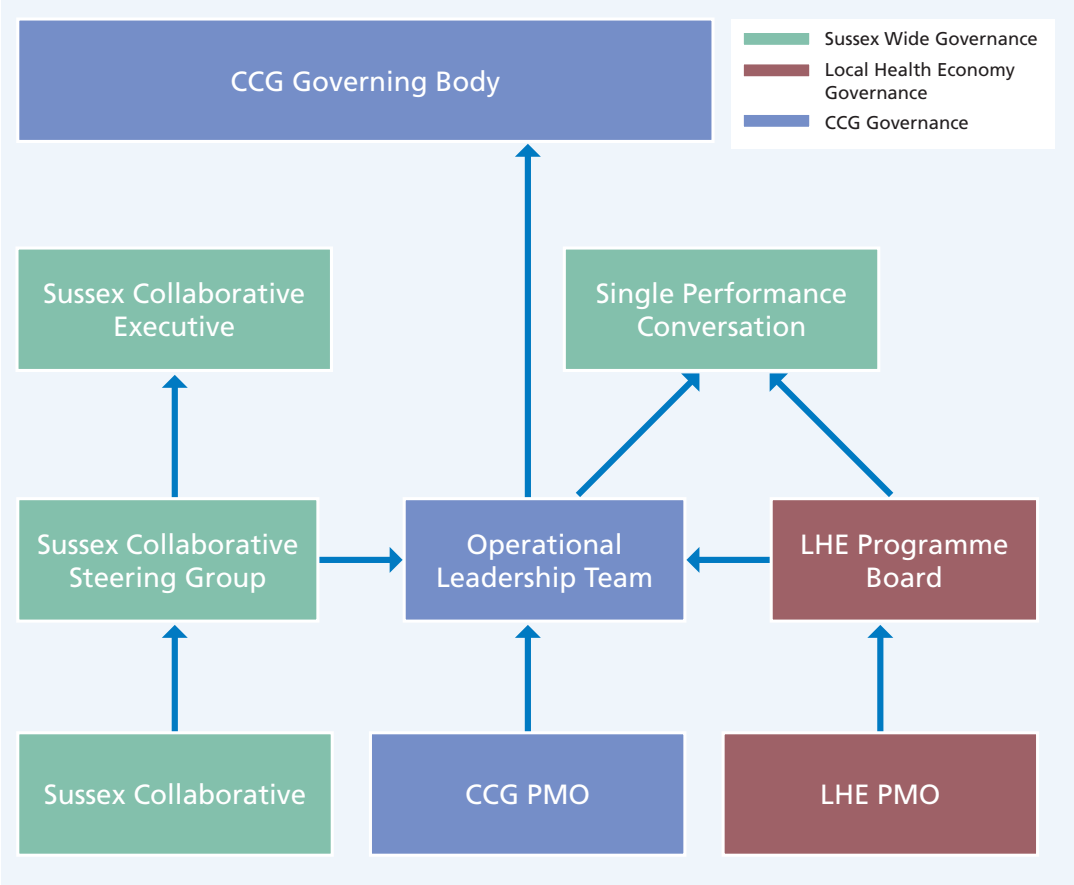
Effective change depends on engagement and support from many different people and organisations including local communities, patients and patient groups, and other stakeholders.

Brighton and Hove patients, carers and residents and will increasingly be involved in shaping the future of local health services through patient participation groups feeding directly into CCG Local Member Groups, a presence on the CCG Board and various other forms of engagement[26].

4.4 Measuring success - governance and performance management

The CCG takes a robust, proactive approach to measuring and monitoring QIPP and the associated outcome, using programme management to monitor and oversee CCG, health economy and Sussex-wide delivery. Figure 13 (below) sets out overarching governance arrangements for performance and delivery:

Figure 13 – Monitoring Delivery of QIPP



[25] The NHS as a Driver for Growth: A Report by the Prime Minister's Council for Science and Technology, September 2011

[26] Engagement for Commissioning Success;Smart Guides to Engagement, Dr Andrew Craig

CCG project management office

Our Project Management Office (PMO) is the mechanism through which the CCG monitors and seeks assurance of progress and attainment against the programmes in the annual operating plan. Its four main duties are to:

- Ensure that each project has a robust set of supporting documents and measures and is mapped to the national outcomes framework;
- Ensure that project documentation is regularly updated;
- Provide robust performance management and escalate issues where necessary; and
- Provide support to commissioners and project managers.

The office provides a summary and escalation report to the operational leadership team which is a sub-committee of the CCG Board.

Local health economy project management office

The local health economy, including BSUH and local CCGs, jointly commission a Project Management Office to support the delivery of the urgent care QIPP. The office:

- Provides strategic leadership and coordinates the delivery of the urgent care programme across the local health economy
- Provides robust governance including reporting and accountability to the Programme Board and Sussex PMO
- Ensures a high quality, consistent approach to project management, planning, reporting and risk management for all key work streams
- Monitors the delivery of key milestones, financial and activity targets, and associated reductions in capacity and infrastructure
- Manages the release of stranded costs in accordance with processes defined by the Directors of Finance
- Establish an informatics hub to inform decision making and measure the effectiveness of programme delivery
- Includes an operational lead function to ensure that system pressures are effectively managed and do not detract from delivery of the programme
- Manages communications and relationships between key stakeholders to ensure local health community commitment to the plans and targets

The CCG PMO provides a summary and escalation report to the Operational Leadership Team, and the health economy PMO can recommend wider escalation if necessary.

4.5 Informatics

We will refresh our local informatics strategy in 2013-2014 and contribute to the refresh of the Sussex-wide strategy. The refresh will take account of the objectives in this strategic commissioning plan and the commissioning intentions in the annual operating plan.

The informatics strategy has four key elements with corresponding work plans:

- Information about me and my care - giving patients information to become proactive partners in care (i.e. patient online access / personal health records)
- Connected information for integrated care - recording and sharing information about health/care across care settings to support integrated care pathways
- Better access to better information - to support decision-making, signpost people to the most appropriate services, and provide more accessible management information
- A quality-driven information system - having the solutions, standards, governance and culture in place to deliver the three initiatives described above.

We have strengthened our in-house informatics service and bought additional support from the Commissioning Support Unit in order to deliver the ambitious informatics plan required by the changes described in our SCP. We have also strengthened internal governance arrangements for informatics, including a member of the Governing Body with lead responsibility for informatics.

5 Conclusion

Our CCG Strategic Commissioning Plan for 2012-2017 demonstrates the dedication, and outlines the drivers and mechanisms, through which the CCG and its partners will ensure collaboratively planned, seamlessly delivered, ever improving, carefully monitored and continually assured healthcare services that meet the needs and priorities of local people.

Our commissioning will continue to be based on local population needs and priorities as identified through the Joint Strategic Needs Assessment, aligned to the local Health and Well Being Strategy. It will also be shaped through the engagement of our member clinicians, patients, public and other stakeholders.

The period covered by this plan will see a further shift from delivering healthcare in hospital to providing it through community and primary care. The CCG will invest significantly in developing these new care models and pathways, and in improving integration across services and sectors to improve quality of care, patient experience and outcomes.

The national and local NHS environment will continue to change, but we are confident that we are well placed to manage that change, meet the challenges it will bring, and successfully deliver better health and health care for the people of Brighton and Hove.

6 Glossary

AEC	Ambulatory Emergency Care
AOP	Annual Operating Plan
AQP	Any Qualified Provider
ASC	Autistic Spectrum Condition
BICS	Brighton and Hove Integrated Care Service
BSUH	Brighton and Sussex University Hospital Trust
CAMHS	Children and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CPL	Clinical Programme Lead
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRRS	Community Rapid Response Service
CSG	Clinical Strategy Group
CSU	Commissioning Support Unit
CVS	Community Volunteer Sector (?)
DES	Direct Enhanced Service
DNA	Did Not Attend
DOS	Directory of Services
GP	General Practitioner
HCAI	Health Care Acquired Infection
HOS-AR	Home Oxygen Service – Assessment and Review
IAPT	Improved Access to Psychological Therapies
ICC	Infection Control Champion
ICS	Integrated Care Service
IOG	Improving Outcomes Guidance
IPA	Inter Practice Agreement
IV	Intravenous
JHWB	Joint Health and Wellbeing Board
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LAC	Looked After Children
LES	Local Enhanced Service
LMG	Local Member Group
LOS	Length of stay
LTC	Long Term Conditions
MDT	Multi-disciplinary Team
MSK	Musculoskeletal
NAEDI	National Awareness and Early Diagnosis Initiative
NHS CB AT	NHS Commissioning Board Area Team
NHS NCB	NHS National Commissioning Board
NICE	National Institute for Health and Clinical Excellence

NOP	National Operating Plan
NRAG	National Radiotherapy Advisory Group
OOH	Out of Hours
PBR	Payment by Results
PCCL	Practice Clinical Commissioning Lead
PCT	Primary Care Trust
PH	Public Health
PPG	Patient Participation Group
PRH	Princess Royal Hospital
PROMS	Patient recorded outcome measures
PSED	Public Sector Equality Duty
QAC	Quality Assurance Committee
QIPP	Quality, Innovation, Productivity and Prevention
ONS	Office of National Statistics
QOF	Quality Outcome Framework
RACOP	Rapid Access Assessment Clinic for Older People
RACH	Royal Alexandra Children's Hospital
RAG	Red Amber Green (rating)
RCA	Root Cause Analysis
RSCH	Royal Sussex County Hospital
RTT	Referral to Treatment Time
SCT	Sussex Community Trust
SCP	Strategic Commissioning Plan
SECAMB	South East Coast Ambulance
SHA	Strategic Health Authority
SIRI	Serious Incident Requiring Investigation
SPFT	Sussex Partnership Foundation Trust
TIA	Transient ischemic attack

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