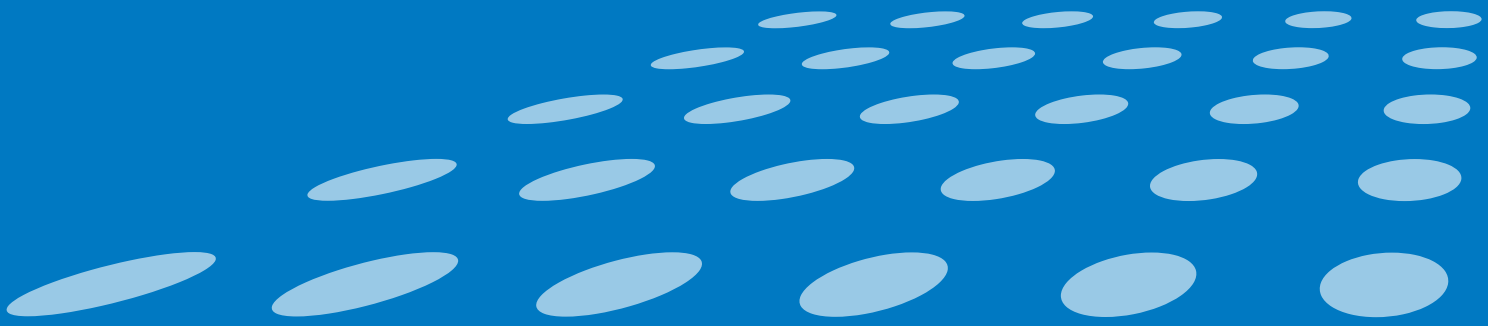
NHS

Wirral Clinical Commissioning Group

2013–2016
Strategic Plan



February 2013

Table of Contents

1. Chairman and Chief Clinical Officer's Introduction

This document presents the NHS Wirral Clinical Commissioning Group (WCCG) Strategic Plan for the period 2013-16. It sets out our vision for the future of health and health care in NHS Wirral.

Our local vision identifies 11 key strategic priorities. These build on and represent a commitment to the NHS Constitution and the NHS Outcomes Framework (Everyone Counts) and reflect our continuing commitment to local service improvement to meet local priorities and needs.

To implement our Strategic Plan we will develop a detailed Commissioning/Delivery/Operational Plan for each of the financial years contained within it. This will include a series of timetabled programme and project plans.

This document therefore draws together a number of key and significant work programmes. It is aimed to provide a comprehensive statement of direction and intent for Wirral CCG and highlight the priorities for service improvement which in turn will require a detailed programme of investment and disinvestment to support service transformation.

NHS Wirral Clinical Commissioning Group has developed a strategic vision for a healthier Wirral.

Our Mission Statement is:

'Your partner in a healthier future for all'

Dr. Phil Jennings
Chairman,
NHS Wirral
Clinical Commissioning Group

Dr Abhi Mantgani
Chief Clinical Officer
NHS Wirral
Clinical Commissioning Group

Our Vision and Plans

Our Vision and Plans will be developed through working closely with all our stakeholders and partners in the NHS, Local Authority and voluntary sector, as well as through active consultation with our patients and the public.

The vision of the Clinical Commissioning Group is that:

"Wirral Clinical Commissioning Group commits to continue to improve health and reduce disease by working with patients, public and partners, tackling health inequalities and helping people take care of themselves"

Our aims are to work with our patients, the public in Wirral and our stakeholders to:

- Improve the health of all Wirral citizens.
- Target inequalities in health experiences and outcomes amongst sections of our population
- Deliver needs based healthcare of the highest quality to all our resident population.
- Promote maximum self care by involving and including our patients in all decisions made about them.
- To reduce waste and inefficiency and duplication within the patient journey and between partners
- To be a high performance, high reputation organisation with ambition.

In this context a number of specific goals based on the local health needs expressed in the Health and Wellbeing Strategy and based on the prioritisation of the Joint Strategic Needs Assessment (JSNA) 2012 are identified throughout this plan.

Our overall goal is to deliver service improvement and change based on our core values of:

- Caring, fairness and responsibility
- Safety and trust
- Person centred care

This document describes our 11 key strategic priorities. They are designed to deliver our vision, goals and plans and support the objectives of the organisation

The concept of Quality, Innovation, Productivity and Prevention (QIPP) is foundational to our strategy and each of its programmes and plans.

We, like all other organisations, face significant financial pressures. Challenges faced by others will impact on our plans. This means working with our stakeholders and colleague organisations, to ensure a collaborative approach, will be vital. This in turn will ensure the optimal use of the resources available to the Clinical Commissioning Group.

We recognise the value and necessity of partnership working to make our plans a reality.

Our Strategic Objectives:

- Prevent people from dying prematurely
- Enhance the quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Ensuring people are treated and cared for in safe environment and protected from avoidable harm

This will be supplemented by a number of key local priorities, identified through the Joint Strategic Needs Assessment (JSNA) and endorsed by the Health and Well Being Strategy (HWBS) which are:

- Meeting the needs of the ageing population
- Alcohol prevention and treatment services
- Mental Health services

Our plans represent a significant challenge and programme of change in light of the current financial climate.

Part of our future funding will include a "Quality Premium" if we secure quality improvements against certain measures from the NHS Outcomes Framework.

We will be targeting the following areas to secure these additional resources:

- Emergency readmissions within 30 days of discharge from hospital (specifically for the elderly population)
- Number of people attending Accident and Emergency Department with alcohol related conditions
- Enhancing quality of life for people with dementia

2. Executive Summary

This 2013-2016 Strategic Plan (and its associated Commissioning and Operational Plans) have been developed in the context of very demanding requirements from Government both in terms of patient and service user expectations and anticipated resource availability.

The key goal is to continue to deliver high quality services during a time of significant financial challenge and a changing NHS landscape.

The focus of the CCG will be to deliver financial sustainability, to deliver national requirements such as those outlined in the 2013-14 Outcomes Framework, and continue to deliver improved quality, evidenced by improving safety, effectiveness and patient experience. This will be the focus for the CCG during the period of this plan and beyond.

This will require continuous and significant service review and transformation.

In addition to national developments and priorities we will focus on local service redesign which will address the specific health needs in Wirral reflecting the sometimes different requirements of its registered population.

In summary we see the Wirral health care system/service in 3 years' time as one that:

- Is patient and primary care centric and based on high quality primary care, secondary and community services.
- Has made step shifts in our balance of focus away from treatment and towards greater investment in prevention.
- Has commissioned services which have a sound evidence base.
- Has redirected investment to services that have been under resourced in the past (e.g. dementia care, adult and children's mental health services, alcohol prevention and dependency services).
- Provides greater equality of access to all.
- Has rigorously developed and agreed care pathways working together with patients to secure their help, understanding, ownership and support of the needed changes
- Has achieved optimal administrative and management costs but has rigorous management and clinical governance arrangements in place.

What key changes can we expect?

Implementation of our strategies will require change. In delivering such change we will:

- Insist on a clearer focus on our key strategic priorities, supported by detailed action and implementation plans, with clear and defined arrangements (including timescale and criteria to monitor) that reflect this.

- Make clear statements about investment and disinvestment opportunities and service re-profiling.

- Pursue a more rigorous and timely approach to performance monitoring and management

- Recognise that continuous embedded patient engagement based on robust clinical leadership and engagement is key. Appendix 5 indicates the extent to which clinicians are involved in our commissioning programmes to date. Clinical leadership will include a role for all professional and staff interests in developing our strategies and implementation plans together with regular feedback from those patients most affected by these strategies and plans.

How will we get there?

- Our strategy will be refined through a rigorous process of clinical and patient dialogue and engagement over the next two months.

- The resulting strategy will then be delivered through a robust process of programme and performance management with results fed back into further engagement by clinicians with our patients and stakeholders.

- Organisational structures will be established to ensure timely, sound and sensitive decision making.

In Summary

- We will embrace the NHS Constitution as a pervasive philosophy in everything we provide
- and commission.
- Sustain progress that has been made by the Wirral Health community in previous years
- Build on the excellent progress made by predecessor organisations.
- Focus on the national and local priorities.

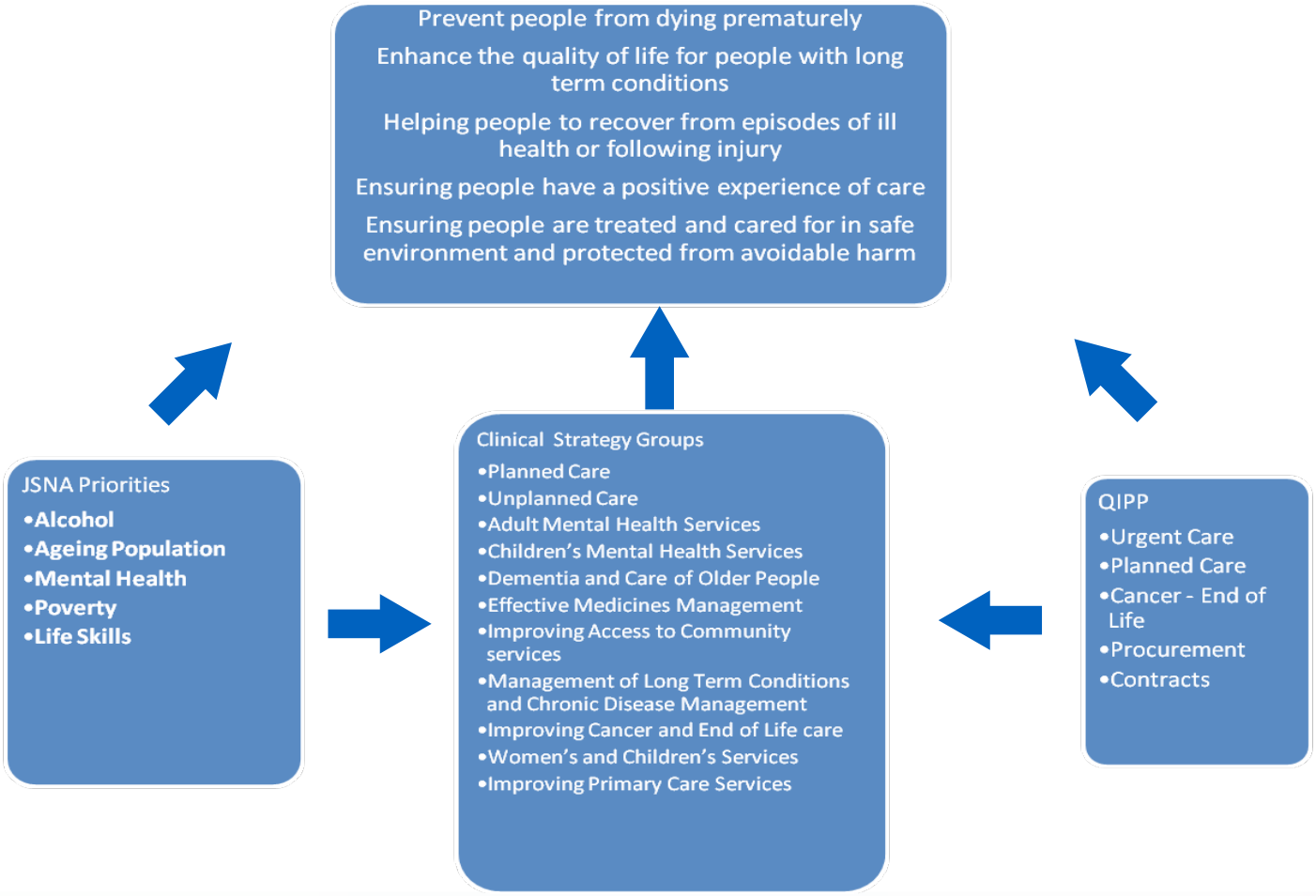
These are:

National
- Prevent People from dying prematurely.
- Enhance the quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Ensuring people are treated and cared for in safe environment and protected from avoidable harm.

Local

- Meeting the needs of the ageing population
- Alcohol prevention and treatment services
- Mental Health services

Our priorities, programmes, plans and structures are interrelated. The relationships are represented diagrammatically as follows:



3. How the Strategy was developed

Our strategy and plans have developed taking account of a number of strands of work including:

Legacy Strategies

- The NHS Wirral Strategic Plan 2008-13
- The 2012-13 CCG Operational Plans
- The Federated CCG Strategic and Operational Plan (2012-15)
- The NHS Constitution

Current Information

- Joint Strategic Needs Assessment (available at http://info.wirral.nhs.uk)
- CSU Annual Status Review
- Everyone Counts: Planning for Patients 2013/14
- Commissioning for Quality and Innovation (CQUIN) 2013/14 guidance.
- Performance Reports
- The views of our member practices
- The views of the public, patients and wider stakeholders based on the CCG's engagement activity

Recent Policies / Publications

- The National Commissioning Board Mandate
- The NHS Outcomes Framework (2013-14)
- Everyone Counts Planning for Patients 2013/14
- Supporting Planning 2013/14 for Clinical Commissioning Groups

Strategies under development and guidance to be adhered to

- The Joint Health and Wellbeing Strategy based on the findings of the JSNA
- Planning and Financial Guidance for 2013-14 and future financial years

In setting our strategic objectives we have sought to provide an appropriate balance between the requirements of the Health and Social Care Bill and our own local intentions and objectives based on a more detailed assessment of local needs.

In the context of the financial challenges that face the healthcare system the delivery of its QIPP targets are paramount to a successful organisation

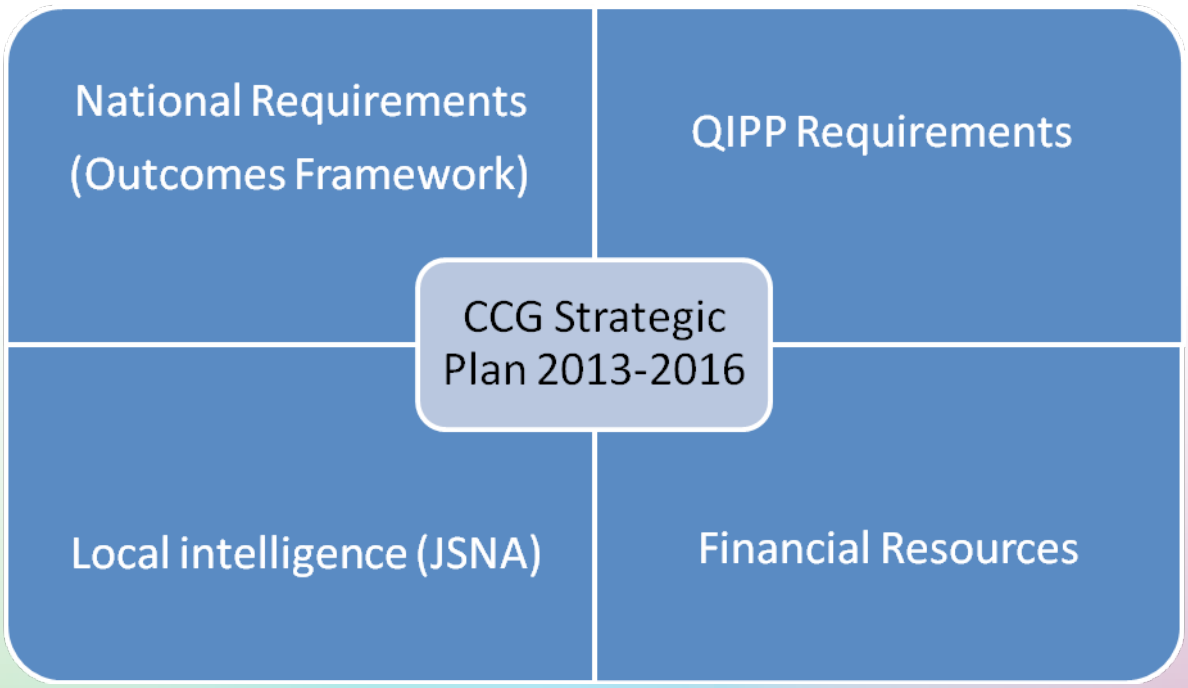
The foundation of our strategy is the recently refreshed JSNA and working in partnership with all stakeholders to achieve the vision of the Wirral Health and Well Being Strategy

The 2013-14 National Outcomes Framework sets out the national policy requirements for the healthcare system. The CCG's commissioning plan and strategic objectives will need to be in line with these outcome requirements but building on the local information from the Joint Strategic Needs Assessment.

The 2013-14 outcomes framework is structured around 5 domains

Domain 1	Preventing people from dying prematurely;
Domain 2	Enhancing quality of life for people with long-term conditions;
Domain 3	Helping people to recover from episodes of ill health or following injury;
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.

The strategic priorities developed by the CCG will need to ensure that they meet all the following requirements



Setting Priorities

In arriving at our strategic priorities a rigorous prioritisation process was agreed by the Wirral H&WB and the JSNA Executive Group. The prioritisation process was undertaken between October and December 2012. It was systematic and transparent.

The process was supported by public and stakeholder consultation and this helped identify the most important priorities for local people.

These were

- Alcohol
- Ageing Population
- Mental Health
- Poverty
- Life Skills

Subsequently a prioritisation methodology was agreed and working principles established. The process identified a priority order and the H&WB subsequently agreed the three strategic health priorities for Wirral in 2013-14 to be:

- Ageing Population
- Alcohol
- Mental Health

Next Steps

NHS Wirral Clinical Commissioning Groups Strategic Plan which embraces these priorities will require significant consultation and wider public and partner stakeholder engagement to support and guide the shape and pace of change.

4. Health Economy Profile

The context in which our Strategy has been developed is described below.

4.1 Population Profile

Wirral is a Borough of contrast and diversity in both its physical characteristics and social demographics. There are both rural areas and townships and urban and industrialised areas in a compact peninsula of 60 square miles. The Borough has a wealth of parks and countryside and over 20 miles of coastline.

- Wirral has a relatively high older population and a relatively low proportion of people in their twenties and thirties compared to England and Wales as a whole.

- The older population (aged 65 years and above) are expected to increase at the fastest rate (than any other age group) over the next decade; between 2011 and 2021 it is estimated that this population group will have increased by 17.4%.

- The population over 85 is projected to increase from 8,460 in 2011 to 10,985 in 2021, which equates to a 29.9% increase.

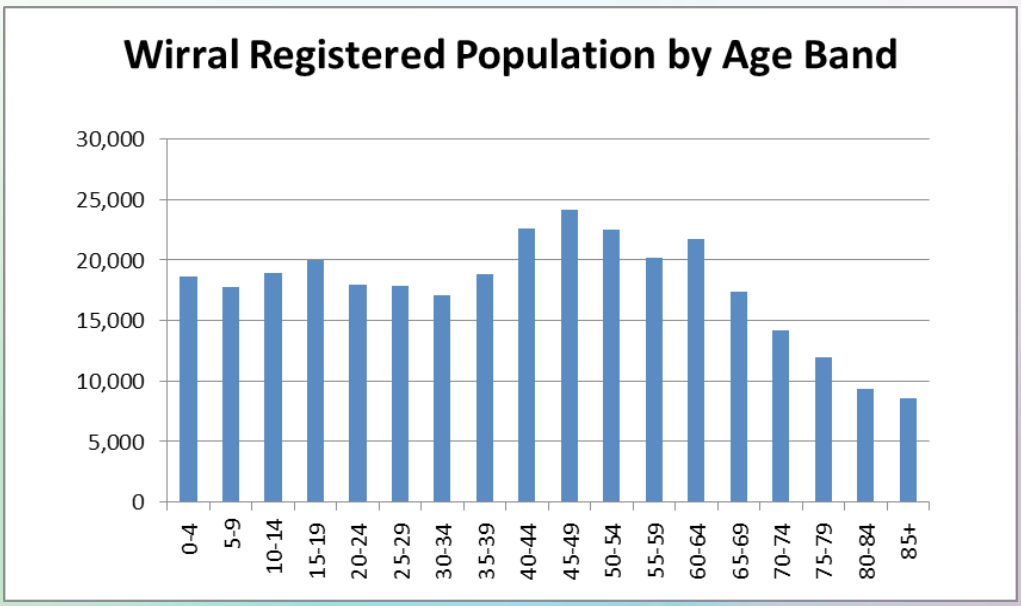
- The biggest decrease is in the 35-59 year age group, from 108,548 in 2008 to 82,061 in 2021.

- Births reached a 15 year high in 2011.

- The Index of Multiple Deprivation (IMD) places 30 of Wirral's LSOAs in the lowest 5% in England and 23 Lower Super Output Areas (LSOA) in the 3% most deprived nationally.

- The Employment domain of the IMD 2010 indicates that Wirral performs poorly on this indicator. This is an indication of the scale of the challenge faced in Wirral and the need for a focused and coordinated approach to tackling worklessness and economic inactivity.

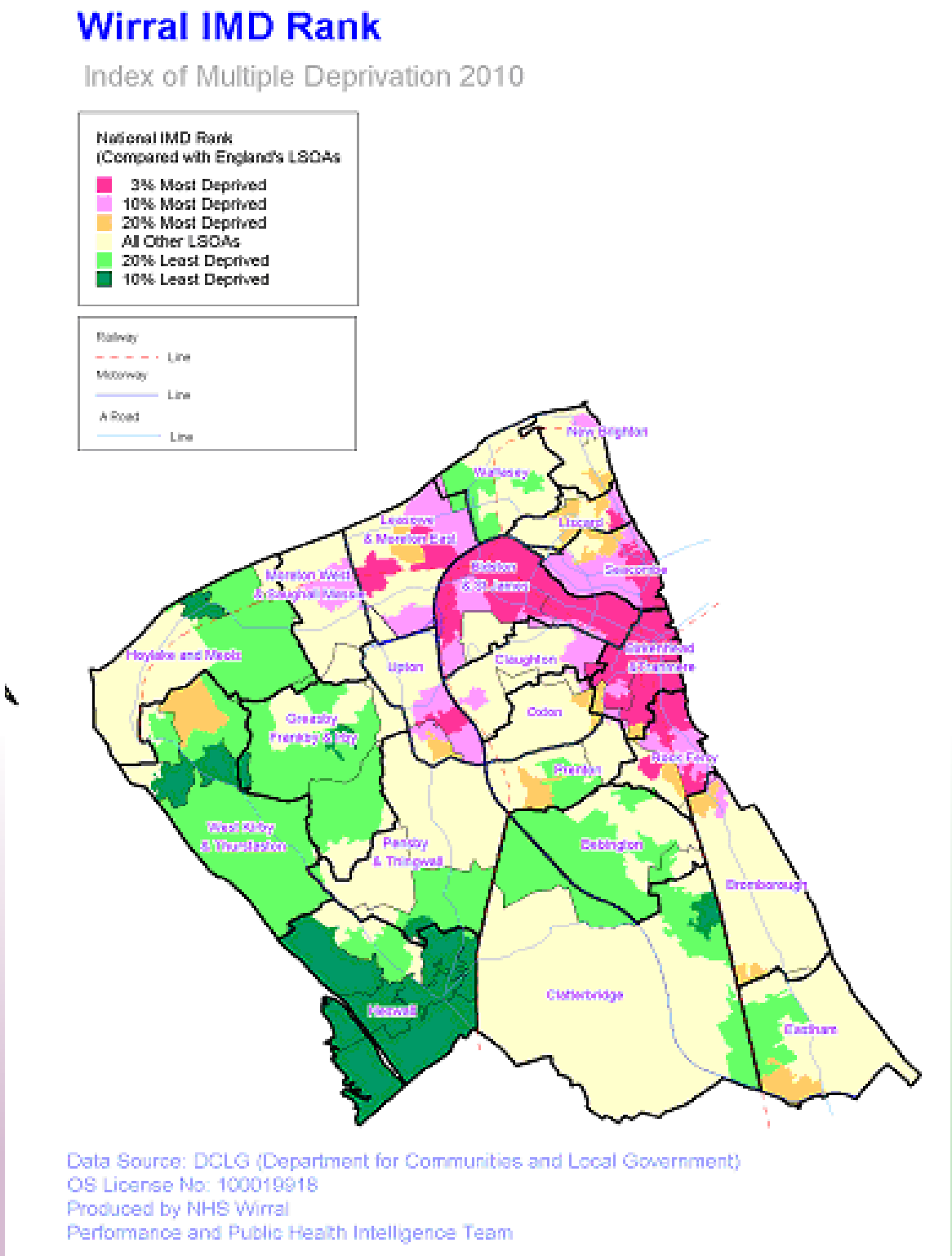
- Wirral has a predominance of Mosaic groups which are at the polar extremes of the income spectrum, indicating that the differential between people on very low and very high incomes is quite pronounced in Wirral.



4.2 Deprivation

The Index of Multiple Deprivation (IMD) IMD 2010 shows that Wirral is the 60th most deprived of the 326 districts in the country and is therefore in the bottom 20% nationally. There has been no change on previous data (IMD 2007).

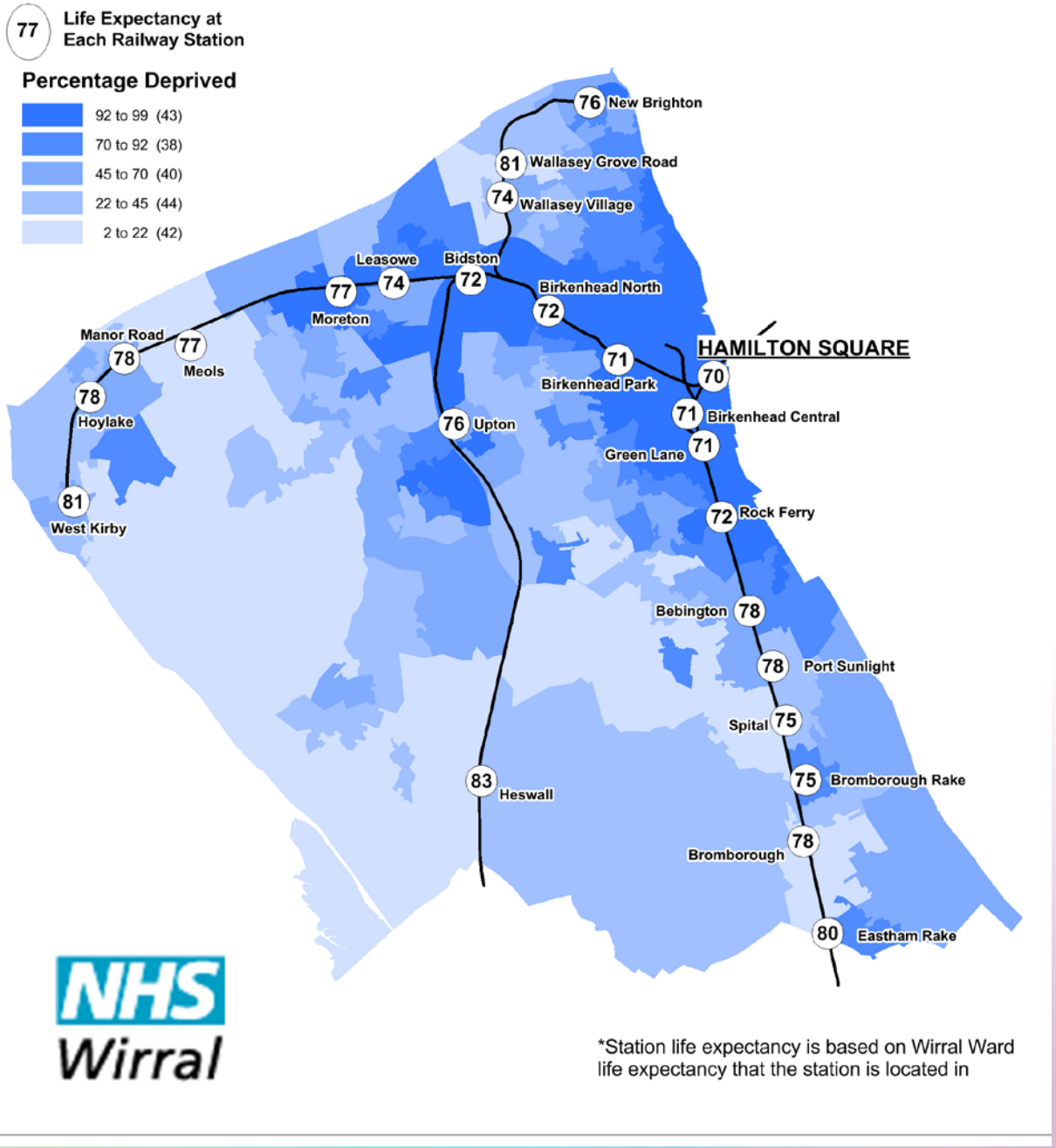
The IMD places 30 of Wirral's Lower Super Output Area's (LSOA) in the lowest 5% in England and 23 LSOAs in the 3% most deprived nationally as described in the table below.



4.3 Life Expectancy

In 2008-10, life expectancy in Wirral was 77.0 for men and 80.8 for women. However life expectancy varies across the peninsula and an example of this is displayed by the below map comparing life expectancy by Wirral Railway Station for the male Wirral population.

Male Life Expectancy at Birth by Wirral Railway Station, Overlaid on IMD 2010 Deprivation Score, by Wirral LSOA, 2008 - 2010 Pooled



The gap in life expectancy between Wirral and England continued to widen in 2008-10. Amongst women in Wirral, life expectancy has actually decreased slightly for the last two time periods recorded (2007-09 and 2008-10)

The gap in life expectancy between the most and least affluent *within* Wirral was 14.6 years for men and 9.7 years for women (Marmot Indicators, 2012)

The Marmot Indicators (2012) also showed that Wirral had the largest gap in Disability Free Life Expectancy (DFLE) for males and females of any authority in England (20.0 years for men, 17.1 years for women)

The main contributors to the gap in life expectancy between Wirral and England was chronic liver disease for men and lung cancer for women. Mortality from chronic liver disease (in both the under 75s and those of all ages) in Wirral men is higher than England. The main contributor to liver disease is alcohol.

4.4 Diversity

Wirral Joint Strategic Needs Assessment (JSNA) 2008/09 acknowledged a significant gap in knowledge about Wirral's Black Minority Ethnic (BME) community including the lack of robust data on population prevalence, and information on its health and well-being needs. Accordingly a piece of research was commissioned to help address the lack of understanding.

A randomised survey of 1728 households has evidenced a relatively small numerical, though significant percentage increase in the size of the BME population in Wirral since the 2001 census which gave a figure of 3.56%, compared to a total today of 5.83% n = 18,291(adjusted figure) This survey is not able to provide a reliable account of the composition of BME population, while the Office for National Statistics (ONS) mid-year estimates based on the 2001 census are increasingly prone to error. An assessment of new National Insurance (NI) registrations tends to support anecdotal accounts of a recent decline of up to 50% in the numbers of Eastern Europeans / Poles in the Wirral.

Ethnic Group	Wirral (2001)	Wirral (2009)	Net Change (from 2001)	% Change
All Groups	315000	308500	-6500	- 2
White: British	303800	289800	-14000	- 5
White: Irish	3100	2700	-400	- 12
White: Other White	2700	5500	+ 2800	+ 103
Mixed: White and Black Caribbean	500	800	+ 300	+ 60
Mixed: White and Black African	300	500	+ 200	+ 66
Mixed: White and Asian	500	900	+ 400	+ 80
Mixed: Other Mixed	500	700	+ 200	+ 40
Asian or Asian British: Indian	700	1900	+ 1200	+ 171
Asian or Asian British: Pakistani	100	900	+ 800	+ 800
Asian or Asian British: Bangladeshi	400	500	+ 100	+ 25
Asian or Asian British: Other Asian	200	500	+ 300	+ 150
Black or Black British: Black Caribbean	200	500	+ 300	+ 150
Black or Black British: Black African	300	900	+ 600	+ 200
Black or Black British: Other Black	100	200	+ 100	+ 100
Chinese or Other Ethnic Group: Chinese	1300	1400	+ 100	+ 8

According to 2009 ONS estimates less than 5% of Wirral's population is from a BME group (i.e. not white British) see table 2.3.1

The table above shows that the ethnic population of Wirral has increased slightly, however overall figures mask large differences between ethnic groups.

The, 'Asian or Asian British: Pakistani' group for example is estimated to have increased in number from 100 in 2001, to 900 people in 2009 which is a 800% increase.

In contrast, the, 'White: Irish' group appears to have shown the largest percentage decrease, from 3,100 in 2001, to 2,700 people in 2009.

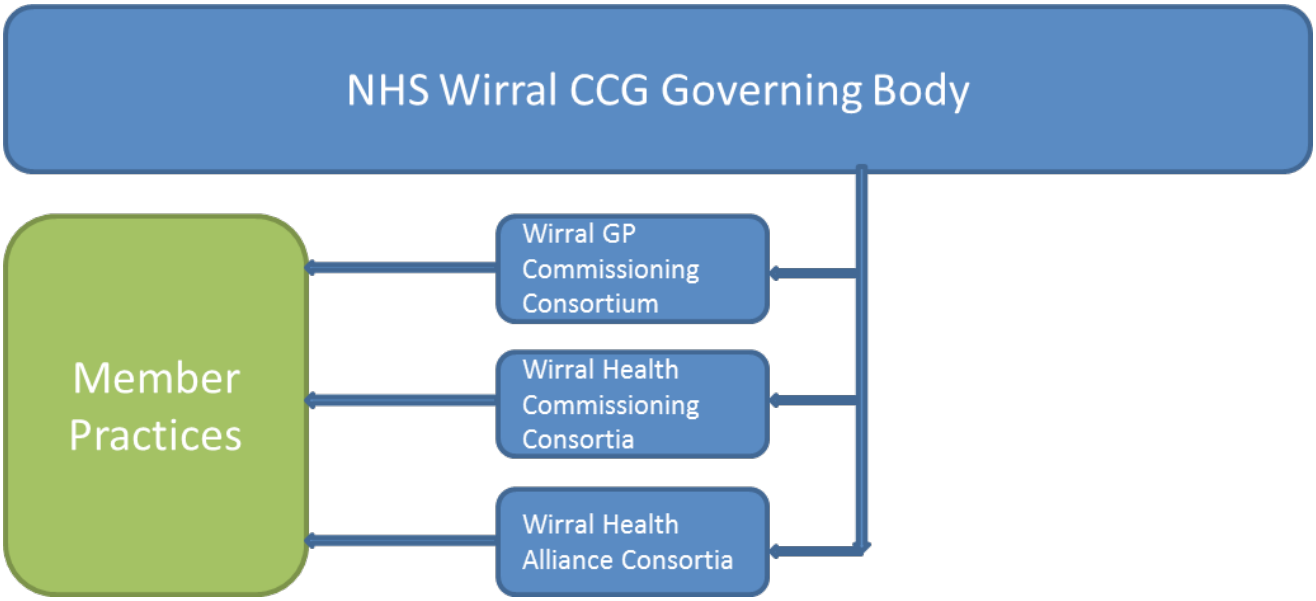
According to the school census, 6.5% of school children in Wirral are from BME groups. The number of pupils has risen from 2,526 pupils in December 2010 to 3,159 pupils, or 6.5%, in December 2012 that had a recorded ethnicity. This is a rise from 5.2% in 2010.

4.5 Other Key Issues

- Wirral has many very high differentials between incomes in different parts of Wirral. This produces very marked impact on health experiences across virtually all indicators.
- Wirral has the largest gap in disability free life expectancy of any authority in England for males and females.
- There are about 38,000 carers in Wirral representing about 12% of the population compared to a national average of 10%
- Dementia is a key and worsening problem for Wirral with an estimated 4,443 people over 65 living with dementia in 2011. This is projected to rise to almost 5,300 within the next 8 years.
- Alcohol is a significant problem for children and young people on Wirral. Death rates from digestive diseases mainly caused by alcohol are increasing very rapidly in the most deprived areas.
- 30,000 over 65s reported in the 2001 Census that they were living with a Limiting Long Term Illness.
- The most deprived areas have much higher emergency hospital admission rates than the rest of Wirral.
- Lifestyle behaviours such as smoking and drinking too much alcohol, as well as obesity, contribute to health inequalities and these behaviours are all more prevalent in Wirral's most deprived areas.
- Birkenhead, Tranmere, Bidston, Seacombe and Rock Ferry have between 50% and 70% of older people living in deprivation.

4.6 Local Health Environment and Practice Profile

NHS Wirral Clinical Commissioning Group is a federated model comprising 3 commissioning consortia as follows:



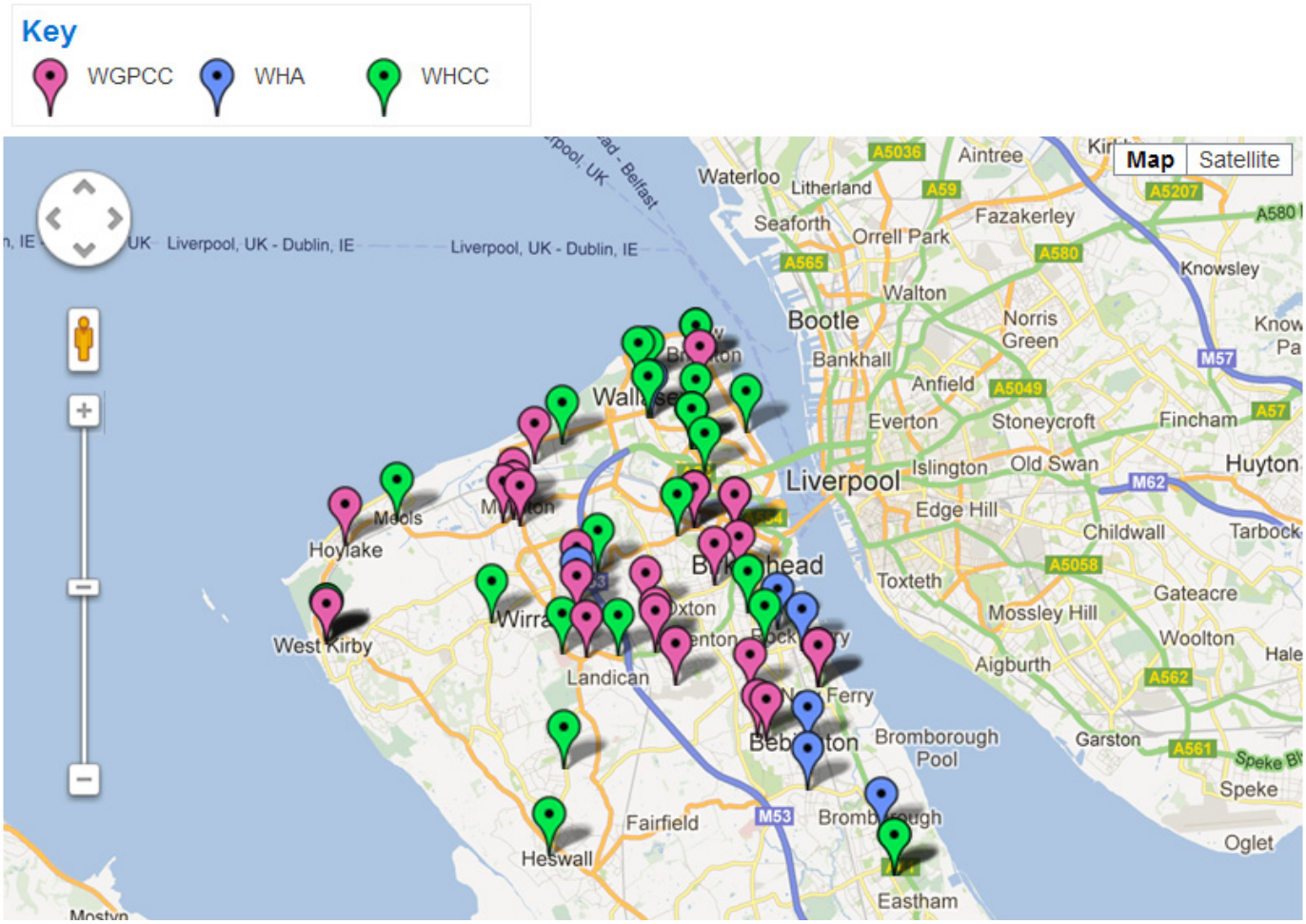
The configuration of each of the consortia is as follows with no discrete geographical boundary

Division	Number of Practices	Number of Patients (approximate)
Wirral Health Commissioning Consortium (WHCC)	27	165,000
Wirral GP Commissioning Consortium (WGPCC)	27	126,000
Wirral Health Alliance (WHA)	7	40,000

In addition to the 61 GP practices there are:

- 33 contracted ophthalmic opticians
- 94 Pharmacists
- 45 Dental Practices

We look after the health needs of about 330,000 people living within Wirral.



4.7 Provider Profile

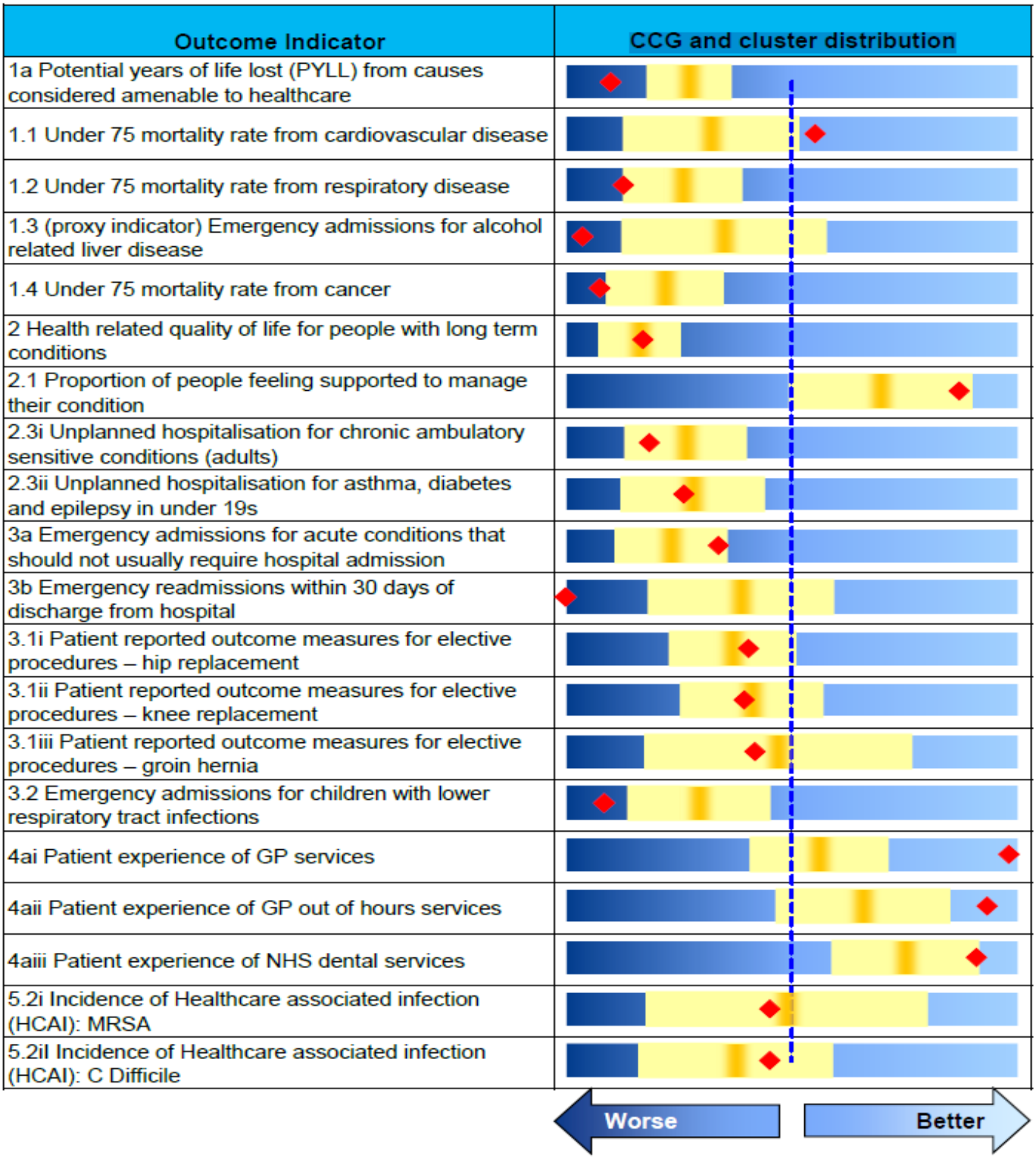
NHS Wirral CCG commissions its services through a range of NHS and Non-NHS providers with the contract monitoring and negotiation process being led by clinical commissioners.

NHS Wirral CCG has 4 main local providers. Fuller information about the NHS Wirral CCG contract portfolio is included as Appendix 1.

- Wirral University Teaching Hospital Foundation Trust
- Wirral Community NHS Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- Clatterbridge Cancer Centre

4.8 NHS Outcomes Framework 2013-14 Indicators

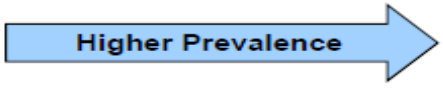
The chart below shows the distribution of the CCGs on each Outcomes Framework indicator in terms of ranks. **NHS Wirral CCG is shown as a red diamond**. The yellow box shows the inter quartile range and median of CCGs in the same ONS cluster as this CCG. The dotted blue line is the England median. Each indicator has been orientated so that better outcomes are towards the right (light blue).



4.9 QOF Disease Prevalence

The table below shows the prevalence (number and percentage) of diseases covered by the QOF for the practices in this CCG in 2010/11. The chart shows the distribution of the CCG's practices' prevalence in terms of ranks. Individual practices are shown as vertical bars with the height of the bar proportional each practice's population. The blue box shows the range of the middle 50% of practices in the CCG. The large diamond shows the average rank for the CCG and the dashed blue line shows the England average

QOF Disease Register	Number (%) and practice ranks chart
Coronary Heart Disease	13,769 (4.1%)
Stroke or Transient Ischaemic Attacks (TIA)	7,359 (2.2%)
Hypertension	49,411 (14.9%)
Chronic Obstructive Pulmonary Disease	7,396 (2.2%)
Hypothyroidism	11,484 (3.5%)
Cancer	5,894 (1.8%)
Mental Health	2,979 (0.9%)
Asthma	21,109 (6.3%)
Heart Failure	2,632 (0.8%)
Heart Failure Due to LVD	1,512 (0.5%)
Palliative Care	732 (0.2%)
Dementia	1,902 (0.6%)
Atrial Fibrillation	6,326 (1.9%)
Cardiovascular Disease Primary Prevention	4,342 (1.3%)
Diabetes Mellitus (17+)	16,122 (6.0%)
Epilepsy (18+)	2,512 (0.9%)
Depression (18+)	38,138 (14.4%)
Chronic Kidney Disease (18+)	13,193 (5.0%)
Obesity (16+)	34,063 (12.5%)
Leaning Disability (18+)	1,500 (0.6%)



5. Resources

5.1 2013-14 Financial Allocation

The financial allocation for NHS Wirral Clinical Commissioning Group for the 2013/14 financial year is as follows

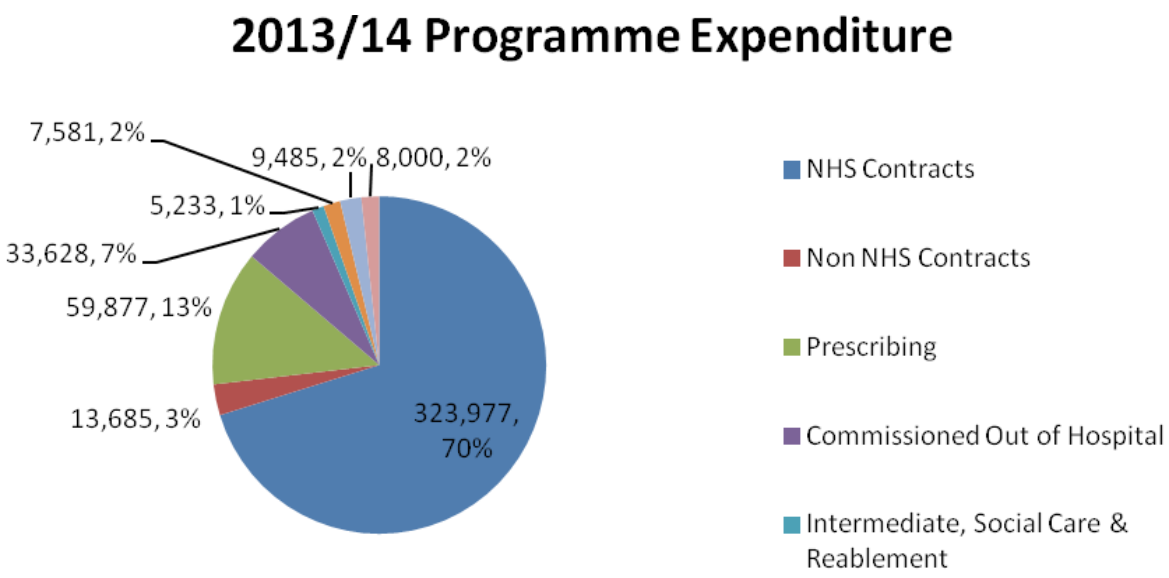
	£ Million
PCT Baseline (CCG Element exc Running Cost)	£463.155
Less Specialised Services Adjustment	(£25.154)
Less PCT 2% Headroom Adjustment	(£2.842)
Adjusted CCG Baseline	£435.159
2.3% Uplift	£10.009
2013-14 Revenue Allocation (Commissioning)	**£445.168**
2013-14 Running Costs Allocation	**£8.000**
2013-14 Total Resource Allocation	**£453.168**
Plus Non-Recurrent Allocation for return of Historic Surplus & Lodgement	£12.395
2013-14 Resources Available	**£465.563**

5.2 Summary of current financial planning assumptions 2013/14 -2015/16

The tables below show a summary of the anticipated resources available and headline expenditure values for the CCG for the period 2013/14 – 2015/16

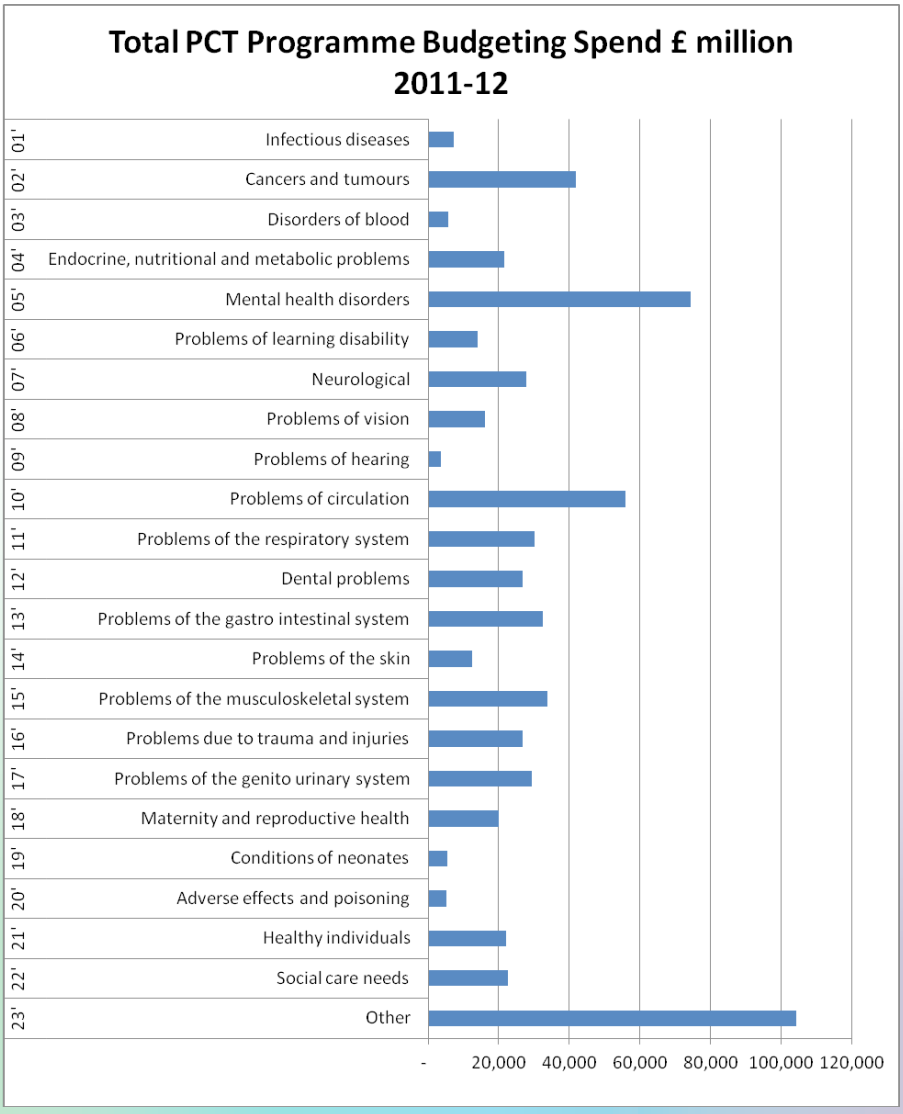
	2013/14	2014/15	2015/16
Programme Budgets	£000's	£000's	£000's
NHS Contracts	319,760	315,635	315,732
Non NHS Contracts	13,471	13,471	13,471
Prescribing	59,295	60,481	61,691
Commissioned Out of Hospital	34,533	31,033	31,033
Intermediate, Social Care & Re-ablement	5,233	5,233	5,233
Other Commissioning Expenditure	8,854	7,111	7,111
CCG Reserves (Contingency / non-rec)	11,965	16,612	19,800
PROGRAMME TOTAL	**453,111**	**449,576**	**454,071**
Running Costs	**8,000**	**8,080**	**8,161**
CCG TOTAL	**461,111**	**457,656**	**462,232**
RESOURCE AVAILABLE	465,563	462,152	466,773
SURPLUS (1%)	(4,452)	(4,496)	(4,541)

5.3 Summary of Programme Expenditure by provider type

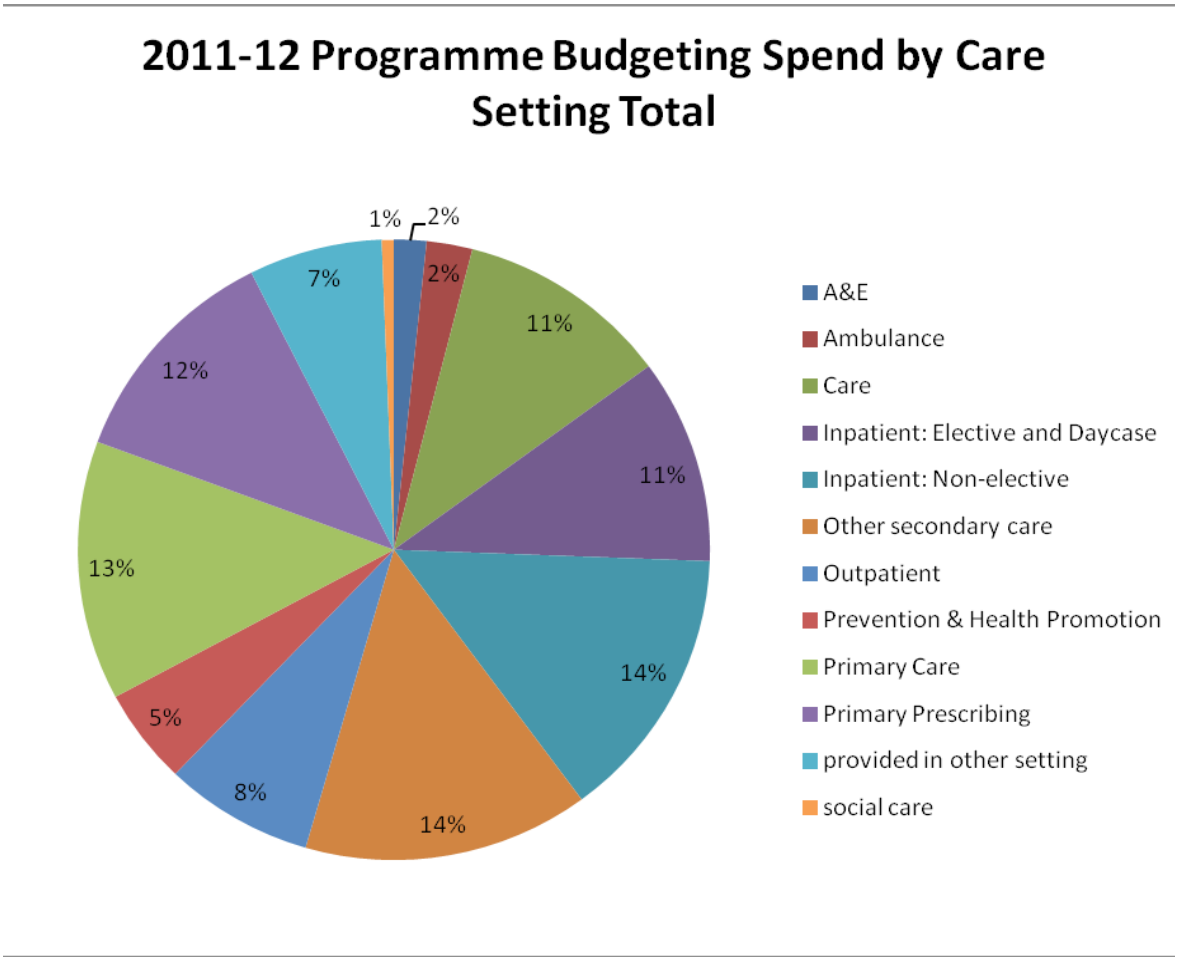


5.4 Programme Budgeting Spend

The bar chart below shows the PCT Programme Budgeting Spend split over the 23 categories using the 2011-12 gross expenditure values



The pie chart below shows the PCT Programme Budgeting Spend split by care setting using the 2011-12 gross expenditure values



5.5 Financial Risks

In summary the key financial risks are:

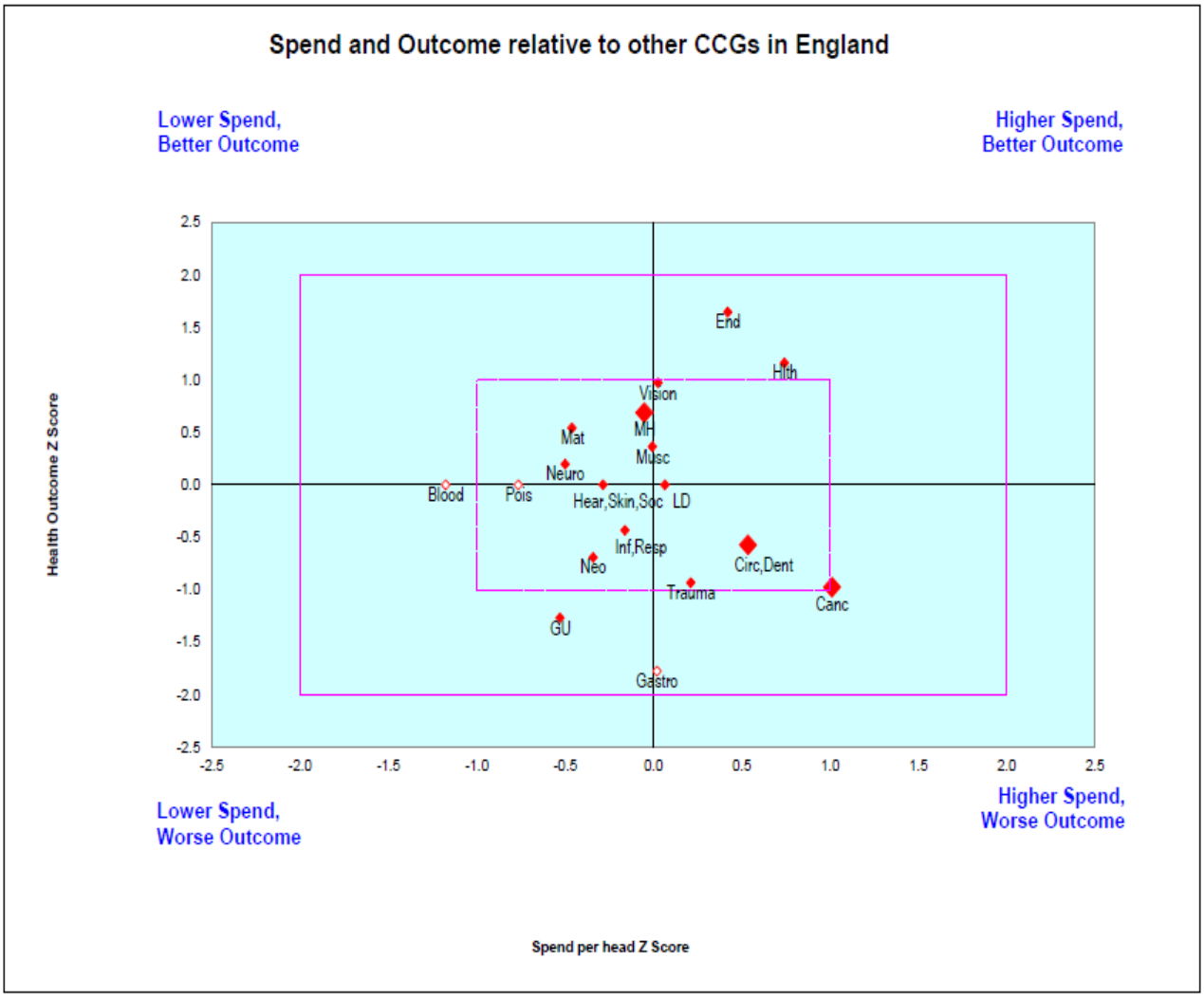
- Increasing secondary care activity
- Increasing Prescribing costs and uplift shortfall
- Increasing Continuing Health Care and packages of care costs
- Non-delivery of QIPP target savings and demand management initiatives

5.6 Activity

With our resources we commission from all our providers approximately:

- 92,000 Accident and Emergency attendances
- 39,000 Day Case procedures
- 10,200 Elective Inpatient procedures
- 51,000 Non elective (Unplanned) procedures
- 106,000 new out patient attendances, 285,000 follow up out patient attendances and
- 39,000 out patient procedures
- PLUS a full range of community based nursing and therapeutic services.

5.7 Programme Budgeting Spend versus Outcomes



◇ No outcome indicators readily available
♦ Outcome indicators available

Programme Area Abbreviations

Infectious Diseases	Inf	Hearing	Hear	Disorders of Blood	Blood
Cancers & Tumours	Canc	Circulation	Circ	Maternity	Mat
Respiratory System	Resp	Mental Health	MH	Neonates	Neo
Endocrine, Nutritional & Metabolic	End	Dental	Dent	Neurological	Neuro
Genito Urinary System	GU	GI System	Gastro	Healthy Individuals	Hlth
Learning Disabilities	LD	Musculoskeletal	Musc	Social Care Needs	Soc
Adverse effects & poisoning	Pois	Trauma & Injuries	Trauma		

The above chart shows the spend vs. outcomes measure based on the comparison of programme budgeting returns for 2010/11 (based on PCT expenditure for same financial year) compared to the relative outcome measures for the same financial period

Although there is a relative time lag in the data and some relative comparator issues between organisations the information provides a useful guide to relative levels.

6. Quality, Innovation Productivity and Prevention (QIPP)

QIPP (Quality, Innovation, Productivity and Prevention) is a large scale transformational programme for the NHS, involving all NHS staff, clinicians, patients and the voluntary sector. The programme is designed to improve the quality of care the NHS delivers whilst making up to £20billion of efficiency savings by 2014-15, which will be reinvested in frontline care by the system

NHS Wirral Clinical Commissioning Group will need to demonstrate achievement of cost efficiencies against its allocation and will need a robust monitoring system on an on-going basis

Details of the original PCT QIPP plan approved by DH as part of £20 billion national requirements are as per below with the aggregated figure for the Wirral economy being circa £105m over 4 years of the comprehensive spending review period (2011-12 to 2014-15) given the inclusion of tariff efficiency, cash releasing and cost avoidance savings.

	Efficiency built into contracts	PCT action to reduce existing spend	TOTAL
	£000s	£000s	£000s
2011-12	15,591	14,168	29,759
2012-13	15,458	8,812	24,270
2013-14	15,413	10,155	25,568
2014-15	15,295	10,084	25,379
TOTAL	61,757	43,219	104,976

Given the changes to the current healthcare system, CCG's will be held responsible for the majority of the final two years (2013-14 & 2014-15) QIPP delivery and that beyond the current comprehensive spending review period, it is envisaged that the level of QIPP challenge shall increase.

It is reasonable to expect that the Wirral economy (through CCG commissioned budgets and Direct Commissioning from the National Commissioning Board) will need to generate a further £25m of efficiency saving in the 2015/16 financial year (and the last year of this 3 year strategic commissioning plan) an aggregated equivalent of circa £76m over the next 3 years.

The CCG will be required to develop an appropriate QIPP strategy for 2013-14 and future financial periods.

QIPP savings can take the form of either cash releasing savings or cost avoidance (being an economic concept of activity that may have happened if no action had taken place)

NHS Wirral CCG will need to work with its partners to ensure a sustainable QIPP programme and that any cash releasing savings are agreed within contracting negotiations

The below calculation predicts the overall level of QIPP saving required by the CCG in the 3 years of the strategic planning period, given an efficiency saving of 4% on contracts / prescribing and a requirement to achieve the original PCT values in 2013-14 and 2014-15, with an assumption that the CCG will be required to achieve a similar level of savings in 2015-16 (being the 1st year of the new comprehensive spending period)

	2013-14	2014-15	2015-16
Assume Overall Efficiency requirement as per share of PCT value (72.5%)	18.6m	18.4m	18.1m
Less Estimated Tariff Efficiency in Contracts	(12.8m)	(12.8m)	(12.7m)
Less Estimated Prescribing Efficiency	(2.4m)	(2.4m)	(2.4m)
Remaining QIPP	3.4m	3.3m	3.0m
Cash Releasing	(3.1m)	(3.0m)	(2.7m)
Cost Avoidance	(0.3m)	(0.3m)	(0.3m)

Initial Planning discussions regarding delivery of the CCG's QIPP targets have produced a number of detailed plans that will be required to be delivered over the course of the next 3 years in order to achieve financial balance and meeting the requirements of the system in achieving substantial savings

The table below defines the potential areas for savings that will need to be realised based on the CCG's current commissioning plans.

Area	2013/14 Financial year		2014/15 Financial year		2015/16 Financial year	
	Cash Releasing £ Million	Cost Avoidance £ Million	Cash Releasing £ Million	Cost Avoidance £ Million	Cash Releasing £ Million	Cost Avoidance £ Million
Urgent Care	(1.75)	(0.17)	(1.68)	0.00	(0.50)	0.00
Planned Care	(1.30)	(0.10)	(0.93)	(0.05)	(0.60)	(0.08)
Cancer - End of Life	0.00	(0.08)	0.00	(0.05)	0.00	0.00
Procurement	0.00	0.00	(0.30)	0.00	(0.35)	0.00
Contracts	0.00	0.00	(0.10)	0.00	(0.10)	0.00
Unidentified	0.00	0.00	0.00	(0.17)	0.00	(1.41)
	(3.06)	(0.34)	(3.00)	(0.27)	(1.55)	(1.48)
Total Cash Releasing + Cost Avoidance		(3.40)		(3.27)		(3.03)

Each QIPP Scheme will be supported by a number of initiatives to support the delivery of the required changes. These will be a mixture of cash releasing which will impact on contracted activity with providers via an anticipated reduction in activity due to redesign / more effective pathways or cost avoidance by preventing activity that would have happened if no changes had taken place

A summary of the overarching proposals are as follows and are supported by the CCG's Clinical Strategy Group and supporting QIPP teams with system wide engagement with other stakeholders

Urgent Care
Urgent Care (often unplanned) activity provides one of the greatest risks to the CCG in terms of its ability to deliver its required financial responsibilities. QIPP Delivery in this area is crucial and revolves around a number of key projects to prevent unnecessary and avoidable admissions, ensure patients are accessing the most appropriate services in line with their needs and facilitating discharge in most effective manner to ensure patient flow through the system

Planned Care
Planned Care is structured around two key areas of Planned Medical and Surgical Work streams. The QIPP initiatives in support of the planned care agenda include a number of service redesign projects with the objective of bringing care closer to the patient's home with more services being provided in the community. An essential part of the QIPP approach in Planned Care is improving the pathways for patients with long term conditions and reducing unnecessary steps within the surgical pathway for an improved patient experience.

Cancer and End of Life Care
The Cancer QIPP work stream is focused on improving patient pathways and outcomes for this cohort of patients, in particular improving standards of care across primary care and nursing / care homes, reducing the requirements for hospital admissions at the end of life stage

Procurement
Through its commissioned services, the CCG will hold a number of healthcare contracts and it is anticipated that a level of QIPP savings can be achieved through increased efficiency in these contract volumes and values. In particular savings would be achieved through an improvement in the approach to purchasing of intermediate / rapid access beds which will be supported by improved pathway across planned and unplanned care workstreams and joint working between all the relevant stakeholders

Contracts
Potential QIPP Savings have been identified across a range of contract areas, in particular it is anticipated that a review of existing block contract areas and a move towards activity based pathway systems will release further savings

Unidentified
There remains an element of unidentified QIPP schemes at this point in the planning cycle, these will need to be identified as soon as possible in order to realise the required QIPP Savings

Quality Premium

Clinical Commissioning Groups can receive additional non recurrent resources in 2014-15 subject to achieving high standards of quality in five measures (as set out in the NHS Outcomes Framework) in 2013-14. The measures are:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people is a safe environment and protecting them from avoidable
- harm.

The Quality Premium will also include three locally identified measures as identified within the Health & Well Being Strategy. The local measures we will be monitoring are

- Emergency readmissions within 30 days of discharge from hospital (specifically for the elderly population)
- Number of people attending Accident and Emergency Department with alcohol related conditions
- Enhancing quality of life for people with dementia

Payment of the Quality Premium will also be dependent upon achieving NHS Constitution and the rights and pledges.

7. Partnership Working

Successful collaboration with NHS and Local Authority colleagues, other statutory agencies and the independent and voluntary sector is recognised as crucial in developing and delivering our strategy.

System Engagement will include:

• Patient and public engagement
• Member Practice Engagement
• Provider Engagement

An engagement structure (the CCG Communications and Engagement Strategy) has been established which ensures that key stakeholders, including patients and clinicians, have the opportunity to shape commissioning intentions.

We will continue to develop relationships with the Local Authority (Adult Care, Children's services, Public Health, Housing, Environmental Health etc).

Collaboration with service providers will be essential in supporting service re-design and QIPP projects.

Provider services will be monitored through formal contract monitoring and performance review. However in taking the local health services through a period of reform and service transformation we will not ignore the need for provider stability. Through all our change programmes there will be a focus on patient safety and service quality and provider engagement.

Our core business support and intelligence will be provided by the CSU on a contract arrangement.

We respect the contribution that all Clinicians can make. Our strategic plans and commissioning programmes and projects will:

- Be clinically driven
- Ensure clinician to clinician engagement
- Reflect best clinical practice
- Promote the development of clinical networks.

Appendix 3 describes the progress thus far in terms of engaging clinicians in the commissioning and service review process.

A number of services can be best commissioned on a wider footprint than Wirral and we will work with other CCGs in support of collaborative commissioning and in developing Specialist Commissioned services.

Patient and public involvement will be embedded as a constant in all our planning and service development proposals.

8. Strategic Priorities

Although a new organisation, we are not a static organisation. We have not ignored the positives of the past and we have ensured that a number of initiatives have been brought to completion in our short journey thus far. Our recent achievements include:

- Continued Implementation and Mainstreaming of NHS Wirral (Primary Care Trust) Strategic Plan
- Key Clinicians providing stability during organisational transition and remaining part of CCG Leadership team
- Three successful applications for Pathfinder CCGs on Wirral
- Response to patient feedback with regards to poorly performing services leading to
- service redesign / re-procurement to improvement patient care
- Maintaining financial balance through a period of investment and disinvestment to
- develop the healthcare market, diversify provision and driving performance improvement.

Our strategic challenges are:

- To halt and reverse the increasing gap in health inequalities across specific health issues and communities.
- To design and commission high quality healthcare services for the elderly and ageing population.
- To enable fair and equal access to all services for all communities.
- To shift high quality care closer to home from acute to community settings

As indicated our Strategic Objectives are to:

a) Prevent people from dying prematurely

- By decreasing the potential years of life lost from causes considered amendable to healthcare
- By decreasing the under 75 mortality rate from cancer, cardiovascular, respiratory and liver disease

b) Enhance the quality of life for people with long term conditions

- By increasing the health-related quality of life for people with long term condition
- By increasing the proportion of people feeling supported to manage their conditions
- By reducing the unplanned hospitalisation for chronic ambulatory care conditions in adults and for asthma, diabetes and epilepsy in under 19's
- By increasing the estimated diagnosis rate for people with dementia

c) Helping people to recover from episodes of ill health or following injury

- By reducing the number of emergency admissions for acute conditions that should not usually require hospital admission
- By reducing the number of emergency readmissions within 30 days of discharge from hospital
- By increasing the total health gain as assessed by patients for both hip and knee replacements, Groin Hernia and varicose veins
- By reducing the number of emergency admissions for children with Lower Respiratory Tract Infections

d) Ensuring people have a positive experience of care

- By increasing the patient experience of primary (GP and Out of Hours) and hospital care
- By improving the findings of the Friends & Family Test for all relevant commissioned services

e) Ensuring people are treated and cared for in safe environment and protected from avoidable harm

- By reducing the incidence of healthcare associated infections in MRSA and C. Difficile

In order to improve services and deliver improvements in these outcomes we have developed 11 strategic priorities which we believe will have the biggest impact on the future health and wellbeing of Wirral residents and support the strategic objectives of the organisation.

These are:

8.1 Delivering High Quality Planned Care (including services for Older People)
8.2 Managing Urgent Care (including unplanned admissions and attendances and services for Older People)
8.3 Adult Mental Health services (Including Learning Disability Services)
8.4 Children's and Adolescent Mental Health Services (Including Learning Disability Services)
8.5 Dementia
8.6 Effective Medicines Management
8.7 Improving Access to Community services
8.8 Management of Long Term Conditions and Chronic Disease Management
8.9 Improving Cancer and End of Life care
8.10 Women's and Children's Services
8.11 Improving primary care services at practice level

These strategic priorities are described in more detail in the following pages.

They are not in priority order.
Each is equally important.
All are inter-dependent.

These strategic priorities take account of local needs but also relate to and support the 5 key domains under the Outcomes Framework.

The table below outlines how the 11 strategic priorities map to the objectives (which are in line with the NHS Outcomes Framework for 2013 -14). Each strategic priority will be more fully described in detailed Programme and Project plans describing their impact, specific goals and their relationship with National and local outcome indicators (as illustrated). They will specify current baselines, map initiatives to measures, forecast impact and be monitored using a developed performance management framework.

	Priorities	*Outcomes Framework Domain*				
		Domain 1 Prevention	Domain 2 Quality LTC	Domain 3 Recovery	Domain 4 Experience	Domain 5 Safety
8.1	Delivering High Quality Planned Care (including services for Older People)	✓		✓	✓	✓
8.2	Managing Urgent Care (including unplanned admissions and attendances and services fro Older People).			✓	✓	✓
8.3	Adult Mental Health services	✓	✓		✓	✓
8.4	Children's and Adolescent Mental Health Services	✓	✓		✓	✓
8.5	Dementia		✓		✓	✓
8.6	Effective Medicines Management		✓			✓
8.7	Improving Access to Community services. Commissioning services closer to home.		✓	✓	✓	
8.8	Management of Long Term Conditions and Chronic Disease Management	✓	✓	✓		✓
8.9	Improving Cancer & End of Life care				✓	✓
8.10	Women's and Children's Services	✓	✓	✓	✓	✓
8.11	Improving primary care services at practice level.				✓	

For each we have set out:

- Our Vision
- The key programmes and projects within each strategic priority
- Specific Programme targets
- Their strategic impact in relation to local and National priorities

Full delivery of these strategies will improve service quality and levels provided to service users. They will guarantee a very different service in the future. They will require some difficult decisions which may not be universally accepted. They do assume resource re-profiling.
Given the significance of the latter we have set out below, in summary, the key planned investments and disinvestments over the period of this plan. We have first summarised our full plan on one page. This is followed by detail for each strategic objective.

Wirral Clinical Commissioning Group – Strategic Plan on Page 2013-2016
"Your Partner in a Healthier Future for All"

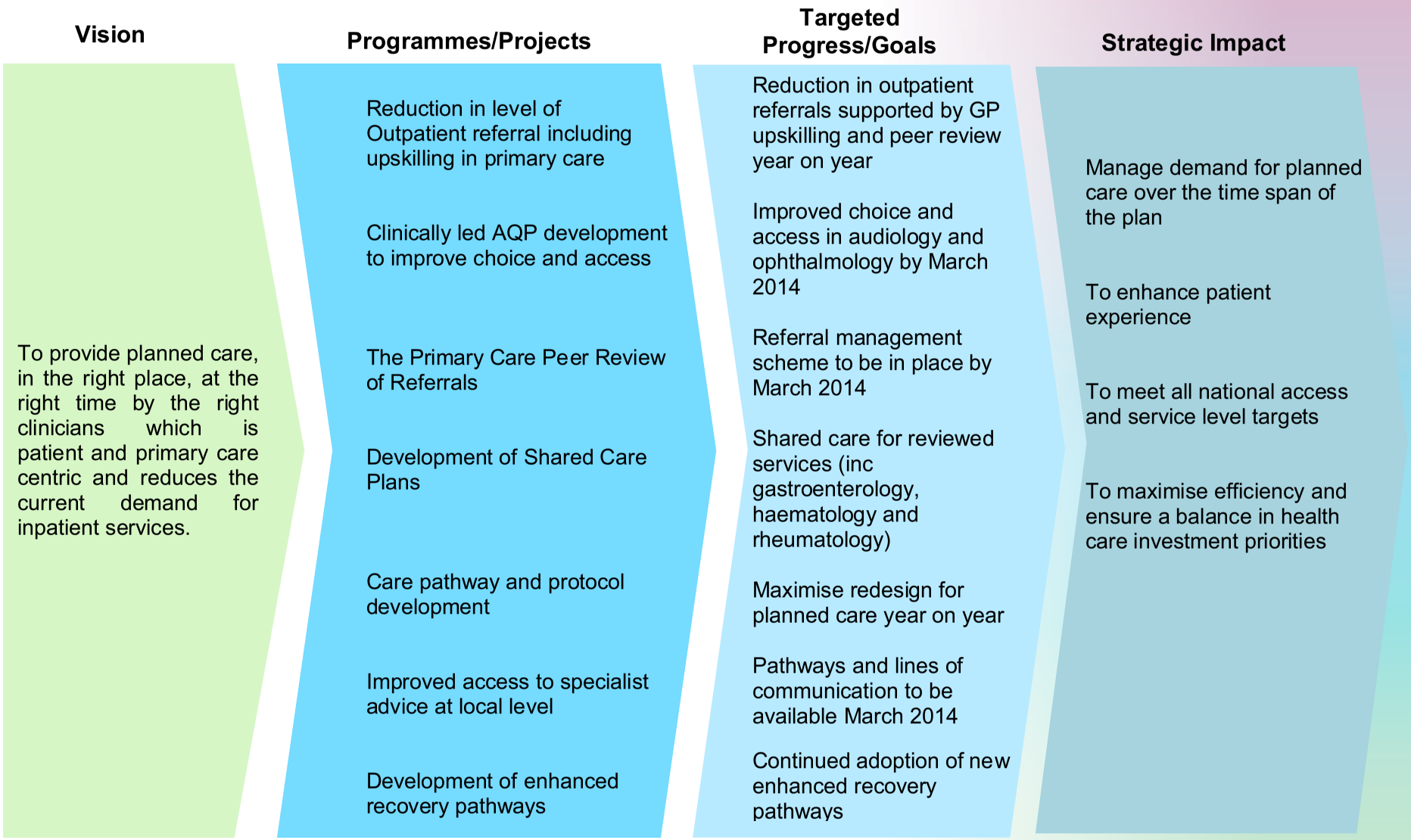
Wirral Clinical Commissioning Group

CCG Vision:	Better Health, Valuing People; Innovation; Working Together; Quality; Integrated services
CCG Values and Principles:	Improving Health. Improving life expectancy. Targeting Inequality. Effective Governance. Empowered Clinicians. Delivery through Partnership. Person Centred Care
Strategic Context:	Resident population of 330,000 people. One CCG with three strong Localities. CCG budget £465m (2013-14)
Strategic Challenges:	Ageing population (75+). High rate of emergency admissions. QIPP Efficiency programme (£25m). System Reform. Deprivation and Lifestyle behaviours; Resource availability.

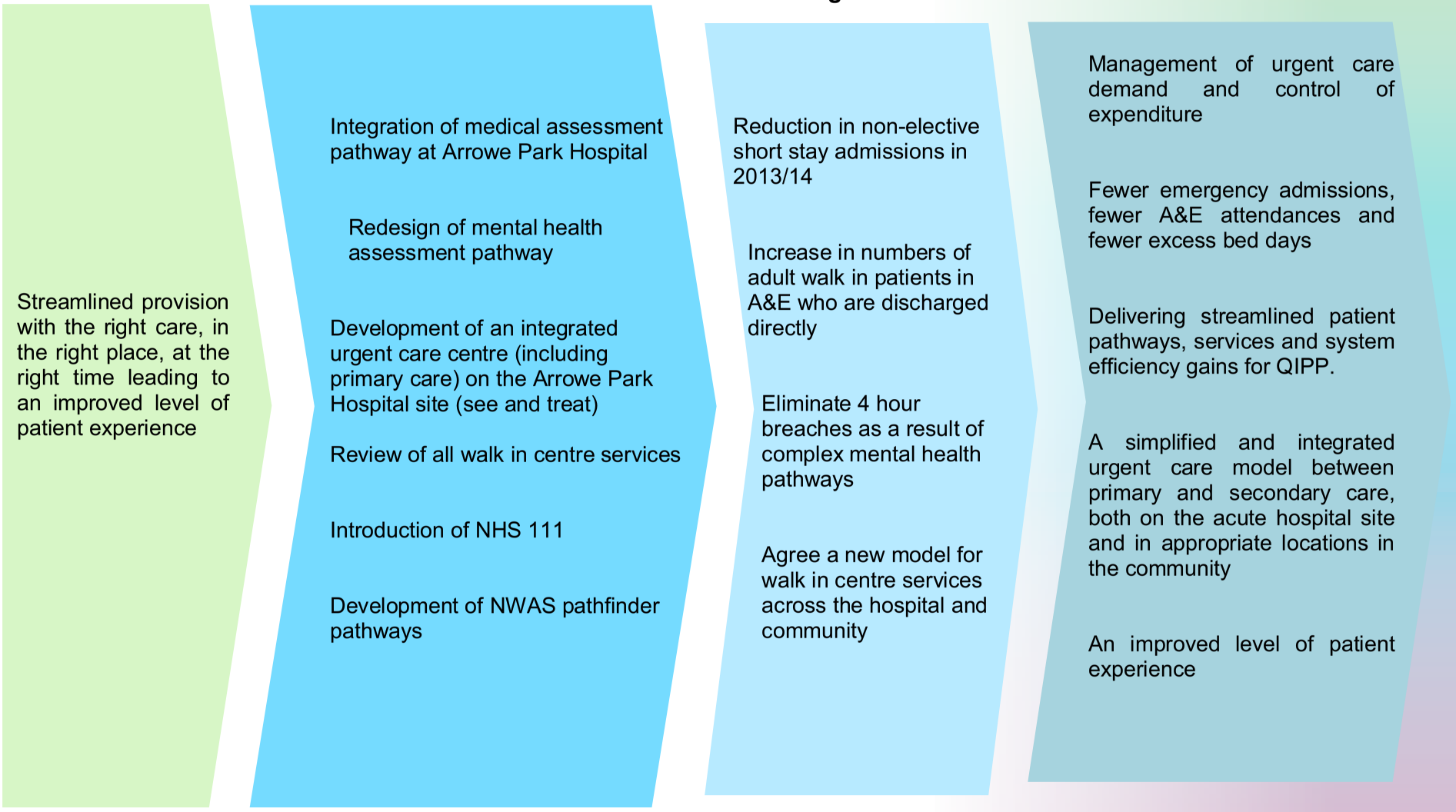
Strategic Objectives	Ambition/Outcomes (in terms of patient safety, quality and performance improvement)	Transformational Change Programmes/Projects/Initiatives/Workstreams	Link to Local Priority	Link to National Outcome Framework
1. Prevent people from dying prematurely	• By decreasing the potential years of life lost from causes considered amendable to healthcare • By decreasing the under 75 mortality rate from cancer, cardiovascular, respiratory and liver disease	Delivering High Quality Planned Care (including services for Older People)	Ageing Population	2,3,4,5
		Managing Urgent Care (including unplanned admissions and attendances and services for Older People).	Alcohol Ageing Population Mental Health	1,3,4
2. Enhance the quality of life for people with long term conditions	• By increasing the health-related quality of life for people with long term condition • By increasing the proportion of people feeling supported to manage their conditions • By reducing the unplanned hospitalisation for chronic ambulatory care conditions in adults and for asthma, diabetes and epilepsy in under 19's • By increasing the estimated diagnosis rate for people with dementia	Adult Mental Health Services (including Learning Disability Services)	Mental Health	1,2,4
		Children's and Adolescent Mental Health Services (including Learning Disability Services)	Mental Health	1,2,4,5
		Dementia	Mental Health	1,2,3,4,5
3. Helping people to recover from episodes of ill health or following injury	• By reducing the number of emergency admissions for acute conditions that should not usually require hospital admission • By reducing the number of emergency readmissions within 30 days of discharge from hospital • By increasing the total health gain as assessed by patients for both hip and knee replacements, groin hernia and varicose veins • By reducing the number of emergency admissions for children with Lower Respiratory Tract Infections	Effective Medicines Management	Mental Health Ageing Population	2,4
		Improving Access to Community services. Commissioning services closer to home.	Mental Health Ageing Population	1,2,3,4
		Management of Long Term Conditions and Chronic Disease Management	Ageing Population	1,2,3,4,5
4. Ensuring people have a positive experience of care	• By increasing the patient experience of primary (GP and Out of Hours) and hospital care • By improving the findings of the Friends & Family Test for all relevant commissioned services	Improving Cancer & End of Life care	Ageing Population	2,4,5
		Women's and Children's Services	Poverty	1,3,4,5
5. Ensuring people are treated and cared for in safe environment and protected from avoidable harm	• By reducing the incidence of healthcare associated infections in MRSA and C. Difficile	Improving primary care services at practice level.	Mental Health Ageing Population	1,2,3,4

Cross cutting themes: Health Inequality and Prevention; Supporting QIPP; Practice Ownership of Commissioning Agenda; Patient and Public Involvement; Effective Clinical leadership; Information and technology; Estates Strategy; Pathway Redesign; Value for Money and Efficiency;

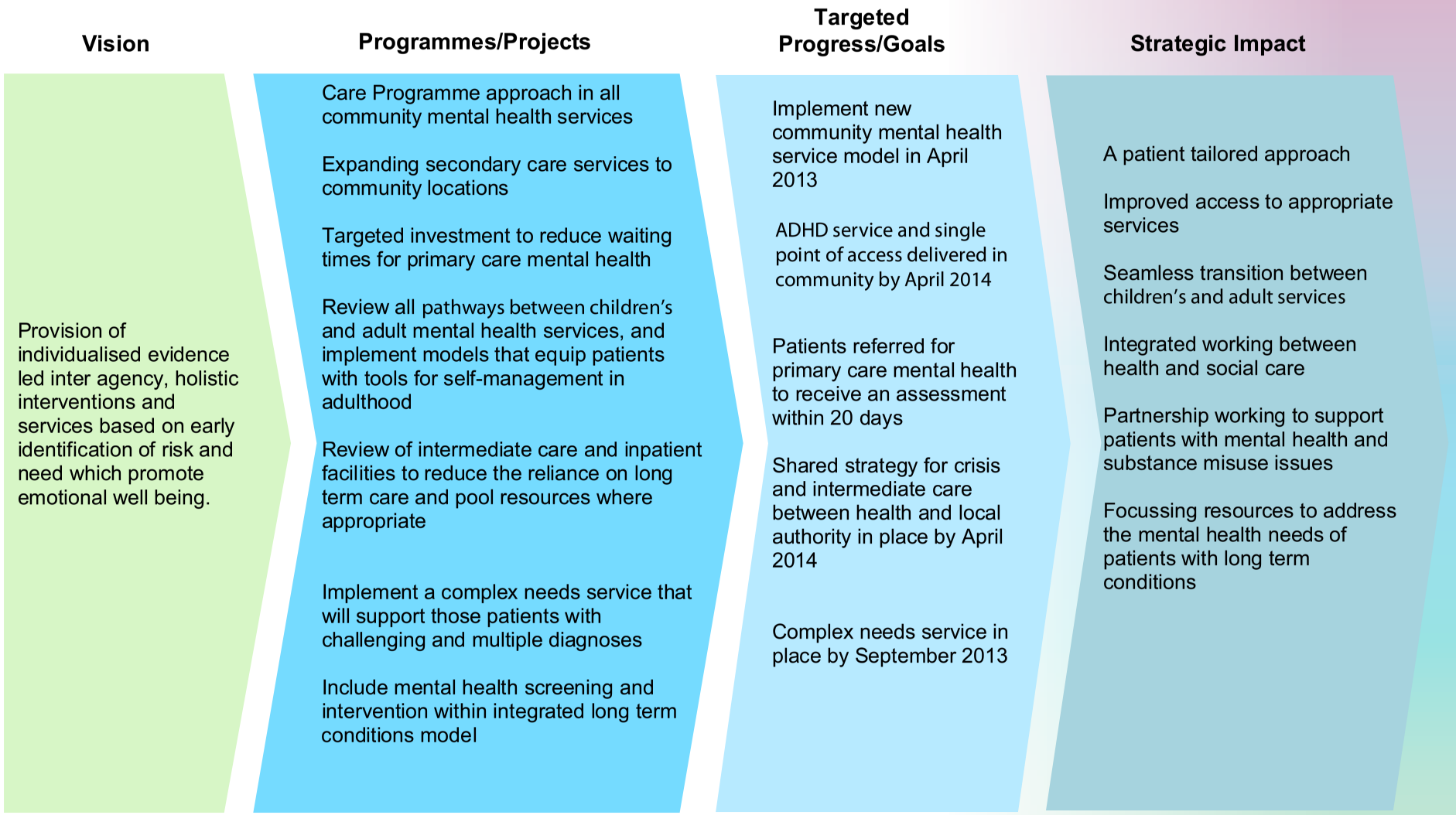
Strategic Priority 8.1: Delivering High Quality Planned Care (including services for Older People)



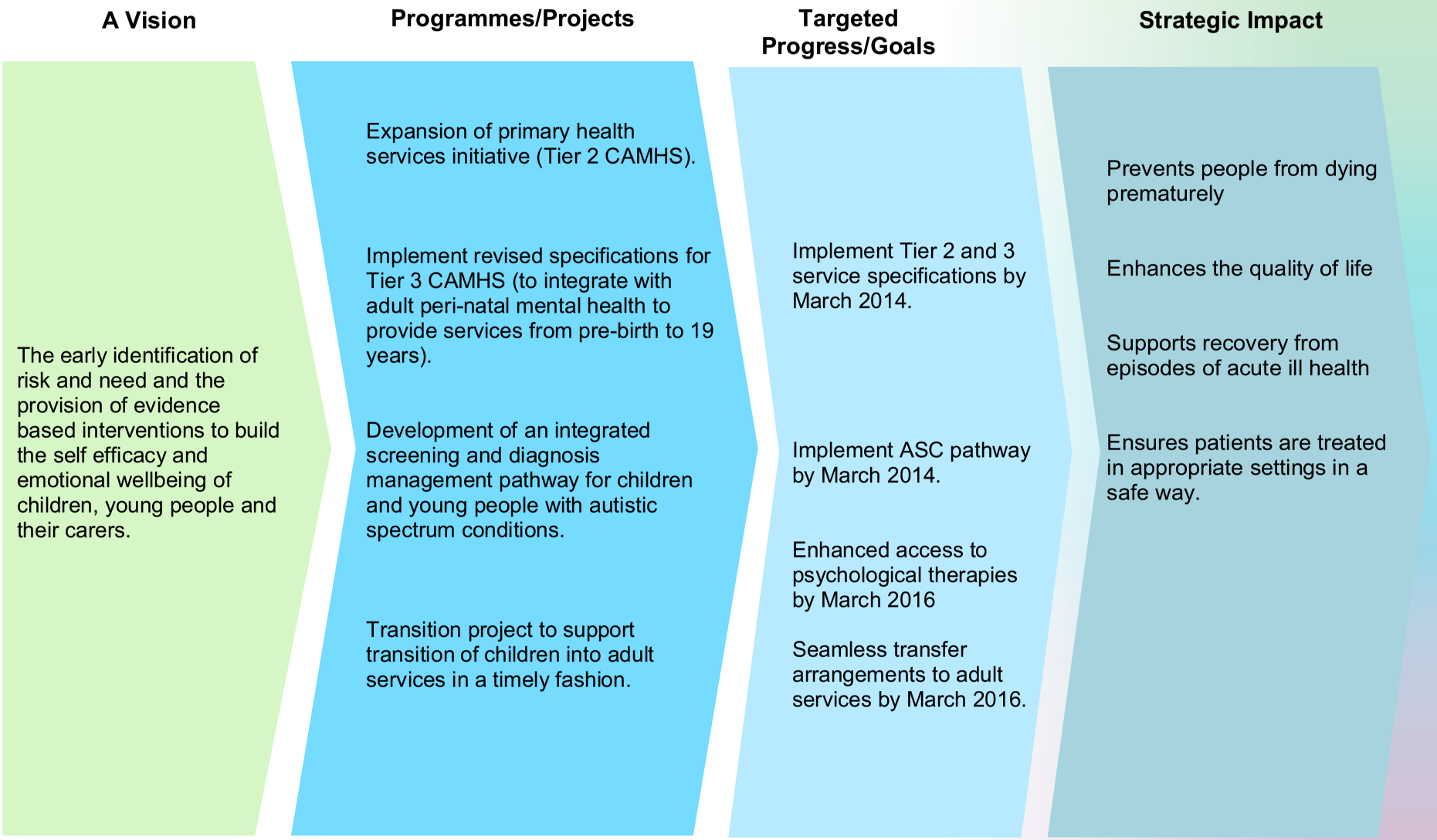
Strategic Priority 8.2: Managing Urgent Care (including services for Older People)



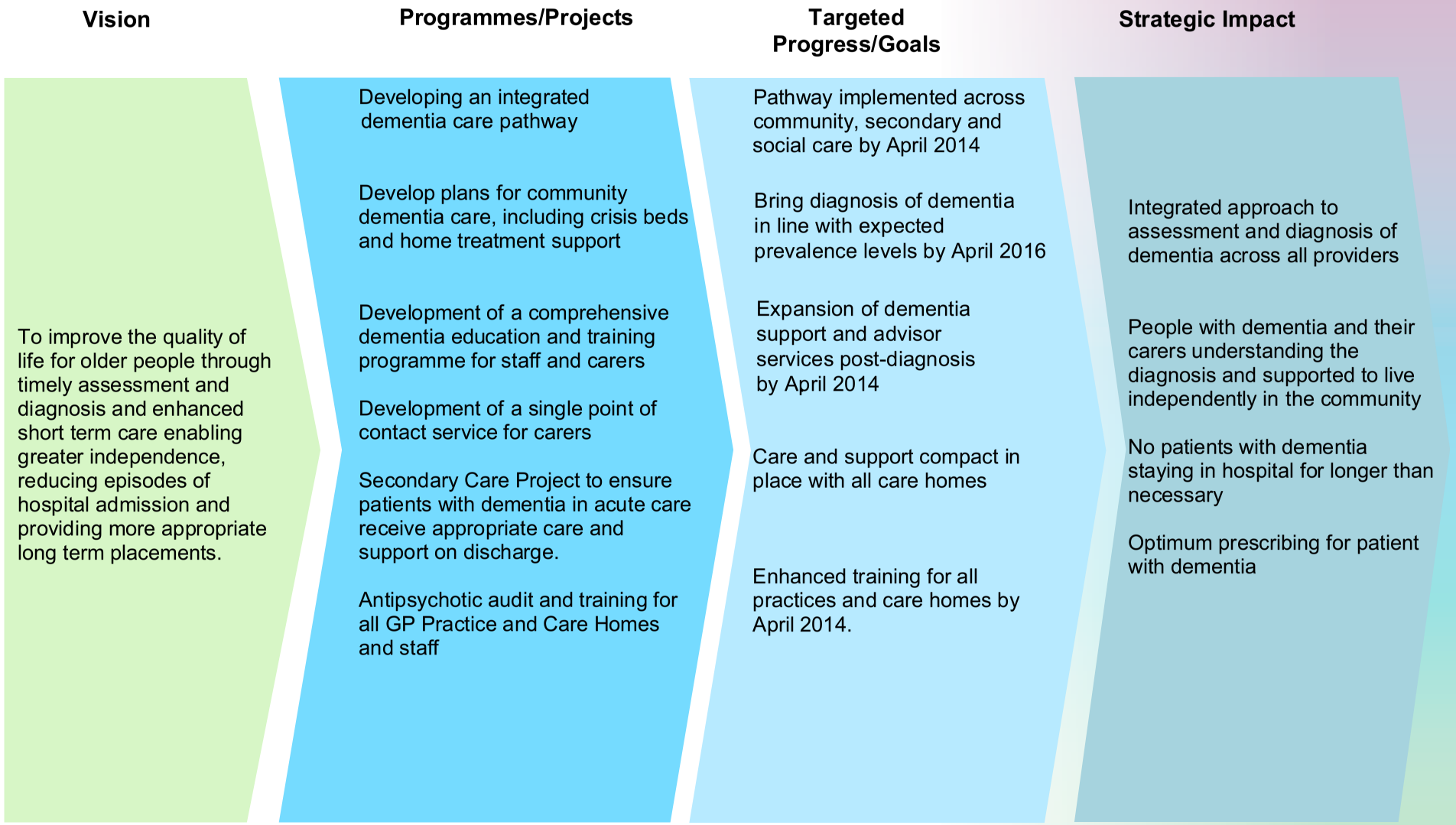
Strategic Priority 8.3: Adult Mental Health Services



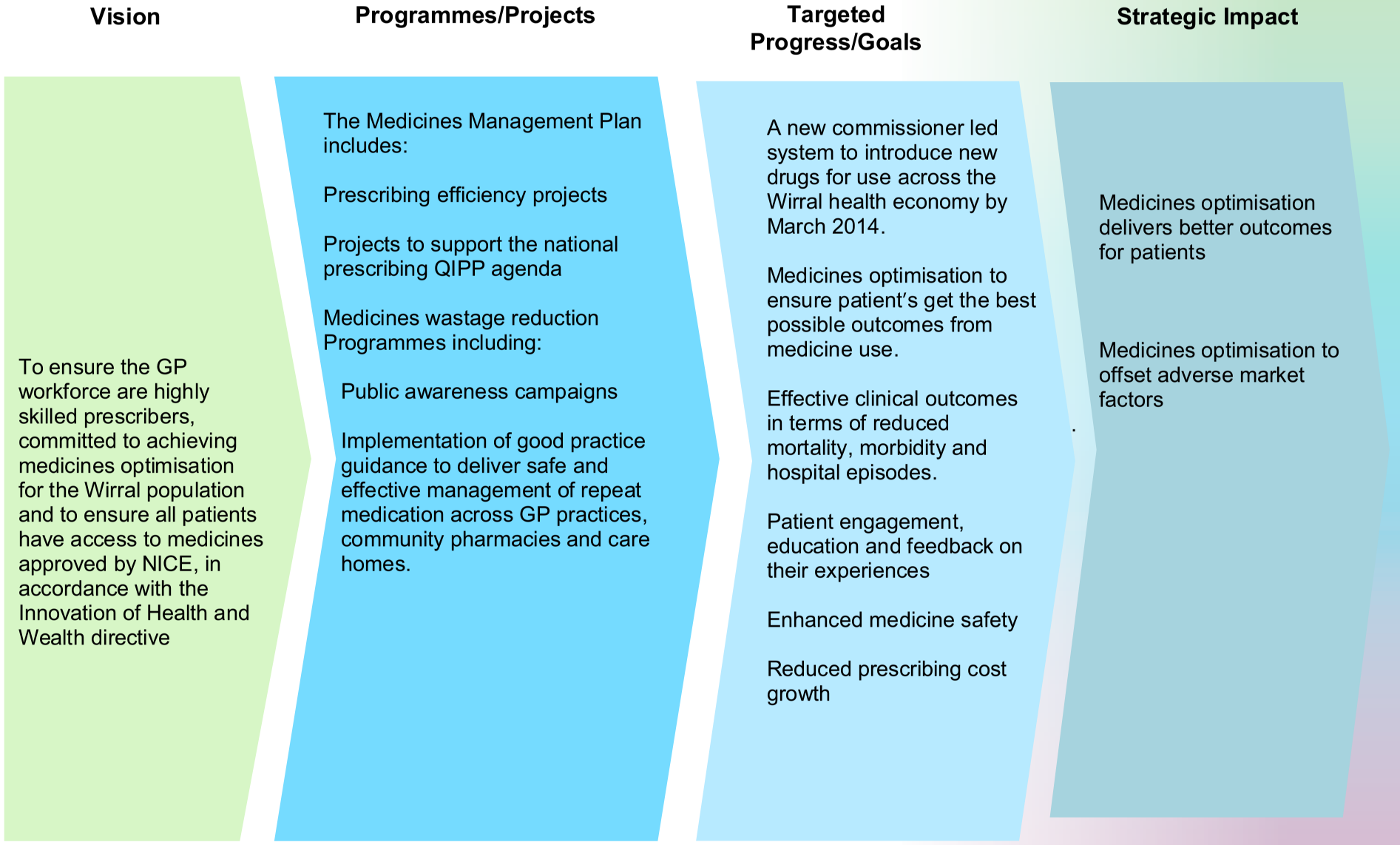
Strategic Priority 8.4: Children's and Adolescent Mental Health Services



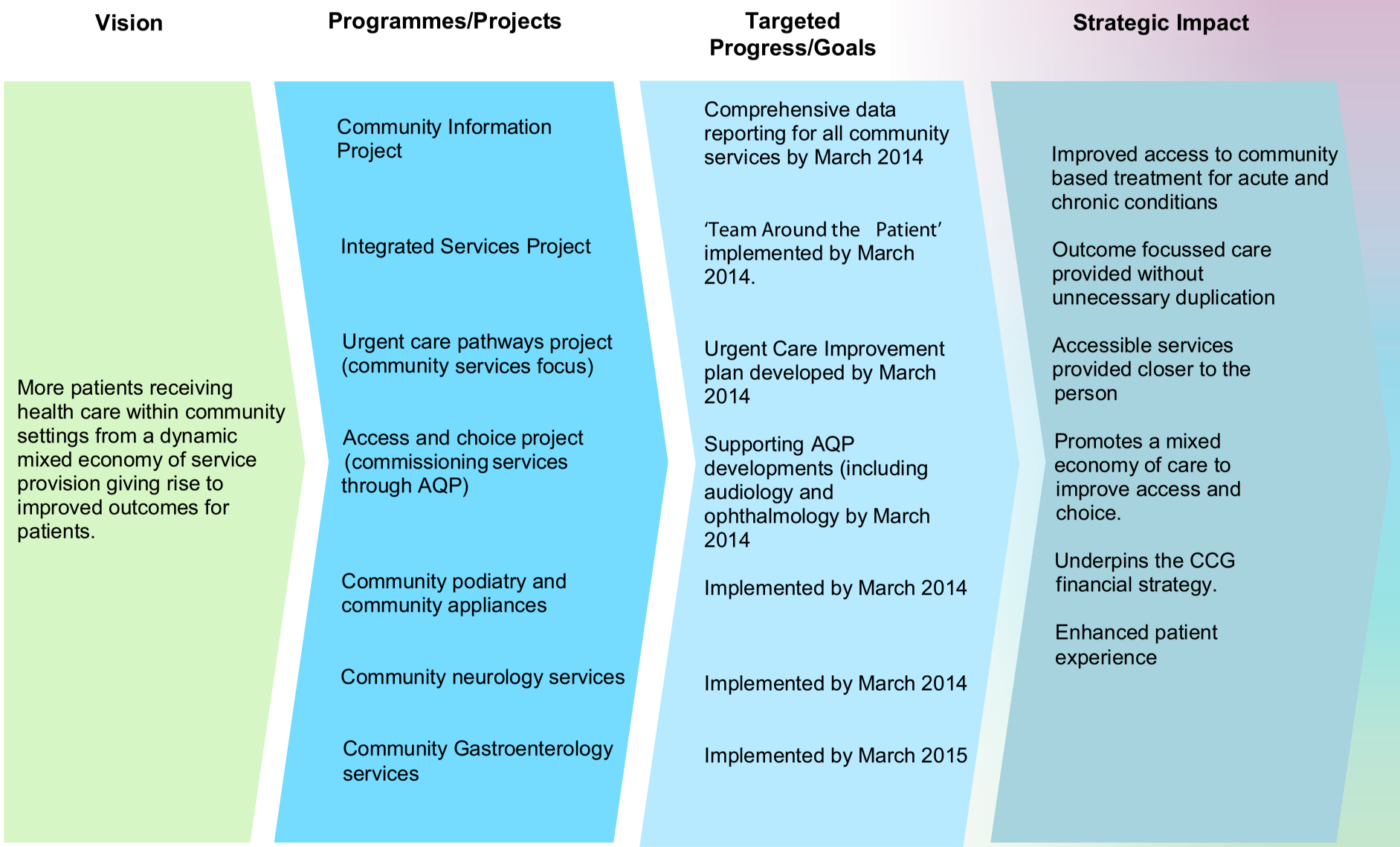
Strategic Priority 8.5: Dementia



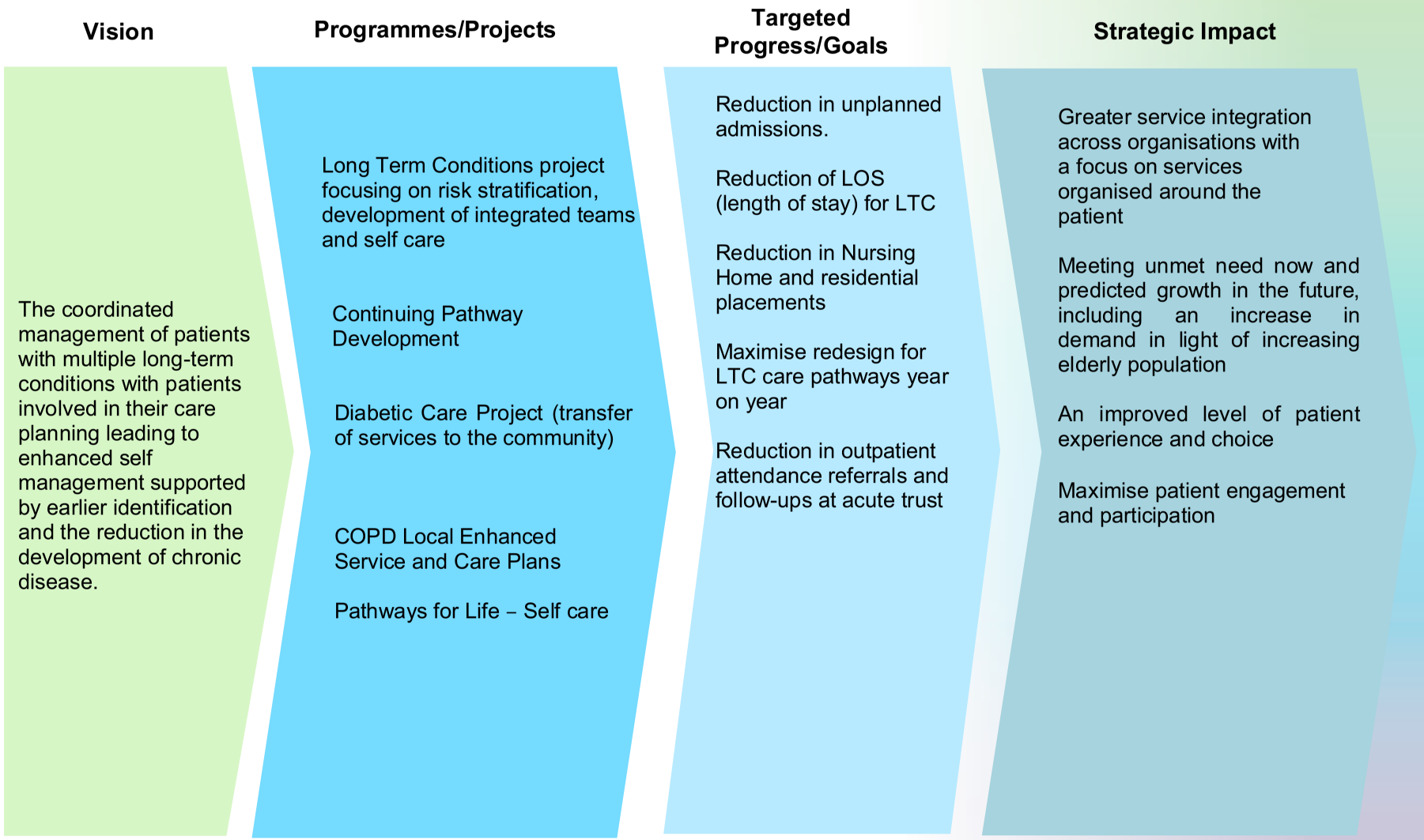
Strategic Priority 8.6: Effective Medicines Management



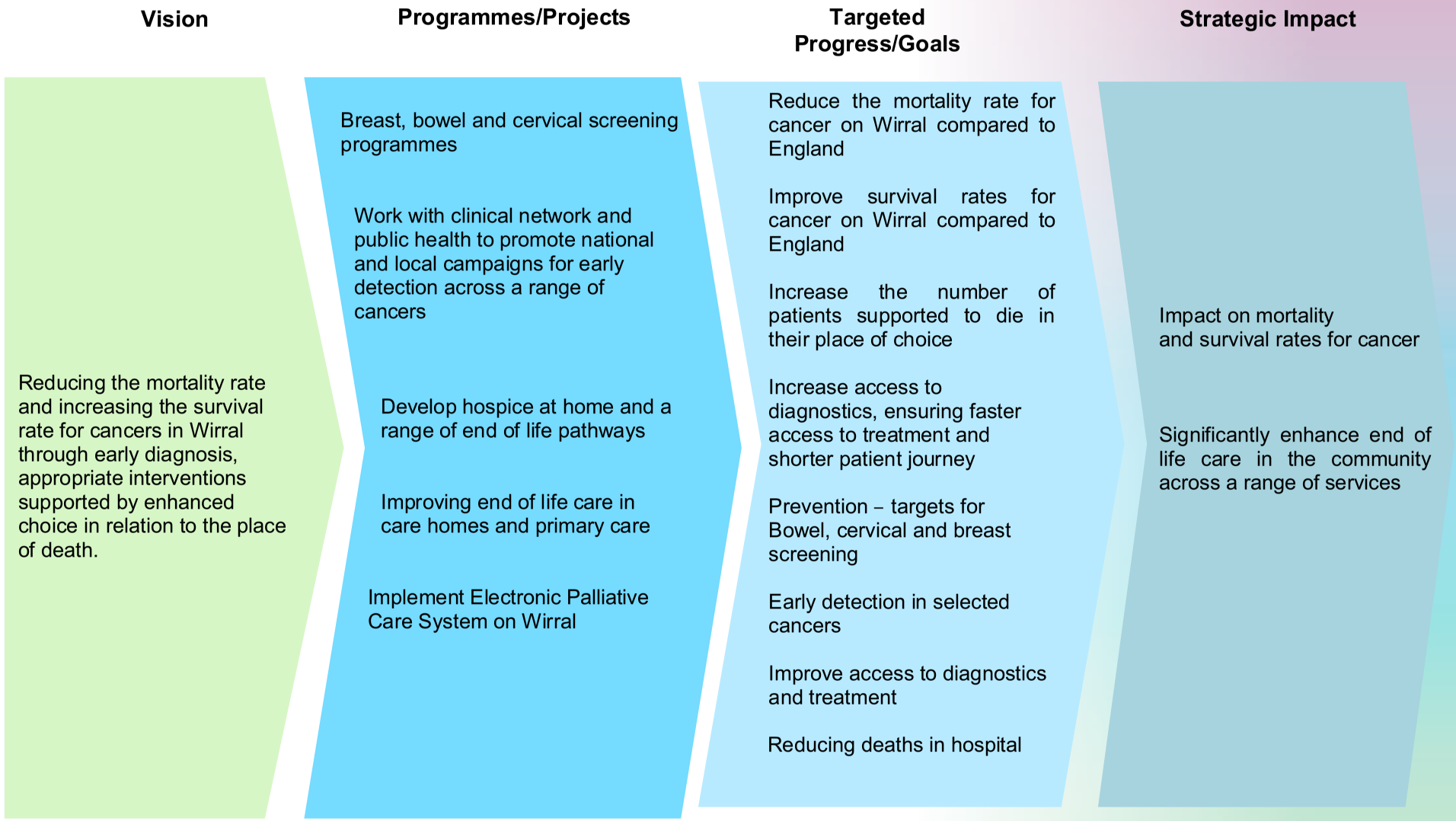
Strategic Priority 8.7: Improving Community Services



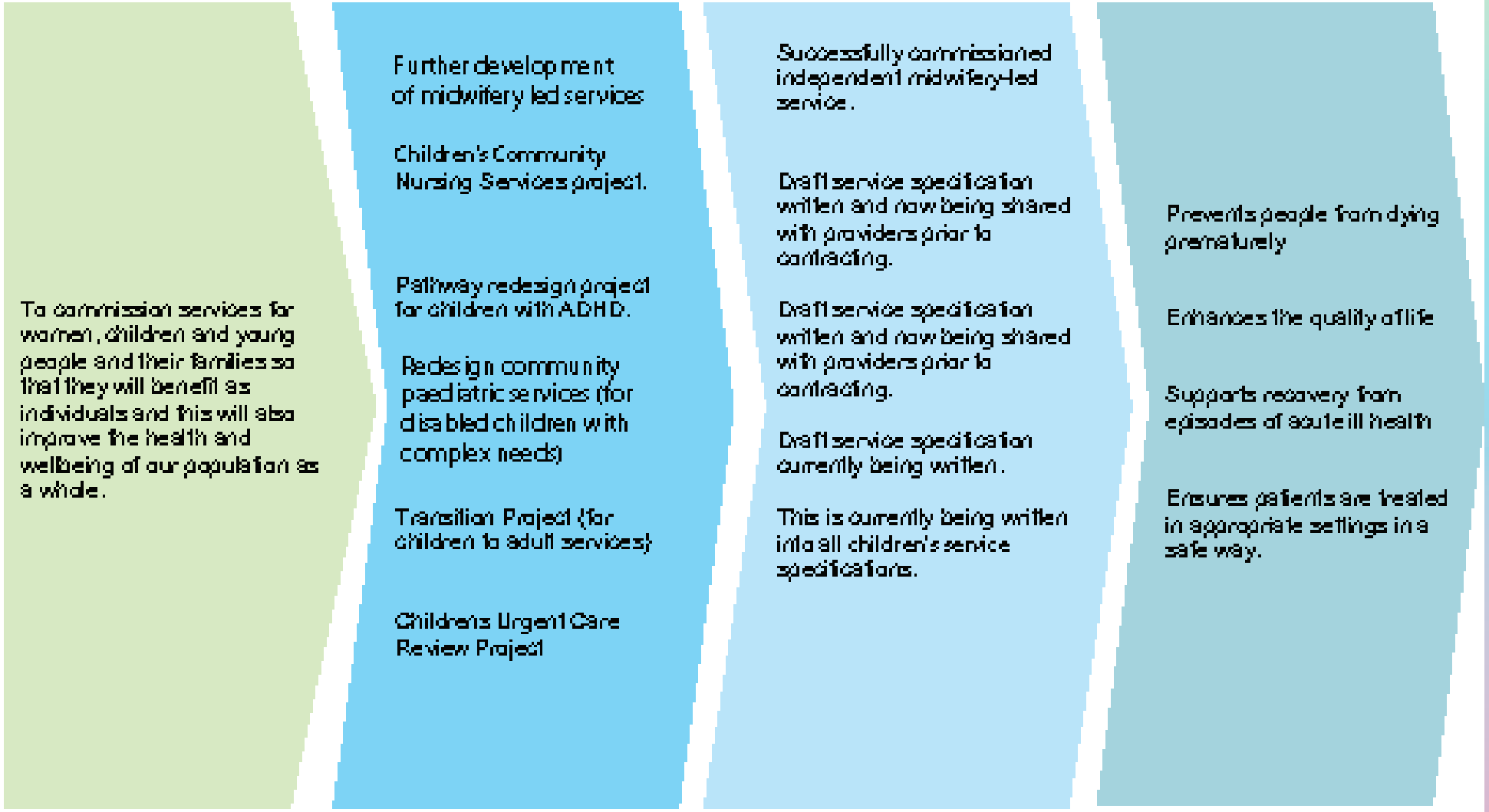
Strategic Priority 8.8: Long Term Conditions and Chronic Disease Management



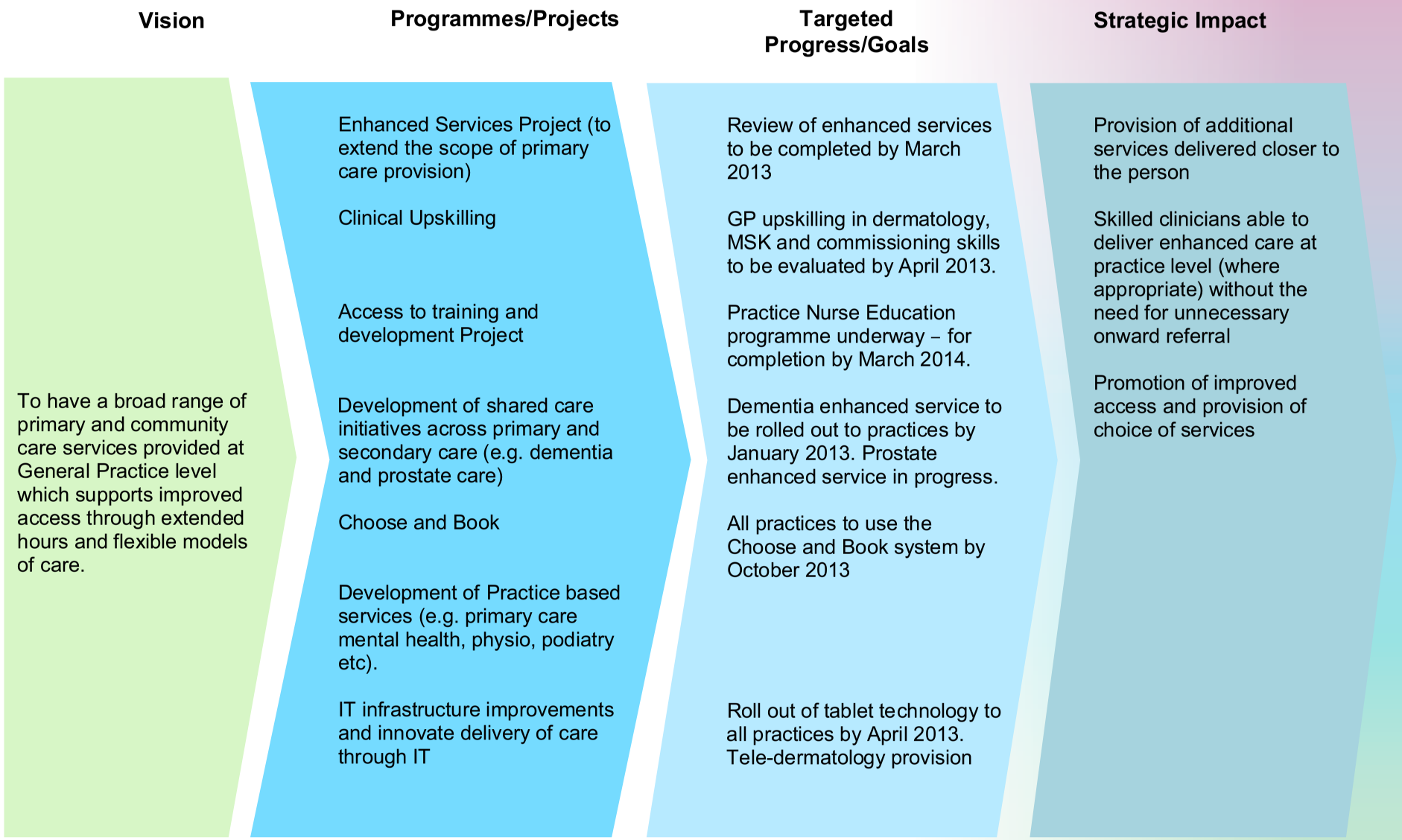
Strategic Priority:8.9 Improving Cancer Services and End of Life Care



Strategic Priority 8.10: Women's and Children's Services



Strategic Priority 8.11: Improving Primary Care Services at Practice Level



9. Strategic Delivery

- Continuity with the past and the stability this brings is not to be ignored. However Wirral CCG is a new organisation. It is and will operate in a different way from predecessor organisations. Its foundation stone is clinical leadership. GP Practices in close association with professional and lay colleagues will shape and commission future health care services. They will also be responsible for delivering best possible outcomes for the local population.

- A formal constitution has been agreed and will be effective from April 2013.

- Real partnership with local clinicians in secondary and primary care, local people and partner agencies will be critical in delivering transformed services.

- Delivery of our strategy will be achieved through clear responsibilities and accountability described in our new organisational structure.

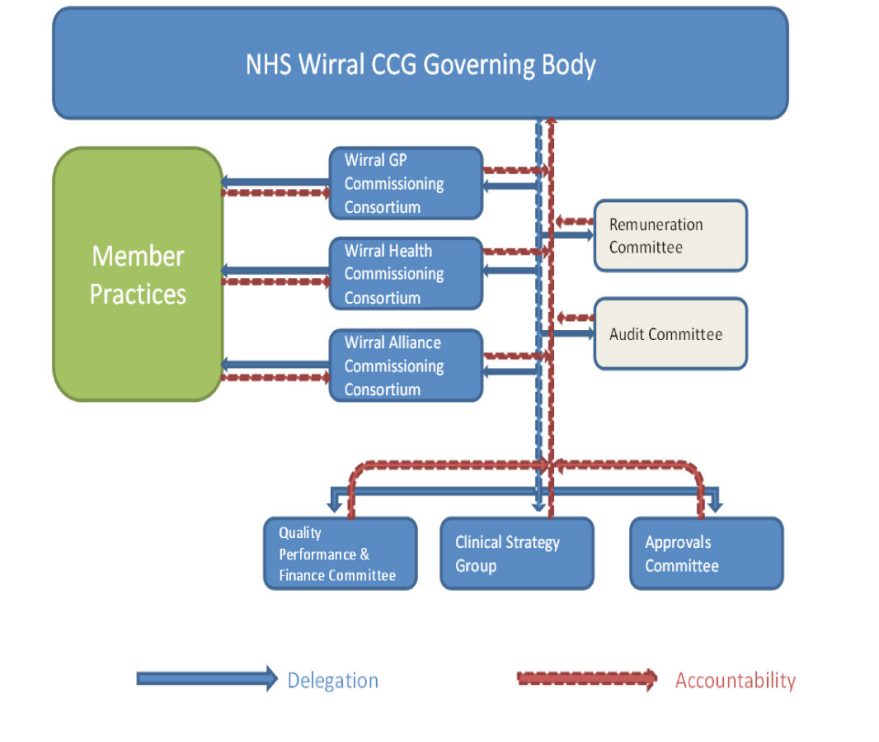
- Delivery will require articulation of the 11 strategic priorities into a series of programmes and projects with a designated clinical and managerial lead for each.

- A robust approach to performance and risk management will underpin Strategic Delivery.

- As part of our culture of innovation and continuous development and improvement we will develop a Strategic Plan Evaluation Framework.

9.1 Structures

- The Wirral CCG structure is represented in the following diagram.



9.2 Roles

- The **Governing Body** of the CCG will be accountable for exercising its statutory functions. In relation to Strategic Implementation it will:

- Set the organisational framework for strategic implementation
- Set strategic priorities
- Oversee delivery of the Strategic Plan through an annual high level Operating Plan.
- Review overall progress and performance at each monthly Board meeting
- Commission recovery plans where necessary
- Monitor the quality and safety of services commissioned by the CCG. This includes working with regulators of healthcare and receiving reports directly from the public and patients
- Hold accountable those individulas or organisations that provide healthcare services and ensure that the public is protected from avoidable harm

- A number of sub committees have been established. In relation to Strategic Delivery: operational delivery of the strategic plan will be monitored by the **Quality, Performance and Finance Sub Committee** on behalf of the Governing Body.

- "Day to day" monitoring and delivery will be led by **Strategic Implementation/QIPP Clinical Engagement Groups**

9.3 **Strategic Implementation Groups**

Wirral CCG has established a number of QIPP Clinical Engagement Groups.

- These groups will be responsible for implementing the CCG Strategic priorities.
- They will operate as clinical strategic implementation groups.
- Each group will report to the CSG through a designated clinical lead.
- They will have clear accountability for the successful implementation of each strategic priority, for patient experience, quality and safety.
- These groups will develop service specific programme and project plans supported by timetabled action plans.

9.4 Delivering through Contracts

- The CCG will commission services for the population of Wirral through a broad range of contracts with diverse service providers.
- Appendix 1 sets out the Wirral CCG contract portfolio for all major contracts.
- A contracting strategy is currently under development. This strategy will set out in detail the CCG contract management and monitoring arrangements.
- All contractors will be required to submit performance management information consistent with the standard terms of the DH contract.
- Contracts will specify national access targets and expected rights and pledges of the NHS constitution (2013-14).

9.5 Assurance of delivery

Each clinical & management lead will be accountable for delivery of agreed strategic plans for their specific service area. They will report monthly to the CSG on

- Performance against key performance indicators
- Delivery against key milestones
- Areas of underperformance and mitigating actions
- Key risks

Performance against project milestones and outcome framework indicators will be monitored as appropriate through the Quality Performance and Finance Committee.

9.6 Risk Management

The CCG has developed systems in place to identify and manage all key risks to ensure delivery of key national and local priorities.

9.7 Supporting Delivery

The CCG recognises its responsibilities to the public of Wirral and colleague organisations. Delivery will be complemented by:

- Public engagement,
- Practice engagement
- System Engagement and collaborative working
- Organisational and leadership development to support delivery

We will engage actively with colleague CCGs, social care partners, patients, staff and the public through our SIG/QIPP groups. We will engage with local Providers at specific issue quarterly meetings as well as through the routine contract and performance monitoring processes.

Appendix 1 NHS Wirral Contract Portfolio

Provider Name	Approximate Contract value
Major NHS Providers (in excess of £1m)	
Wirral Hospital NHS Trust	£208m
Wirral NHS Community Trust	£44m
Cheshire and Wirral Partnership Trust	£34m
North West Ambulance Service	£9m
Royal Liverpool University NHS Trust	£7m
Aintree NHS FT	£3m
Countess of Chester NHS FT	£2m
Liverpool Women's NHS FT	£2m
Independent / Non NHS Providers	
Spire (Murrayfield)	£3m
St. John's Hospice	£1.6m
Independent Midwifery	£1m
Spa Medica	£0.5m
Claire House	£0.2m
Hoylake Cottage Hospital	£0.2m
Assura	£0.2m

Appendix 2 The National Picture

1. NHS White Paper and Health and Social Care Bill

The NHS White Paper 'Equity and Excellence: Liberating the NHS' sets out a vision for the NHS that is built around patients, places clinicians at the heart of decision-making, and sees responsibility for healthcare budgets shift from Strategic Health Authorities and Primary Care Trusts, to Clinical Commissioning Groups. The Health and Social Care Bill makes provision for delivery of the five key objectives within the White Paper:

- strengthening commissioning of NHS services
- increasing democratic accountability and public voice
- liberating provision of NHS services
- strengthening public health services
- reforming health and care arm's-length bodies

Emergent CCGs are currently preparing to undergo a period of authorisation, during which the extent to which they prepare to take on full commissioning responsibility for their patient population will be tested, across six domains (Developing Clinical Commissioning Groups: towards authorisation):

- A **strong clinical and professional focus** which brings real added value;
- **Meaningful engagement** with patients, carers and their communities;
- **Clear and credible plans** which continue to deliver the **QIPP** (quality, innovation, productivity and prevention) challenge within financial resources, in line with national outcome standards and local joint health and wellbeing strategies;
- **Proper constitutional and governance arrangements**, with the capacity and capability to deliver all their duties and responsibilities including financial control as well as effectively commission all the services for which they are responsible;
- **Collaborative arrangements for commissioning** with other CCGs, local authorities and the NHS Commissioning Board as well as the appropriate external commissioning support; and
- **Great leaders** who individually and collectively can make a real difference.

Wirral CCG will only be able to pass through this authorisation process with the collaboration of its constituent divisions. The Divisions are supported through this period of transformation by the overarching PCT Cluster: Cheshire, Warrington and Wirral, which will seek assurance that the development of the CCG and the Divisions, and their commissioning intentions and strategic plan, are in line with the authorisation framework, and the vision established within the White Paper. The Governing Body of the CCG will be responsible for overseeing the completion of the authorisation process.

2. NHS Operating Framework

The NHS Operating Framework sets out the planning, performance and financial requirements for NHS Organisations, in order to meet the challenges of the White Paper, and to support the reforms enshrined within the Health and Social Care Bill, in what it describes as 'a year for improvement and transition'.

The four key themes are:

- putting patients at the centre of decision making in preparing for an outcomes approach to service delivery, whilst improving dignity and service to patients and meeting essential standards of care;

- completion of the last year of transition to the new system, building the capacity of emerging clinical commissioning groups (CCGs) and supporting the establishment of Health and Wellbeing Boards so that they become key drivers of improvement across the NHS;

- increasing the pace on delivery of the quality, innovation, productivity and prevention (QIPP) challenge;

- Maintaining a strong grip on service and financial performance, including ensuring that the NHS Constitution right to treatment within 18 weeks is met.

Requirements are set out in the areas of **quality**, **reform**, **finance and business rules**, and **planning and accountability**.

3. NHS Outcomes Framework 2013/14

The NHS Outcomes Framework provides NHS Organisations with a set of indicators that will enable quality and patient outcomes to be measured in a way that is meaningful, equitable and that allows for accountability and transparency. These indicators are updated from those within the Outcomes Framework 2012/13, to reflect the changing landscape, and to drive up quality and performance to the level that is required from the White Paper's vision for the NHS. These indicators are grouped within the five NHS Operating Framework domains.

Domain 1	Preventing people from dying prematurely;
Domain 2	Enhancing quality of life for people with long-term conditions;
Domain 3	Helping people to recover from episodes of ill health or following injury;
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.

Each of the domains contains a number of overarching indicators and improvement areas by which the Clinical Commissioning Group will be judged.

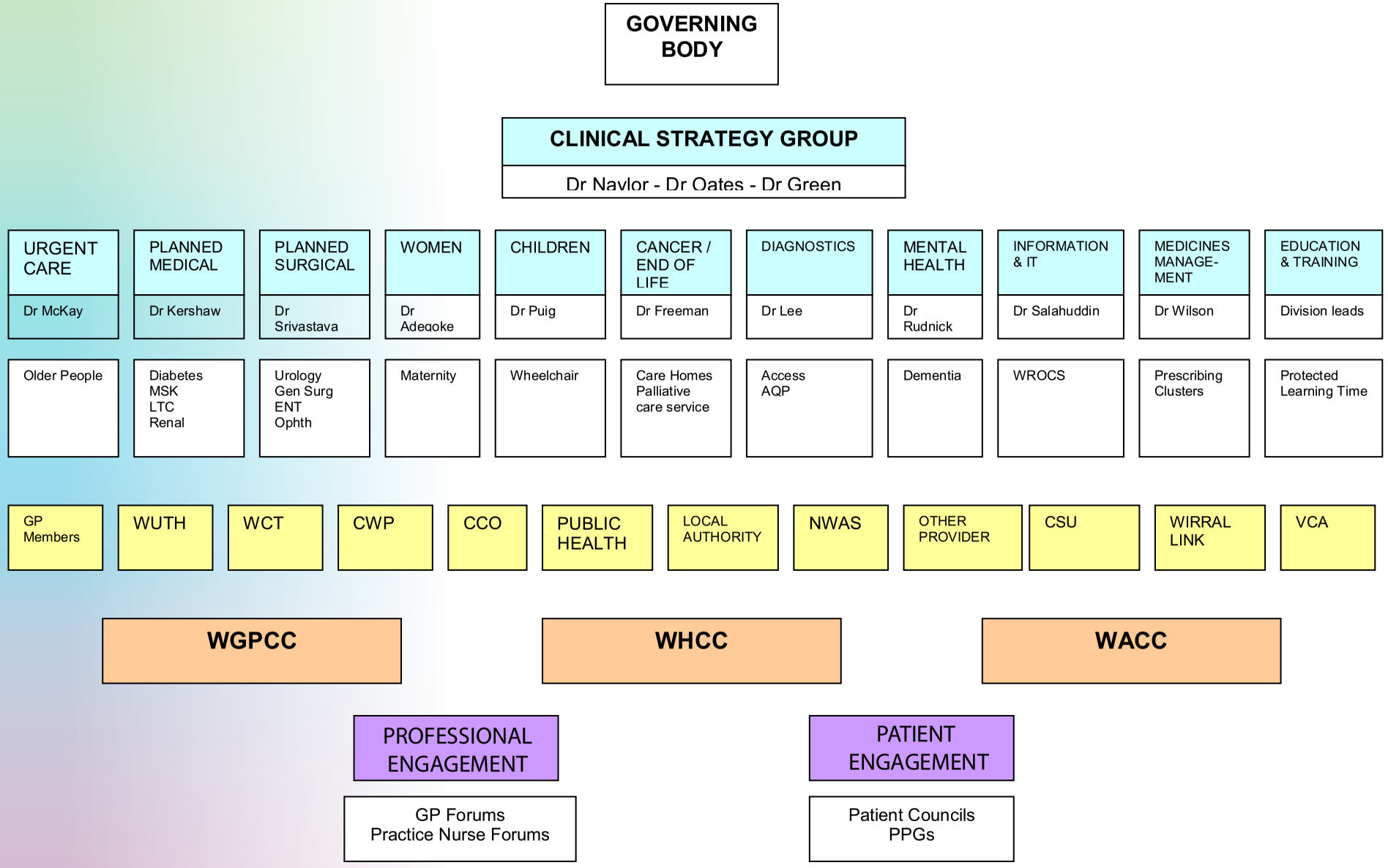
A summary of these indicators are included below based on the document released by the Department of health on the 13th November 2013 (link below)

https://www.wp.dh.gov.uk/publications/files/2012/11/121109-NHS-Outcomes-Framework-2013-14.pdf

NHS OUTCOMES FRAMEWORK 2013-14				
Domain 1	**Domain 2**	**Domain 3**	**Domain 4**	**Domain 5**
Preventing people from dying prematurely	**Enhancing quality of life for people with long-term conditions**	**Helping people to recover from ill-health or following injury**	**Ensuring people have a positive experience of care**	**Treating and caring for people in a safe environment and protecting them from avoidable harm**
Overarching indicator	**Overarching indicator**	**Overarching indicators**	**Overarching indicator**	**Overarching indicators**
1a Potential Years of Life Lost (PYLL) from causes considered amenable to health care i Adults ii Children and Young people	2 Health related quality of life for people with long-term conditions	3a Emergency admissions for acute conditions that should not usually require hospital admission	4a Patient experience of primary care	5a Patient safety incident reporting
1b Life expectancy at 75 i males ii females		3b Emergency readmissions within 30 days of discharge from hospital	i GP services ii GP out-of-hours services iii NHS Dental Services	5b Safety incidents resulting in severe harm or death
			4b Patient experience of hospital care	5c Hospital deaths attributable to problems in care
			4c Friends and Family test	
Improvement areas	**Improvement areas**	**Improvement areas**	**Improvement areas**	**Improvement areas**
Reducing premature mortality from the major causes of death	**Ensuring people feel supported to manage their condition**	**Improving outcomes from planned treatments**	**Improving people's experience of outpatient care**	**Reducing the incidence of avoidable harm**
1.1 Under 75 mortality rate from cardiovascular disease	2.1 Proportion of people feeling supported to manage their condition	3.1 Total health gain as assessed by patients for elective procedures	4.1 Patient experience of outpatient services	5.1 Incidence of hospital-related venous thromboembolism (VTE)
1.2 Under 75 mortality rate from respiratory disease	Improving functional ability in people with long-term conditions	i Hip ii Knee replacement iii Groin Hernia iv Varicose veins	**Improving hospitals' responsiveness to personal needs**	5.2.i Incidence of MRSA
1.3 Under 75 mortality rate from liver disease	2.2 Employment of people with long-term conditions	v Psychological therapies	4.2 Responsiveness to in-patients' personal needs	5.2.ii Incidence of C difficile
1.4 Under 75 mortality from cancer	Reducing time spent hospital by people with long-term conditions	**Preventing lower respiratory tract infections (LRTI) in children from becoming serious**	**Improving people's experience of accident and emergency services**	5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
i One and ii Five -year survival from all cancers	2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	3.2 Emergency admissions for children with lower respiratory tract infections (LRTI)	4.3 Patient experience of A&E services	5.4 Incidence of medication errors causing serious harm
1.4.iii One and iv Five-year survival from breast, lung and colorectal cancer	**Enhancing quality of life for carers**	**Improving recovery from injuries and trauma**	**Improving access to primary care services**	**Improving the safety of maternity services**
Reducing premature death in people with serious mental illness	2.4 Health-related quality of life for carers	3.3 Proportion of people who recover from major trauma	4.4.i Access to GP services	5.5 Admission of full-term babies to neonatal care
1.5 Excess under 75 mortality rate in adults with serious mental illness	**Enhancing quality of life for people with mental illness**	**Improving recovery from stroke**	4.4.ii NHS Dental services	**Delivering safe care to children in acute settings**

Reducing deaths in babies and young children	2.5 Employment of people with mental illness	3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months	**Improving women and their families' experience of maternity services**	5.6 Incidence of harm to children due to 'failure to monitor'
1.6.i Infant mortality ii Neonatal mortality and stillbirths iii Five-year survival from all cancers in children	**Enhancing quality of life for people with dementia**	**Improving recovery from fragility fractures**	4.5 Women's experience of maternity services	
Reducing premature death in people with learning disabilities	2.6.i Estimated diagnosis rate for people with dementia ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life	3.5.i The proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 days ii The proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 120 days	**Improving the experience of care for people at the end of their lives**	
1.7 Excess under 60 mortality in people with learning disabilities		**Helping older people to recover their independence after illness or injury**	4.6 Bereaved carers' views on the quality of care in the last 3 months of life	
		3.6.i Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services ii Proportion offered rehabilitation following discharge from acute or community hospital	**Improving the experience of healthcare for people with mental illness**	
			4.7 Patient experience of community mental health services	
			Improving children and young people's experience of healthcare	
			4.8 An indicator is under development	
			Improving people's experience of integrated care	
			4.9 An indicator is under development	

Appendix 3 - Delivering QIPP through Clinical Engagement



Appendix 4

Expected rights and pledges from the NHS Constitution 2013/14 (subject to current consultation) including the thresholds the NHS Commissioning Board will take when assessing organisational delivery

Referral To Treatment waiting times for non-urgent consultant-led treatment
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%
Diagnostic test waiting times
Patients waiting for a diagnostic test should have been waiting no more than 6 weeks from referral – 99%
A&E waits
Patients should be admitted, transferred or discharged within 4hours of their arrival at an A&E department – 95%
Cancer waits – 2week wait
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%
Cancer waits – 31 days
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%
Cancer waits – 62 days
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set
Category A ambulance calls
Category A calls resulting in an emergency response arriving within 8minutes – 75% (standard to be met for both Red 1 and Red 2 calls separately)
Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%
Mixed Sex Accommodation Breaches
Minimise breaches

Cancelled Operations
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.
Mental health
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%.

Additional measures NHS Commissioning Board has specified for 2013/14.

Referral To Treatment waiting times for non-urgent consultant-led treatment
Zero tolerance of over 52 week waiters
A&E waits
No waits from decision to admit to admission (trolley waits) over 12 hours
Cancelled Operations
No urgent operation to be cancelled for a 2nd time
Ambulance Handovers
All handovers between ambulance and A & E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. Financial penalties, in both cases, for delays over 30 minutes and over an hour.

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