Operational Plan 2019/20 Introduction

• The NHS Long Term Plan set out the vision for health services over the next 10 years.
• Basildon and Brentwood CCG Operational Plan for 2019/20 outlines the transformation journey that it will undergo over the next two years and some of the key milestones along the way.
• The Plan sets out the priorities for the forthcoming year and outlines the outcomes it expects to deliver in line with the NHS Operating Planning & Contracting Guidance for 2019/20.
• The CCG is an active member of the Mid and South Essex STP and it recognises the partnership working required with other commissioners, providers, local government and our local communities to deliver the ambitions of this plan and that of the NHS Long Term Plan.
• A separate more detailed planning submission was made to NHS England covering activity, finance capacity and constitutional target delivery.
Basildon and Brentwood CCG Overview

Population of Basildon and Brentwood: 279,000

Where we plan to spend our money:
- 59% Acute
- 10% Primary Care
- 10% Community
- 10% Mental Health
- 4% CHC
- 4% Other

GP appointments last year: 1.25 million
GP practices: 35

A&E attendances for last year: 97,700
Outpatient attendances: 60,000

Community service contacts: 31,000

Budget 19/20:
- £376m
- Required £3.8m surplus towards repaying historic debt

Primary Care Networks: 6 proposed

Mental health contacts: 60,000

Our partners:
Basildon and Thurrock University Hospitals NHS Trust
North East London NHS Foundation Trust
Essex Partnership University NHS Foundation Trust
Essex County Council
Basildon Council
Brentwood Council

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Basildon and Thurrock University Hospitals NHS Trust
North East London NHS Foundation Trust
Essex Partnership University NHS Foundation Trust
Essex County Council
Basildon Council
Brentwood Council
We will work with partners and the local population to ensure a sustainable health and care system to improve health and wellbeing.

Objectives
We will:
• Work in partnership with our communities to enable people to live full, active, and independent lives, promoting self-care and building resilience
• Lead and enable our partners to deliver safe, high quality, equitable care with less variation
• Give clear and consistent messages on the availability of health services and fund the things we know will work and reduce waste
• Be an organisation of clinical and managerial leaders who have the necessary skills, capacity and capability to lead positive change for the communities we serve.

Transformation Programme
• Primary Care development: change how care is delivered by moving towards GP led services supported by a wider range of roles, delivered at scale through Primary Care Networks
• Partnership working: move towards an Integrated Care System (ICS) that improves the health and well being of our local population
• Service delivery: transform out of hospital care and align services where possible around Primary Care Networks. Reconfigure acute hospital services to create larger specialist teams (STP led)

Cross Cutting Programme
• Urgent & Emergency Care Ensure patients receive the right care in the right place
• Mental Health Improve access to services and crisis response services
• Children & Young People Establish system wide plan
• Maternity Improve safety, choice and personalisation
• Transforming Care Improve services and support for people with learning disabilities
• Continuing Healthcare & PHBs Adoption of best practice including Personal Health Budgets
• Medicines Management Ensure optimal prescribing
• Cancer and Elective Care Improve access and patient pathways (STP led)

Enablers
• Organisational form & governance: adapts to the changing commissioning and ICS landscape whilst supporting CCG staff through the change
• Workforce: create a modern health workforce that attracts and retains staff
• Infrastructure: provision of digital solutions, IT, data analytics and Estates that supports new models of care within available resources

Outcomes
• Finance
  - Move towards financial balance
  - Achieve QIPP savings
  - Support overall system sustainability
  - Effective use of investment
  - Deliver Mental Health Investment Standard
• Quality
  - Better experience of care
  - Improved access
  - Better Health outcomes for people with long term conditions, cancer and mental health issues
  - Sustainable workforce
• Performance
  - Achieve constitutional standards
  - Deliver NHSE Targets on Mental Health, Primary Care and LD
  - Reduction in activity growth in acute sector

Our values
B Be Honest
B Be Accountable
C Clinically Led
C Compassionate and Respectful
G Growing Together
Basildon and Brentwood CCG Transformation Journey towards our vision – April 2019 to March 2021

Service Delivery

April – Sept 2019
- Clearly defined community, mental health and social care offer to aligned teams
- Agree local approach to health information portals
- Agree initial outcome measures
- Roll out signposting model (6 pathways)
- Align terms of reference across the STP
- Patient engagement

Oct 2019 – March 2020
- Rapid community response
- Review Dementia pathway & service model
- Define approach to working with voluntary sector
- PCN Clinical Director Group formed
- Implement new roles in primary care (19/20)
- Implement new roles in primary care (20/21)
- Five CCGs working collaboratively
- Develop new organisational structure with workforce

April 2020 – March 2021
- Acute reconfiguration commenced
- Implement ICS
- On line consultation software roll out
- Share care record implemented
- Identify new system workforce requirement
- Prepare for change training for CCG staff
- STP wide workforce planning (e.g. availability of specific professions)
- Identify skills development opportunities for staff

Partnership Working

- Reset the Strategic Oversight Group (change terms of reference and membership)
- Align terms of reference across the STP
- Strengthen partnership working across health and social care
- PCN Clinical Director Group formed
- Implement recommendations from ECC Intermediate Care Partnership review
- Implement new roles in primary care (20/21)

Primary Care Development

- Appointment of PCN Clinical Directors
- Prioritise non-recurrent 19/20 Primary Care investment
- Implement pump priming schemes that will support PCN delivery 20/21
- Establish PCN Management structure
- Implement new ways of working to ensure compliance with national PCN specifications
- Five CCGs working collaboratively
- Develop new organisational structure with workforce

- Governance and funding distribution agreed
- Completion of extended access for whole pop.
- Clarify support role of CCGs
- Develop a business case relating to delegated primary care commissioning
- Vote on decision to take delegated responsibility to commission primary care
- Five CCGs working independently
- Five CCGs working collaboratively
- Develop a business case relating to delegated primary care commissioning
- Share care record implemented

- Registration of PCNs
- Confirm PCN footprint
- Confirm role of ‘Place’ based commissioning and BBCCG role
- Define approach to working with voluntary sector
- Implement new roles in primary care (20/21)
- PCN Clinical Director Group formed
- On line consultation software roll out
- PCN dashboard released

Organisational form and Governance

- Key
  - STP level
  - Five CCG level
  - B&B level
  - PCN level

Infrastructure

- Acute reconfiguration commenced
- Implement ICS
- On line consultation software roll out
- Share care record implemented
- Identify new system workforce requirement
- Prepare for change training for CCG staff
- STP wide workforce planning (e.g. availability of specific professions)
- Identify skills development opportunities for staff

Workforce

- PCN Clinical Director Group formed
- Single management team for five CCGs
- PCN dashboard released
- Identifying new system workforce requirements
- On line consultation software roll out
- Share care record implemented
- Identify new system workforce requirements
- Prepare for change training for CCG staff
- STP wide workforce planning (e.g. availability of specific professions)
- Identify skills development opportunities for staff
Basildon and Brentwood CCG Operational Plan 2019-20 has been structured using a standard layout for each transformation, cross cutting and enabler work programme areas.

**Programme: Primary Care Development**

- **Objective**: Implementation of the Primary Care Strategy that moves towards care being delivered by GP supported by wider range of roles and at scale through the newly formed Primary Care Networks.

**Key milestones**

1. Finalise and approve Network DES requirements and Q1 PCN Clinical Directors appointed July 2019
2. Data sharing framework for all Practice end of Q1
3. Completion of workforce baseline PCNs to develop workforce plans for Clinical Pharmacists and Social prescribers
4. Review of extended access appointment utilisation with plans to increase
5. PCNs to deliver requirements of Extended Hours by end Q1
6. PCNs to develop plans for 20/21 workforce expansion
7. PCNs to determine model for access for 2020/21

**Measurable Outcomes**

- PCNs in place that cover all population by June 2019, Network Agreements in place for all PCNs
- Risk stratification tool implemented by PCNs
- Expanded workforce in place by end of 2019/2020
- Extended hours access available to all population from July 2019

**Governance oversight**

- Exec Lead: William Guy
- Clinical Lead: Dr Boye Tayo
- Primary Care Transformation Board (PCTB)

**Benefits**

- Establishment of sustainable model of delivery for primary care
- Expanding Primary Care workforce to release GP time and offer longer consultations to patients

**Risks & Dependencies**

- Link to reduction in CCG running costs of 20% including impact on AGEM contract (B2 services)
- Risk of recruitment to expanded roles

**Key deliverables based on national requirements and local priorities**

- Current assessment as at 1 April 2019
- Delivery yet to commence/behind schedule
- Further progress required
- Requirement met

**Assessment of likely 19/20 delivery**

- Risk to delivery of requirements not yet mitigated
- Risk to delivery that will need to be mitigated/delivery over more than one year
- Confident that outcome will be delivered

**Dependencies with other work programmes**
**Objective:** Implementation of the Primary Care Strategy that moves towards care being delivered by GP led services supported by a wider range of roles and at scale through the newly formed Primary Care Networks.

**Programme: Primary Care Development**

- **Formation of the Primary Care Networks (PCNs)**
  - Finalise and approve Network DES requirements end Q1
  - PCN Clinical Directors appointed July 2019
  - CCG to issue support offer to PCNs
  - Establish PCN Management & Governance Structure
  - Prioritise non-recurrent 19/20 Primary care Investment by Q2
  - Implement pump priming schemes
  - Prepare for 20/21 changes to the Network Contract
  - PCNs in place that cover all population by June 2019.
  - Network Agreements in place for all PCNs

- **PCNs will be supported by appropriate data and analytics**
  - Data sharing agreements in place for all Practices by end of Q1
  - Engage with Clinical Directors to understand data requirements for PCNs
  - Deliver on initial PCN data requirements
  - Roll out AGEM risk stratification tool to PCNs
  - Work with AGEM to deliver national Network Dashboard from April 2020
  - Risk stratification tool implemented by PCNs

- **Expansion of the Primary Care workforce**
  - Completion of workforce baseline
  - PCNs to develop workforce plans for Clinical Pharmacists and Social prescribers
  - Review transfer arrangements for Clinical Pharmacists and Medicines Optimisation in Care Homes Scheme by end Q2
  - Recruitment to additional roles
  - PCNs to share impact analysis through Clinical Directors Group
  - Recruitment to additional roles
  - PCNs to develop plans for 20/21 workforce expansion
  - Expanded workforce in place by end of 2019/2020

- **Deliver extended hours and extend access services**
  - PCNs to deliver requirements of Extended Hours by end Q1
  - Review of extended access appointment utilisation with plans to increase
  - PCNs to determine model for access for 2020/21
  - Extended hours access available to all population from July 2019
  - Extended Access Appointment Utilisation >75%

**Benefits**
- Establishment of sustainable model of delivery for primary care
- Expanding Primary Care workforce to release GP time and offer longer consultations to patients

**Risks & Dependencies**
- Link to reduction in CCG running costs of 20% including impact on AGEM contract (BI services)
- Risk of recruitment to expanded roles

**Governance**
- Exec Lead: William Guy
- Clinical Lead: Dr Boye Tayo
- Primary Care Transformation Board
- CEG & F&P
Objective: Transition towards an Integrated Care System (ICS) that improves the health and wellbeing of our local population.

- Move towards ‘Place’ based planning and delivery
  - Reset the Strategic Oversight Group (overseeing aligned teams) to Partnership and Integration Group
  - Align terms of reference of ‘Place’ based groups across STP
  - Agree initial outcome measures
  - Partnership and Integration Group to provide strategic direction on implementation of LTP
  - Out of Hospital requirements
- Develop plan for moving towards an ICS in 2020/21

- Contribute to STP 5 year strategic plan
  - Incorporate the challenges posed in the Health and Wellbeing strategy e.g. prevention, isolation and self care
  - Engage with STP Board and STP Chairs group on development of the strategy
  - Engage with local communities on the plan including voluntary sector PCNs to have an active voice in plan’s development
- Develop implementation plan for 2020/21

- Support Health prevention by improving diet and increasing physical activity
  - Implementation of Connexus Signposting system across Practices by end Q2 and systems established to review uptake
  - Ongoing promotion of Diabetes Structured Education Programme
  - Engage with Basildon Council on Sports England LDP initiative
  - Expand pilot of clinical pharmacists undertaking clinical medicines review for Diabetes patients
- Increase pathway access via signposting model

- Strengthen partnership working across health and social care
  - Agree BCF priorities for 19/20
  - Strengthen relationships with ECC and review joint projects
  - Implement BCF plan and improve reporting on BCF spending
  - Contribute to the ECC Intermediate Care Partnership review and way forward
  - Future commissioning arrangements and decisions undertaken jointly
- Implement 19/20 BCF priorities

Benefits:
- Clear shared vision across partners of the path towards ICS
- Defined plan that outlines how the benefits from the NHS long term plan will be delivered

Risks & Dependencies:
- Link to reconfiguration of CCGs
- Link to Living Well Essex Strategy & focus on Place
- Risk of clarity of governance arrangements
Programme: Service Delivery

**Objective:** Transform out of hospital care and align services where possible around Primary Care Networks

### Teams aligned around PCNs
- Clearly defined community, mental health and social care offer to aligned teams
- Greater co-location of link workers
- Increase use of care navigation
- Review and implement ‘My plan’
- Aligned teams undertake a proactive response to high risk patients
- Services integrated and aligned around PCNs

**Benefits**
- Integrated personalised care that enables patients to be cared and supported out of hospital
- Reduction in admissions to hospital
- Reduction in GP referrals

**Risks & Dependencies**
- Link to Cross cutting work programmes particularly Urgent & Emergency Care
- Living Well Essex Strategy
- Cultural change required from providers

### Implementation of Right Care projects
- Support Cardiovascular Disease (STP Priority) by targeting diagnosed AF patients not Anti-coagulated
- Embed shared care for DMARDs
- Co-ordinate MSK review across STP
- Engage with STP led projects on Respiratory, Diabetes and High Intensity users
- Develop implementation plan for 2020/21

**Benefits**
- Increase number of patients under shared care
- Reduce Number of AF patients that are not anticoagulated or exception reported

**Risks & Dependencies**
- Link to Cross cutting work programmes particularly Urgent & Emergency Care
- Living Well Essex Strategy
- Cultural change required from providers

### Engage with STP system transformation schemes and review of pathways
- Promote use of e-RS and uptake of Advice & Guidance by Primary Care
- Work with BTUH to roll out Advice & Guidance to remaining specialties
- Contribute to Outpatient transformation plan to reduce face to face hospital appointments and move to an out of hospital setting
- Support actions to reduce spend on high cost drugs and implement use of Avastin
- Board to support national recommendations on Evidence based Interventions

**Benefits**
- Deliver cost savings of £450k
- Reduce GP referrals against 19/20 planned level

**Risks & Dependencies**
- Link to Cross cutting work programmes particularly Urgent & Emergency Care
- Living Well Essex Strategy
- Cultural change required from providers

### Develop models for outpatient delivery within the PCN/Place
- Early work with the MSB Group to agree principles for shift of care
- Develop model for community geriatric care

**Benefits**
- Implement new ways of working to support a reduction in acute activity growth

**Risks & Dependencies**
- Link to Cross cutting work programmes particularly Urgent & Emergency Care
- Living Well Essex Strategy
- Cultural change required from providers

**Governance**
- **Exec Lead:** William Guy
- **Clinical Lead:** Various
- **Partnership & Integration Group CEG**
**Programme: Urgent and Emergency Care**

**Objective:** To deliver alternatives to A&E, avoid admissions and improve flow and effective discharge.

<table>
<thead>
<tr>
<th>Task</th>
<th>Actions</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reduce A&amp;E by default on the Directory of Services</strong></td>
<td>Review current A&amp;E dispositions from 111</td>
<td>A&amp;E default selections on the DoS is less than 1% by March 2020</td>
</tr>
<tr>
<td><strong>Redesign urgent care services outside of A&amp;E</strong></td>
<td>Review existing Orsett MIU against national UTC requirements, Review current A&amp;E flows in Q1</td>
<td>UTC designated by Dec 19 or exception agreed based on development of new front door model</td>
</tr>
<tr>
<td><strong>Implement an integrated approach to crisis management in a non acute setting</strong></td>
<td>Review current pathway and provision against ‘strawman’ and agree required changes by end of Q2, Implement the required pathway changes in Q2</td>
<td>Reduce the demand on A&amp;E to commissioned growth rate of 3.8%</td>
</tr>
<tr>
<td><strong>Implementation of High Intensity User (Frequent flyer) initiative</strong></td>
<td>Agree process for sharing data with PCNs, trigger points &amp; process by end Q1</td>
<td>Implementation of High Intensity initiative that meets requirements of NHSE</td>
</tr>
<tr>
<td><strong>Develop an effective winter 2019/20 plan</strong></td>
<td>Undertake review of 2018/19 winter and identify issues for resolution by end Q1</td>
<td>Mobilise Winter plan</td>
</tr>
</tbody>
</table>

**Benefits**
- Reduce ambulance conveyance to ED
- Effective management of A&E demand in non acute setting
- Reduction in delayed discharges

**Risks & Dependencies**
- Links to Mental Health 24/7 community crisis service implementation and ECC intermediate Care Review

**Exec Lead:** William Guy  
**Clinical Lead:** Dr Nimit Dabas

**A&E Delivery Board**  
CEG & F&P
**Programme: Mental Health**

**Objective:** To deliver the objectives of the Mental Health Strategy to rebalance the system in favour of prevention, early intervention and resilience and recovery.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Requirement met. 19/20 Plan and budgets meet investment standard.</th>
<th>Growth in Mental Health spend of 6.5% on 2018/19 Outturn by end of 2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>All CCGs must meet the Mental Health Investment Standard</td>
<td>Mobilisation of new IAPT service</td>
<td>Access at min. 4.75% of local prevalence and 5.5% by Q4, recovery &gt;50%, 75% treated within 6 weeks and 95% within 18 weeks</td>
</tr>
<tr>
<td>Deliver IAPT standards for improved access, recovery and waiting times</td>
<td>Recovery of waiting list &amp; backlog clearance completed by end of Q2</td>
<td>Develop plans and improve access to IAPT for people with SMI</td>
</tr>
<tr>
<td>Expand IAPT workforce and co-location of therapists in primary care</td>
<td>Integration of IAPT with Long Term condition pathways</td>
<td>IAPT staff co-located with aligned teams</td>
</tr>
<tr>
<td>Improve dementia diagnosis rate and post-diagnosis pathway</td>
<td>Develop plans and improve access to IAPT for people with SMI</td>
<td>Additional 5 new trainee PWPs by Q4 2019/20 and 13 WTE staff co-located in primary care</td>
</tr>
<tr>
<td>People with Serious Mental Illness receive a full annual physical health check</td>
<td>Map existing Dementia pathways Review scope and effectiveness of Memory Assessment Clinic</td>
<td>Recover performance to 66.7% by June 2019</td>
</tr>
<tr>
<td></td>
<td>Review future service model and begin implementing changes</td>
<td>Commissioning intentions for 2020/21 confirmed</td>
</tr>
<tr>
<td></td>
<td>Neighbourhood supported delivery or alternative model at scale service commences in Q3</td>
<td>All people with SMI offered health checks by end of Q4</td>
</tr>
<tr>
<td></td>
<td>Approve incentive scheme Neighbourhood trajectories agreed</td>
<td>60% of people with SMI receive a physical health check by end of Q4</td>
</tr>
<tr>
<td></td>
<td>33% of health checks undertaken by Q2</td>
<td></td>
</tr>
</tbody>
</table>
**Objective:** To deliver the objectives of the Mental Health Strategy to rebalance the system in favour of prevention, early intervention and resilience and recovery.

- **Contribute to the multi-agency Suicide prevention plan:** Sign off suicide prevention plan at Mental Health Partnership Board by Q2
- **Commissioning of the Community Crisis and Home Treatment Service:** Approval of Business case in Q1
- **Deliver NICE concordance commitment for Early Intervention in Psychosis:** Funding agreed for recruitment of Psychologists to deliver Cognitive Behaviour element

**Governance**
- **Exec Lead:** William Guy
- **Clinical Lead:** Dr Ken Wrixon
- **Mental Health Transformation Board CEG & F&P**

**Benefits**
- Improve access to services for people with mental health
- Integration of mental health services with physical health services to support parity of esteem
- Reduction in hospital based attendances & admissions
- Reduction in premature mortality

**Risks & Dependencies**
- Workforce expansion and ability to recruit at a time where all systems looking to attract to new posts
- Links to STP wide Mental Health programme and Living Well Essex Strategy
Programme: Children & Young People (CCG leading on behalf of 5 CCGs)

**Objective:** To deliver a comprehensive plan for CYP services that includes the commitments set out in the Open Up Reach Out strategy & Essex Children and Young People’s Strategic Plan

### Increase access to CYP Emotional Wellbeing & Mental Health services
- Backlog clearance undertaken in Q1
- Commissioning footprint agreed for EWMHS
- Service specification and proposed approach agreed for award of contract for 2020/21 onwards
- Engagement and assurance from CYP VSO’s for data flow via MHSDS to capture access by end Q2
- At least 34% of CYP with Mental Health condition receive treatment in 2019/20

### Improving access and waiting times for CYP with an eating disorder
- NELFT recruitment to additional posts
- Continued review of performance with exception reporting for any breaches
- 87.5% of routine referrals are seen within 4 weeks and 1 week for urgent referrals in Q4 2019/20

### Improve services for CYP with End of Life/Life-Limiting Conditions
- Identification of the variations for provisions across Essex for CYP with palliative care
- Review of EPIC, a children’s respite service, to understand capacity in the system
- Draft Essex wide programme from feedback from data analysis of waiting lists and family questionnaire
- Implementation of a Pan-Essex palliative care model by close Q4 for 20/21
- Ensure continuity across Essex for families with children with End of Life and Life Limiting Conditions

### Improve outcomes for CYP with neuro-developmental disorders
- Agree vision and service mapping by end Q1
- Design draft service model and identify governance routes by end of Q2
- Establishment of working groups on specific clinical and commissioning aspects of the pathway
- Work towards an agreed pathway by end Q4 to aid implementation of pilot in 20/21
- Establish model and pathways for CYP with neuro development disorders

### Improve response for those CYP that are in Mental Health crisis
- Re-modelling of current crisis service provision agreed with NELFT end of Q1
- Pilot the new (crisis) Enhance Community Response from Q2
- Roll out of pilot crisis model across Essex by End Q3
- Review impact of Enhanced Community response & refine model
- Improved access for CYP in Mental Health crisis

### Governance
- **Exec Lead:** Lisa Allen
- **Clinical Lead:** Dr Sooraj Natarajan
- Paediatric CEG
- CEG & F&P

### Benefits
- Improve access to CYP Mental Health services
- Reduction in A&E attendances and admission
- Promote and support emotional wellbeing and health

### Risks & Dependencies
- Identified capacity to support workstream
- Commissioning and procurement decision across Southend, Essex & Thurrock
Objective: To deliver a comprehensive plan for CYP services that includes the commitments set out in the Open Up Reach Out strategy & Essex Children and Young People’s Strategic Plan

Reducing demand for urgent care services

- Identify variation in clinical practice across the health and care system
- Agree work streams, priorities and outcome measures
- Engage with stakeholders and involve patients in the development of services

Improving support and services for children and young people with SEND

- Completion of a joint health/education/social care whole school audit by end Q1
- STP wide mapping exercise to understand demand and capacity of current local offer
- Development of joint commissioning framework and vision across STP
- Establishment of an accurate and needs led local offer, co-produced services and joint commissioning.

Benefits
- Improve access to CYP Mental Health services
- Reduction in A&E attendances and admission
- Promote and support emotional wellbeing and health

Risks & Dependencies
- Identified capacity to support workstream
- Commissioning and procurement decision across Southend, Essex & Thurrock

Governance

- Exec Lead: Lisa Allen
- Clinical Lead: Dr Sooraj Natarajan
- Paediatric CEG
- CEG & F&P
Objective: Implementation of STP Local Maternity Services Plan to improve choice and safety of maternity care

Benefits:
- Reduce infant mortality and maternal deaths
- Improve choice and personalisation of maternity services

Risks & Dependencies:
- Workforce recruitment & retention
- Standardisation across all 3 hospital sites
- Links to Mental Health Perinatal pathway development

Governance:
Establish Maternity safety sub-group to review incidents and implement actions by Q2

Programme: Maternity (CCG leading on behalf of 5 CCGs)

- Increase continuity of carer in pregnancy, birth and postnatally
  - Evaluation of midwifery models piloted on continuity of carer.
  - Establish model for targeted continuity of carer model for most vulnerable mothers. Plan(s) for CoC pilots in place which factors in both workforce and financial implications
  - 35% of women are booked on to a continuity of carer pathway by March 2020

- Reduce stillbirths, neonatal deaths, maternal deaths & brain injuries
  - Increase the use of Magnesium Sulphate to prevent neurological damage
  - Establish Maternity safety sub-group to review incidents and implement actions by Q2
  - Implementation of the Savings Babies Lives Care Bundle by Q3
  - Reduce neonatal mortality and still births

- Deliver improvements in choice and personalisation
  - Implement standardised pathways so more women can have choice of midwife and place of birth in Q1
  - Embed personalised care plan to cover 50% of women by end of Q2
  - Continuity of Carer pilots evaluation by end Q3
  - Implementation of choice of offer made prior to initial contact with midwife Q4
  - 80% of women offered a choice for birth
  - 95% have a personalised care plan by end of Q4

Exec & Clinical Lead: Teresa Kearney
Mid & South Essex LMS Board
CEG & PSQ
### Objective: Transforming care for people with learning disabilities and/or Autism to reduce health inequalities

<table>
<thead>
<tr>
<th>People with Learning Disabilities receive a full annual physical health check</th>
<th>Neighbourhood trajectories agreed Support provided by LD Facilitators to individuals to attend</th>
<th>42% of health checks undertaken by Q2</th>
<th>Neighbourhood supported delivery or alternative model at scale service commences in Q3</th>
<th>All people with LD offered health checks by end of Q4</th>
<th>924 people with LD delivered a physical health check by end of Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working with partners to implement the ‘Place Plan’</td>
<td>Review of resource allocation and sign off of Plan to deliver improved outcomes by Q1</td>
<td>Each Neighbourhood has named Strategic Health Facilitation link person</td>
<td>Training &amp; support provided to primary care Named link person established as part of aligned team</td>
<td>Redistribution of support resource from Q4 resulting in additional 1.5 WTE</td>
<td></td>
</tr>
<tr>
<td>People with LD and/or Autism are on correct psychotropic medication (STOMP &amp; STAMP)</td>
<td>Multi-agency pathway agreed and implemented by Q2</td>
<td>Identified cohort of Clayhill and West Basildon reviewed and strategies put in place to support needs by end of Q3</td>
<td>Implementation of identified care plans from Q3 onwards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure Learning from Deaths report (LeDeR) undertaken &amp; themes actioned</td>
<td>Trajectory agreed for undertaking the backlog of reviews</td>
<td>Quarterly report received regarding progress of reviews Analysis undertaken on key themes</td>
<td>Actions identified and implement that deliver improvements in care</td>
<td>Agree and implement plan to address backlog of reviews</td>
<td></td>
</tr>
<tr>
<td>Avoid unnecessary hospital admissions</td>
<td>Clear pathways in place particularly for Frailty, Dementia, Epilepsy and for End of Life by end of Q2</td>
<td>Strategic Health Facilitators provide support and training to providers in Q3 SEND needs of young people identified along with access to appropriate care</td>
<td>Review of alternative community intervention and support solutions</td>
<td>Pathway effectiveness reviewed in Q4</td>
<td></td>
</tr>
</tbody>
</table>

#### Benefits
- Reduce health inequalities
- Improve access to services for people with LD
- People with LD can live in an environment that is not overly restrictive

#### Risks & Dependencies
- Realignment of Strategic Health Facilitation resources
- Funding to clear backlog of LeDeR reviews

**Governance**

**Exec Lead:** Teresa Kearney  
**Clinical Lead:** Dr Ken Wrixon

**Transforming Care Board**  
CEG & PSQ

**Programme:** Transforming Care (LD)
## Programme: Continuing Health Care & PHBs

### Objective: Adoption of best practice including Personal Health Budgets

<table>
<thead>
<tr>
<th>Objective</th>
<th>Action Plan</th>
<th>Benefits</th>
<th>Risks &amp; Dependencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption of best practice and utilisation of national tools to support QIPP delivery</td>
<td>Review and implement CHC Opportunity mode and compliance with CHC framework</td>
<td>Continued review of high cost packages</td>
<td>Implementation identified improvements to support delivery</td>
</tr>
<tr>
<td>Ensure less than 15% of all full assessments for CHC funding take place in hospital</td>
<td>Continue with active monitoring</td>
<td>Review effectiveness of Discharge to Assess model and End of Life pathway</td>
<td>Implement changes to improve DTA model and EoL pathway</td>
</tr>
<tr>
<td>All new CHC home-based packages offered as Personal Health budgets as default</td>
<td>Implement process to enable Home-based package to be offered as PHBs as default from Q1</td>
<td>Monitor uptake of CHC PHBs and understand reasons if uptake is low</td>
<td>Implement changes to processes to improve uptake of PHBs</td>
</tr>
<tr>
<td>Development of a sustainable social care market</td>
<td>Implement Care Home tracker by Q2 Roll out IRN Framework from Q2</td>
<td>Support ECC with the implementation of the Care Market Strategy 2017-21</td>
<td>Confirm BCF requirements to support social care market</td>
</tr>
<tr>
<td>Increase personalised care by providing Personal Health Budgets</td>
<td>Review local offer for PHBs (CHC, Learning Disabilities, Mental Health, SEND, Wheelchairs and Equipment)</td>
<td>Roll out PHBs to wheelchair services in Q1 Promote greater uptake of local offer</td>
<td>Develop CCG strategy for personalisation of care</td>
</tr>
</tbody>
</table>

### Exec & Clinical Lead: Teresa Kearney

CEG & PSQ

### Benefits

- Timely and appropriate assessment of peoples continuing healthcare needs
- People given more choice and control of health care they receive

### Risks & Dependencies

- Small number of high cost packages can impact on spend
- Sustainability of Care Home market
## Programme: Medicines Management

**Objective:** Ensure optimal medicines prescribing to improve outcomes, reduce wastage and improve medicines safety

<table>
<thead>
<tr>
<th>Establish an effective antimicrobial stewardship programme</th>
<th>Approval of the Medicines management Antibiotic Prescribing Strategy by end of Q1 Promote early identification of Sepsis</th>
<th>Identified Meds. Management strategic lead to provide support to practices. East Basildon initial priority</th>
<th>Monthly monitoring to commence with reports to PCNs. Encourage Practice audits and peer support and learning</th>
<th>Engagement with msb group microbiologists and support development of STP plan</th>
<th>Move to East region average for prescribed antibiotic items per STAR-PU Improvement in IAF indicators on Antimicrobial resistance out of LQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce spend on medicines that have limited clinical value or are available over the counter</td>
<td>Continued focus on over the counter medicines for dry eye, vitamins and minor pain control</td>
<td>Reduce use of Liothyronine including secondary care initiation</td>
<td>Focus with primary care on prescribing of Trimipramine, Fentanyl IR and Tadalafil.</td>
<td>Reduce prescribing of low clinical value drugs to deliver cost savings of £300k</td>
<td></td>
</tr>
<tr>
<td>Ensure cost effective prescribing</td>
<td>Continued focus on use of scriptswitch and support practices uptake</td>
<td>Maximise rebates</td>
<td>Implement of prescribing incentive scheme with quarterly monitoring to practices</td>
<td>Deliver cost effective prescribing and deliver QIPP of £1.7m</td>
<td></td>
</tr>
<tr>
<td>Optimise prescribing and improve medicines safety</td>
<td>Embed use of Eclipse, identifying clinical champions and supporting Practices use by end of Q1</td>
<td>Contribute to STP plan to expand Eclipse to risk stratification and integrated care in Q2</td>
<td>Establish impact monitoring from Eclipse Focus on prescribing in priority areas including Chronic pain &amp; COPD in 19/20</td>
<td>Monthly spend on Drugs in priority areas of spend</td>
<td></td>
</tr>
</tbody>
</table>

### Benefits

- Use of medicines is optimised especially antimicrobial stewardship
- Improved patient outcomes in areas of focus
- Patient safety improved by identifying at patients at risk

### Risks & Dependencies

- Medicines Management team resource to support programme
- No cheaper stock obtainable
- LD work on STOMP & STAMP
- Partnership working with BTUH on early identification of Sepsis

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**Executive Lead:** Emma Timpson  
**Clinical Lead:** Dr Arv Guniyangodage

**Governance**

- CEG & F&P  
- Medicines Management Committee
**Objective:** CCG adapts to changing commissioning and ICS landscape whilst supporting CCG staff through the change

<table>
<thead>
<tr>
<th>Programme: Organisational form &amp; governance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Decision on Primary Care delegated commissioning</strong></td>
</tr>
<tr>
<td>- Develop a business case on primary care delegated commissioning in Q1</td>
</tr>
<tr>
<td>- Board decision to whether a proposal put to membership vote in Q2</td>
</tr>
<tr>
<td>- Work with other CCGs to confirm common approach</td>
</tr>
<tr>
<td>- Application to NHSE for delegated commissioning powers, dependent on membership vote</td>
</tr>
<tr>
<td>- Preparation, if required, including establishing contract support arrangements</td>
</tr>
<tr>
<td>- Board decision on primary care delegated commissioning</td>
</tr>
</tbody>
</table>

| **Transition to single CCG management team** |
| - Case for change to Board for decision about one AO, 5 CCGs or similar |
| - Develop new organisation structure engaging with staff |
| - Confirm new structure delivers reduction in running costs requirement |
| - CCG staff working more collaboratively across projects |
| - Staff consultation process |
| - Implement HR process to support transition to new structure |
| - Plans in place for single management team, as per NHS Long Term Plan |

| **Reduction in running costs** |
| - Confirm running costs for 2019/20 and identify required reduction |
| - Development of change management policy |
| - Review opportunities for reducing non-pay costs and implement changes (including the CCG constitution) |
| - Work collectively with CCGs to confirm reduction on AGEM contract |
| - Establish premises requirements for CCGs for 20/21 |
| - Running costs reduced by 20%, on 17/18 baseline, from April 2020 |

| **Governance arrangements to reflect change in management arrangements** |
| - Review of CCG Governance arrangements and committee structures to deliver 19/20 requirements |
| - Review governance arrangements in light of Case for change outcome |
| - Implement changes to governance arrangements |
| - Governance arrangements updated to reflect changes to commissioning structures |

| **Complete implementation of OD Plan** |
| - OD Strategy developed by end Q1 |
| - Complete the implementation of the OD plan by end of Q1 |
| - Board members development plans in place |
| - Conduct 6 month review of Board development Programme by end Q2 |
| - OD Plan fully implemented |

**Exec Lead:** Lisa Allen  
**Clinical Lead:** Dr Boye Tayo

**Benefits**
- Reduction in running costs, enabling more investment into patient facing services
- More strategic commissioning function, removing need for duplication

**Risks & Dependencies**
- Links to Infrastructure and workforce programmes
- Risk collective CCG Boards agreement to appointment of a single AO and management team
**Objective:** Infrastructure developed that supports new models of care within available resources

| Deployment of IT infrastructure to support primary care delivery | HSCN migration to commence, led by EPUT | Local preparation for Primary Care Enabling Services (NHS Mail, IG and Registration Authority) | Completion of Windows 10 upgrade in Q4 |
| Digital technology is employed to support primary care delivery | Local CCG implementation of NHS App in Q1 | Practices to make at least 25% of appointments available for on-line booking by end of Q2 | Support implementation of Shared Care Record |
| Primary Care and CCG estate fit for purpose | Laithdon Full Business Case presented to Board Q2 | Identify service model to support Estate development | Review available estates to deliver integrated services |
| Develop Population Health Management capabilities | Contribute to work of STP on Population Health & Prevention led by ECC | Review implications for evolving PCN dashboard | Work with public health colleagues to establish ‘place’ plan and defined outcomes |

**Governance**

**Exec Lead:** Dee Davey  
**Clinical Lead:** Not required

**Benefits**
- Improved access to services for patients and carers  
- Release time in primary care  
- Improved Estates utilisation  
- Information that supports effective Population Health management

**Risks & Dependencies**
- Dependant on establishment of Partnership & Integration Group  
- National IT and Digital programme implementation
### Programme: Workforce

**Objective:** Create modern health workforce that attracts and retains staff

<table>
<thead>
<tr>
<th>Develop resilient CCG workforce</th>
<th>Identify skills development opportunities for staff Q1</th>
<th>‘Prepare for change’ training for CCG staff</th>
<th>Review opportunities for staff with providers and PCNs</th>
<th>Develop workforce to meet changing requirements</th>
<th>Support staff through the change process</th>
<th>Staff survey results and objective measurements such as sickness absence, demonstrate that staff supported through period of change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support work of Local Workforce Action Board</td>
<td>Confirm STP wide projects that support recruit and retention Promote GP and primary care workforce programme via PCNs</td>
<td>Support continued expansion and development of primary care nursing workforce</td>
<td>Support development of hybrid roles across health and care provision</td>
<td>Support work of STP Mental Health Workforce sub group</td>
<td>Increase in Number of GPs and practice nurses and wider primary care workforce (full-time equivalent) per 1,000 weighted patients by CCG</td>
<td></td>
</tr>
</tbody>
</table>

### Governance

- **Exec Lead:** Teresa Kearney
- **Clinical Lead:** Not required
- **Primary Care Transformation Board CEG**

### Benefits

- Improved access to services for patients and carers
- Development of motivated workforce

### Risks & Dependencies

- Local Workforce Action Board
- Ageing workforce profile
- Ability to recruit and retain staff
The CCG’s Clinical Accountable Officer (CAO) is a member of the Mid and South Essex STP Board. The CCG’s Chair sits on the advisory STP Chair’s Group. The CAO and Chair both sit on the Joint Committee.

Assurance and reporting against the 2019/20 Operational Plan will be via the CCG Board, the Clinical Executive Committee and the relevant governance committees, as outlined in each programme summary.

The Operational Plan is intended to be used as a live document and will be formally refreshed on a six monthly basis as we work in greater collaboration with our partners.
Appendix 1  Basildon and Brentwood CCG Values

Our Values

Be Honest
We will communicate honestly.
We will make fair decisions.
We will be open and transparent.
We will be honest about our mistakes and learn from them.

Be Accountable
We will strive to commission the highest possible standards of healthcare.
We will strive to achieve value for money when spending public funds.
We will challenge failures and poor practice.
We will take responsibility for tough decisions and explain why these are made.

Clinically Led
We will listen to clinical leaders as we work to incorporate national clinical guidelines.
We will deliver patient-focused services that are evidence-based.
We will be open to new ways of delivering innovative care.
We will enable our patients to make informed health decisions.
We will empower our local population in self-care.

Compassionate and Respectful
We will show empathy to the opinions, views and feelings of others.
We will actively listen to patients, families and our colleagues.
We will protect the privacy and dignity of all individuals.
We will treat everyone with courtesy and respect.

Growing Together
We will involve patients and stakeholders in our decision-making.
We will work with GPs and our partners to achieve the best quality of care for all.
We will empower and enable our staff to do their very best.
We will embrace the diversity of our patients and our colleagues.
## Appendix 2  
### Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AF</td>
<td>Atrial Fibrillation</td>
</tr>
<tr>
<td>AGEM</td>
<td>Arden &amp; GEM Commissioning Support Unit</td>
</tr>
<tr>
<td>ARMS</td>
<td>At Risk Mental State</td>
</tr>
<tr>
<td>BCF</td>
<td>Better Care Fund</td>
</tr>
<tr>
<td>BI</td>
<td>Business Intelligence</td>
</tr>
<tr>
<td>BTUH</td>
<td>Basildon &amp; Thurrock University Hospital</td>
</tr>
<tr>
<td>CBTp</td>
<td>Cognitive Behavioural Therapy for Psychosis &amp; Bipolar Disorder</td>
</tr>
<tr>
<td>CEG</td>
<td>Clinical Executive Group / Committee</td>
</tr>
<tr>
<td>CHC</td>
<td>Continuing Healthcare</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>CYP</td>
<td>Children &amp; Young People</td>
</tr>
<tr>
<td>DES</td>
<td>Directed Enhanced Scheme</td>
</tr>
<tr>
<td>DMARDs</td>
<td>Disease Modifying Anti-Rheumatic Drugs</td>
</tr>
<tr>
<td>DoS</td>
<td>Directory of Services</td>
</tr>
<tr>
<td>DSEP</td>
<td>Diabetes Structured Education Programme</td>
</tr>
<tr>
<td>DTA</td>
<td>Discharge to Assess</td>
</tr>
<tr>
<td>ECC</td>
<td>Essex County Council</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>EoL</td>
<td>End of Life</td>
</tr>
<tr>
<td>EWMHS</td>
<td>Emotional Wellbeing &amp; Mental Health Services</td>
</tr>
<tr>
<td>F&amp;P</td>
<td>Finance &amp; Performance Committee</td>
</tr>
<tr>
<td>IAF</td>
<td>Improvement Assessment Framework</td>
</tr>
<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
</tr>
<tr>
<td>ICS</td>
<td>Integrated Care System</td>
</tr>
<tr>
<td>IRN</td>
<td>Integrated Residential &amp; Nursing (Framework)</td>
</tr>
<tr>
<td>LD</td>
<td>Learning Disabilities</td>
</tr>
<tr>
<td>LDP</td>
<td>Local Delivery Pilot</td>
</tr>
<tr>
<td>LeDeR</td>
<td>Learning from Deaths Report</td>
</tr>
<tr>
<td>LMC</td>
<td>Local Medical Committee</td>
</tr>
<tr>
<td>LMS</td>
<td>Local Maternity Service</td>
</tr>
<tr>
<td>LTC</td>
<td>Long Term Condition</td>
</tr>
<tr>
<td>LTP</td>
<td>Long Term Plan</td>
</tr>
<tr>
<td>LQ</td>
<td>Lower Quartile</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>MHSDS</td>
<td>Mental Health Services Data Set</td>
</tr>
<tr>
<td>MIU</td>
<td>Minor Injuries Unit</td>
</tr>
<tr>
<td>MSB</td>
<td>Mid, Southend &amp; Basildon Hospitals</td>
</tr>
<tr>
<td>MSK</td>
<td>Musculo-Skeletal</td>
</tr>
<tr>
<td>NELFT</td>
<td>North East London Foundation Trust</td>
</tr>
<tr>
<td>NHSP</td>
<td>NHS Property</td>
</tr>
<tr>
<td>OD</td>
<td>Organisational Development</td>
</tr>
<tr>
<td>PCN</td>
<td>Primary Care Network</td>
</tr>
<tr>
<td>PHB</td>
<td>Personal Health Budget</td>
</tr>
<tr>
<td>PSQ</td>
<td>Patient Safety &amp; Quality</td>
</tr>
<tr>
<td>PWP</td>
<td>Psychological Wellbeing Practitioner</td>
</tr>
<tr>
<td>QIPP</td>
<td>Quality, Innovation, Productivity, Performance</td>
</tr>
<tr>
<td>SEND</td>
<td>Special Educational Needs and Disability</td>
</tr>
<tr>
<td>SMI</td>
<td>Serious Mental Illness</td>
</tr>
<tr>
<td>STAMP</td>
<td>Supporting Treatment and Appropriate Medication in Paediatrics</td>
</tr>
<tr>
<td>STOMP</td>
<td>Stopping Over Medication of People with a Learning Disability, Autism or both</td>
</tr>
<tr>
<td>STP</td>
<td>Sustainability Transformation Partnership</td>
</tr>
<tr>
<td>UTC</td>
<td>Urgent Treatment Centre</td>
</tr>
<tr>
<td>VSO</td>
<td>Voluntary Sector Organisation</td>
</tr>
<tr>
<td>WTE</td>
<td>Whole Time Equivalent</td>
</tr>
</tbody>
</table>