NHS

North East Essex
Clinical Commissioning Group

North East Essex Urgent Care Strategy

2014-2019

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Foreword

The North East Essex Clinical Commissioning Group (the CCG) is fervently committed to commissioning high quality and effective patient care true to our values and vision, set out in the CCG Year Plan[1] "Embracing Better Care for All" for the population of North East Essex (NEE). The Urgent Care Strategy (the strategy) aims to keep our vision at its centre, keeping true to our values as an organisation.

The strategy describes the existing system of urgent and emergency care provision in NEE, the case for change and our approach to redesigning and improving urgent and emergency care services in NEE that are open for business 24/7, responsive to patients needs and lifestyles, high quality and cost effective, easy to navigate and that will deliver the key objectives defined in this strategy.

The strategy highlights the key challenges we face both now and in the future and defines specific CCG work programmes, built around agreed primary objectives, which deliver a shared collective responsibility for the whole patient journey.

The CCG will work with our providers and population to create a new and co-ordinated urgent care system that delivers an outstanding level of care at whatever point in the pathway a person enters it and that treats them with respect and dignity. The CCG will undertake a whole system redesign that integrates health and social care to ensure people receive joined up and seamless services. By ensuring "every contact counts" [2] we will reduce hospital admissions and ensure that people receive the most appropriate care based on their individual needs, in a setting of their choice.

As an organisation, the CCG will direct all those responsible for the individual urgent care work programmes to work in partnership and to ensure that the patient remains at the heart of everything we do and in every decision we make.

Local public and stakeholder discussions have helped inform and develop this strategy. Our patients have clearly told us how they feel about the current urgent care system and what they need. We will use this information to simplify the way urgent and emergency care is accessed and delivered in NEE in the future

[1] North East Essex Clinical Commissioning Group Five Year Strategic Plan 2014-19 Final
[2] An Implementation Guide and Toolkit for Making Every Contact Count: Using every opportunity to achieve health and wellbeing, Developed by the East Midlands Health Trainer Hub

Executive Summary

The NEE health and social care community have jointly committed, through an extensive consultation and engagement process, to radically transform the urgent and emergency care system in order to develop integrated, holistic, and patient centred services over the next five years. The overall aim is to ensure that each individual is seen at the right place, at the right time, by the right person. Ultimately services will no longer be fragmented and patients, the public and health professionals will not be confused about which service to contact for help or where to go for care.

All local healthcare organisations have enthusiastically committed to this whole system approach and have agreed key aims and created key projects, with defined milestones, to meet and offset the demands and challenges we face in NEE.

Urgent and emergency care services in NEE have historically evolved in response to evidence based practice, national guidelines, NHS policy changes and in reaction to local challenges. This has created an intricate system of services with multiple connections and complex patient flows which both patients, carers and health and social care professionals find difficult to navigate with ease.

In NEE there has been a continued rise in patient demand for urgent and emergency care across the whole system, from increased attendance at accident and emergency departments (A&E), increased attendance at local walk in centres (WIC) and increased patient demand and expectation on general practice and on the Out of Hours Service.
There is a need to reduce the overall demand on urgent care services by addressing the underlying reasons why patients access these services. This requires an alignment of services, working together to provide a cohesive, safe and more effective system that will deliver an improved patient experience and will ultimately improve clinical quality and safety.

Managing increasing patient demand and expectation in the future, within the current health and social care system configuration, will be progressively difficult. As technology and clinical techniques advance, patients will need to access health and social care services in more modern, convenient and flexible ways.

Continuing to work to refine and manage the already stretched hospital centred urgent care system will only have limited success in meeting the growing demands of our population. We need to focus on need prevention to reduce the demand for urgent and emergency care.

We will design a new urgent care system in direct response to NEE patient aspiration and vision:

"When I need help and advice very quickly I know how to get it. It is simple to use and responds to my needs. It helps to prevent me reaching a crisis but reacts quickly if I do".

All our partners and stakeholders share a collective ambition and responsibility for the delivery of this vision.

The strategy includes a commitment in Appendix 5**,** which will be signed by urgent care stakeholders, to deliver the key project work programmes set out within this document which are:

- Urgent Care Centre
- Primary Care Support to Care Homes
- Reablement & Intermediate Care
- Primary Care Access
- Patient & Public Education
- Patient Risk Profiling
- Patient Care Planning & Case Management
- Mental Health Services

This strategy will link with the Clinical Commissioning Groups Care Closer to Home Strategy[3] and NHS England Primary Care Strategy[4] to ensure the delivery of safe consistent patient pathways across the health and social care system.

[3] NHS North East Essex CCG Care Closer To Home Integrated Community Strategy 2013-2018
[4] Transforming Primary Care in Essex, The Heart of Patient Care, Published by NHS England © 2014

Background

North East Essex CCG (the CCG) is responsible for commissioning the majority of health services for the people who reside in the areas covered by Colchester Borough Council and Tendring District Council. The CCG has 42 GP practices situated across NEE providing primary care services to a registered population of approximately 331,000.

NEE is serviced by one acute hospital, Colchester Hospital University Foundation Trust (CHUFT), and two community hospitals situated in Clacton and Harwich. A Walk in Centre (WiC) is situated in Colchester, and there are Minor Injuries Units (MIU) located in both Clacton and Harwich.

Essex County Council, Tendring and Colchester District Councils, local voluntary services and many other private sector organisations contribute to the NEE health economy.

1.1 National Context

NHS England (NHSE) is leading on the development of a national framework for urgent care which will aid CCGs in 2015/16 in the commissioning of consistent, high quality urgent care services across the country within available resources. Did you want to include a line about how this will benefit patients?

The national framework will be built from the NHSE Urgent and Emergency Care Review published in 2013, and subsequently updated in August 2014, and from the discussion document on options for reform; Report on Reimbursement of Urgent and Emergency Care published in 2014[5].

The review identified four emerging principles for improved systems in England which are:

1. Provision of consistently high quality and safe care, across all 7 days of the week
2. Simple services that guides good choices by patients and clinicians
3. Provision of the right care in the right place, by those with the right skills, the first time
4. Efficiency in the delivery of care and services

From these principles, twelve 'System Design Objectives' have been outlined as suggested outcomes which should be delivered by any future urgent and emergency care system:

No	Design Objectives
1	Make it simpler for me or my family/carer to access and navigate urgent and emergency care services and advice
2	Increase my or my family/carer's awareness of early detection and options for self-care and support me to manage my acute or long term physical or mental condition
3	Increase my or my family/carer's awareness of and publicise the benefits of 'phone before you go'
4	If my need is urgent, provide me with guaranteed same day access to a primary care team that is integrated with my GP practice and my hospital specialist team
5	Improve my care, experience and outcome by ensuring early senior clinical input in the urgent and emergency care pathway
6	Wherever appropriate, manage me where I present (including at home and over the telephone)
7	If It's not appropriate to manage me where I present (including at home and over the telephone), take or direct me to a place of definitive treatment within a safe amount of time; ensure I have rapid access to a highly specialist centre if needed
8	Ensure all urgent and emergency care facilities are capable of transferring me urgently and that the mode of transport is capable, appropriate and authorised
9	Information, critical for my care, is available to all those treating me
10	Where I need wider support for my mental, physical and social needs ensure it is available
11	Each of my clinical experiences should be part of a programme to develop and train the clinical staff and ensure their competence and the future quality of the service is being constantly developed
12	The quality of my care should be measured in a way that reflects the urgency and complexity of my illness.

[5] Reimbursement of urgent and emergency care: discussion document on options for reform

The CCG will work closely with the NHSE Area Team to ensure that all plans align with national urgent and emergency care policies as they evolve.

1.2 Local Context

The NEE Urgent Care Strategy represents a whole system strategy that has been developed with CCG members based on discussions, agreements and outcomes from a series of system workshops held throughout 2014 facilitated by NHS Improving Quality (NHSIQ). The strategy also encompasses the work of the Urgent Care Working Group with representation from all stakeholders within the NEE urgent care system. The strategy's objectives and plans will also be shared with the local police and fire services as providers of front line emergency services.

The system partners and the CCG recognise that patient demand for urgent care services is unpredictable and acknowledge that there are demand 'hot spots' experienced by CHUFT based on activity trends, population demographic changes and seasonal trends. It is evident however, that identified peaks in demand are possibly symptoms of lack of capacity, lack of integration and poor demand management within other service areas, e.g. general practice, community services and social care.

The system has prioritised 4 key areas leading to 13 key actions detailed in section 5.

Key Players

There are a number of key providers and stakeholders that influence the urgent care system in NEE.

Colchester Hospital University Foundation Trust (CHUFT) has two main sites: Colchester General Hospital and Essex County Hospital. The Trust provides healthcare services to approximately 370,000 people residing in NEE. In addition to the 596 inpatient beds (general and anaesthetic), 44 maternity beds (including those at Clacton and Harwich hospitals) and 12 critical care beds, the acute hospital also provides oncology wards and outpatient services. Although it is the hospital's strategy to centralise acute services at Colchester General Hospital, services are also provided at the community hospitals in Clacton, Harwich and Halstead hospitals. CHUFT works closely with the CCG and other partners within the urgent care system to improve demand management and the continuous improvement of acute services for NEE patients.

East of England Essex Ambulance Trust in NEE are key participants in local system wide discussions concerning the redesign of the urgent care system. The East of England Ambulance Service is engaged with the NEE Health Forum – a group run by patients, public, carers and service users who want to make a difference and improve services across Colchester and Tendring. . This has led to the formation of an Ambulance Working Group which has prioritised the following work areas:

- To focus on public education regarding the appropriate use of 999 ambulance services and sharing messages;
- To use the Health Forum as an engagement platform to drive and promote the imminent service changes;
- To communicate and promote good news stories;
- To improve collection of patient feedback so experience is captured and used to drive service improvements.

The CCG is considering the implementation of a local pilot that is specifically designed to improve integration and the relationship between the ambulance service and GP practices. This system will allow them to raise issues and share best practice.

Anglian Community Enterprise (ACE) provides in excess of 40 NHS community healthcare services to a population of 990,000 north Essex residents but predominantly to those residing in Colchester and Tendring. ACE currently manages three GP practices in Tendring, holds contracts for the two local minor injuries units and provides much of the community nursing support for the area.

North Essex Partnership Foundation Trust (NEPFT) is the local mental health services provider delivering support to over 23,600 individuals and their families in NEE.

Care UK is commissioned to provide the Colchester Walk in Centre and the NEE Out of Hours Service. The Walk in Centre is open 7 days a week between 7am and 10pm, is accessible to all NEE residents and visitors and provides a range of GP and nurse appointments. The Out of Hours Service provides advice, information and treatment for NHS patients who become unwell during the out-of-hours period when their own GP practice is closed. The service is accessed via the national NHS 111 call line.

Essex County Council (ECC) commissions both adult and children's social services in the Colchester and Tendring areas, which are then delivered by a range of providers or arranged independently using a personal budget if eligible (as criteria applies). Services are mainly accessed via ECC's operational teams based locally or Social Care Direct, which is a centralised call centre. ECC has made a long term commitment to integrated working and commissioning. Key priorities are:

- promoting higher levels of community health and well-being
- prevention and early intervention through improving the information and advice to patients to promote self-care and to empower them to make informed choices
- supporting family carers to enable them to enjoy a good quality of life and maintain their caring role

The Better Care Fund (BCF), which is due to come into effect during 2015, is a pooled budget to support health and social care services to work more closely together in local areas. The Fund is intended to be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change. The CCG is working with Essex County Council to deliver the key Better Care Fund outcome which is the reduction of 3.5% in emergency admissions, along with the following national outcomes:-

1. Reduction in permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population;
2. Increase in proportion of older people (65 and over), who are still at home 91 days after discharge from hospital, into reablement / rehabilitation services;
3. Reduction in delayed transfers of care from hospital per 100,000 population (average per month);
4. Improved patient / service user experience;
5. Plus a locally agreed outcome of increasing the coverage of reablement. (This metric will measure an expansion in the number of referrals from community into reablement.)

GP Primary Choice (GPPC) is a newly established collaborative organisation representing 38 of the 42 NEE GP Practices. The company, after recently winning the procurement for providing a phlebotomy service in the local area, is seeking to extend this success and procure and provide further services within the community setting for the population of NEE.

NHS 111 commenced service provision in November 2013. The service is designed to give people quick and easy access to local NHS healthcare services 24 hours a day, 365 days a year. . It is not designed to deal with 999 emergencies. . The service in north Essex is provided by a community interest company, Integrated Care 24 (IC24). IC24 employs a team of fully trained advisers, supported by experienced clinicians, who have knowledge of the local healthcare services via a localised directory of services.

Local Community Voluntary Services now work closely with the CCG and are included in the NEE governance structure. A representative is a member of the Transformation and Delivery Committee and is therefore a contributor to key decision making and also brings a knowledge and understanding of available voluntary patient support to help improve and enhance local services.

CCG public, patient and carer local health forums have been established for over 12 months. Operating in three areas of NEE the forums give the public the opportunity to influence and contribute towards local commissioning discussions and decisions. A considerable level of intelligence has been gained from the local forums ensuring CCG decisions are localised and person centred. Health forum representatives sit on each of the key CCG governance committees promoting views from each of the groups.

Local Healthcare Needs Assessment

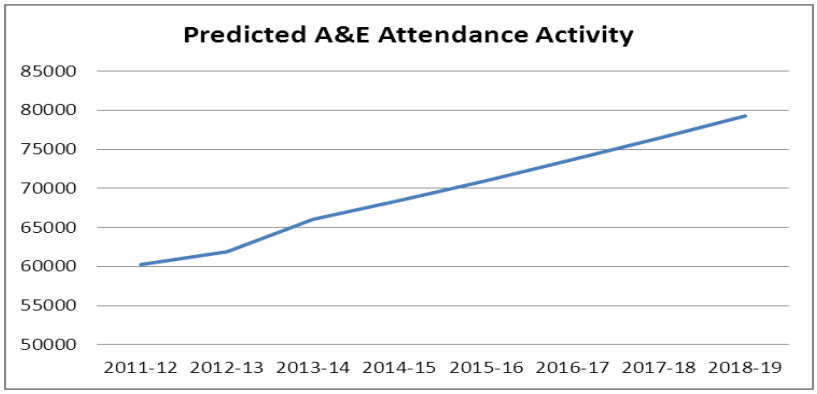
The population of NEE, as at April 2011, was 324,141 and as at April 2014 was 330,915, which is a growth of 2.09% and higher than the England average of 0.55%. By 2021 NEE is predicted to see a further 13% (43,000) population increase to 357,121, with a diverse population and a high proportion of elderly residents.[6]

Population health need is driven by a number of variables, including the wider determinants of health that includes housing, education and income. In NEE we experience variability on life expectancy – particularly in the male population and deprived communities. Deprivation is associated with a higher burden of ill health and worse health outcomes. To calculate relative health need by GP practice is complex. However, use of available data on practice population size, age profile, current hospital activity levels and deprivation levels (as a proxy for unmet need) can be used to illustrate how health need varies between practice populations and also demonstrates how designing and delivering an urgent care system for our population is potentially difficult.

The analysis in Figures 1 and 2 show projected Emergency Department (ED) attendances for future years based on the assumption that the configuration of current services and the rate of use of services continues in the same trend.

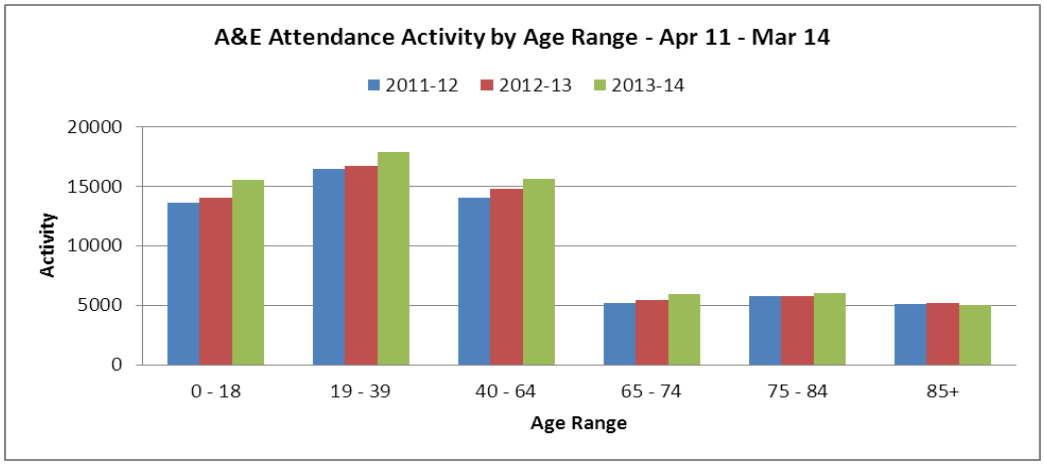
Therefore, to cope with projected demand, all future service delivery will need to consider and include options for people, where appropriate, to be managed outside of hospital, closer to home and also in managing their own care.

FIGURE 1: Projected number of attendances at ED *(April 2011 – March 2019)*



Summary of findings: With the anticipated overall population increase and increase in the elderly population, predicted ED attendances will continue to rise indicating the need for improved capacity planning

FIGURE 2: Attendances at ED in 2013/14 by age group *(April 2011-March 2014)*



Summary of findings: EDattendances continue to be highest within the 19-39 age range, with all age ranges showing an increase year on year.

[6] NHS North East Essex Clinical Commissioning Group Profile, A product of the Essex Joint Strategic Needs Assessment, 2013

Long Term Conditions (LTCs) and minor injuries are a major cause of ill health and presenting complaint for urgent attendance at ED, often leading to admission. These are typically conditions which could be seen, treated effectively and proactively managed by other community based health care services resulting in decreased attendance at ED.

Figure 3 shows the prevalence of LTCs in NEE:

FIGURE 3: Prevalence of LTCs in NEE Population *(2013 North East Essex JSNA)*

Disease Prevalence	Number on NEE registers	NEE Prevalence	England Average	Lowest in England (PCT)	Highest in England (PCT)
CHD	12,618	3.9%	3.4%	1.3%	5.1%
Stroke or TIA	6,265	1.9%	1.7%	0.7%	2.5%
Hypertension	51,691	15.8%	13.6%	7.9%	17.4%
Diabetes	16,095	6.0%	5.8%	3.4%	9.3%
COPD	6,734	2.1%	1.7%	0.8%	3.5%
Epilepsy	2,318	0.9%	0.8%	0.4%	1.1%
Hypothyroidism	15,001	4.6%	3.1%	1.3%	4.9%
Cancer	6,642	2.0%	1.8%	0.7%	2.8%
Mental Health	2,720	0.8%	0.8%	0.5%	1.5%
Asthma	20,210	6.2%	5.9%	3.6%	7.1%
Heart Failure	2,943	0.9%	0.7%	0.3%	1.2%
HF due to LVD	1,370	0.4%	0.4%	0.2%	0.9%
Palliative Care	622	0.2%	0.2%	0.1%	0.6%
Dementia	1,772	0.5%	0.5%	0.2%	0.9%
Depression	27,061	10.3%	11.7%	4.7%	20.3%
CKD	15,308	5.8%	4.3%	1.6%	9.0%
Atrial Fibrillation	6,243	1.9%	1.5%	0.4%	2.4%
Obesity	32,762	12.1%	10.7%	6.1%	15.8%
Learning Disability	1,819	0.7%	0.5%	0.2%	0.8%

Significantly higher than England average
Significantly lower than England average
Not significantly different than England average

Summary of findings: NEE LTC prevalance continues to be significantly higher than the national average. This may be due to the higher average age, increased number of local hospital admissions and increased length of stay in hospital. These patients tend to be more complex in their recovery and rehabilitation needs. We need to create a system wide plan to ensure patients are treated and managed appropriately following discharge utilising community care

As a result of the stakeholder workshops, the local healthcare needs assessment evidenced an increased pressure on the ED department. With ED attendance remaining the default route for many people needing to access same day / urgent care, the confusing nature of the current system and a growing population with increasingly complex needs, all urgent care partners recognise the necessity to make changes to our current system to ensure demand is met in the most effective way.

Within the NEE strategy this relates to an emphasis on self-care, improved primary care and community care access and the effective utilisation of the ED department.

Local Service Challenges

In delivering high quality urgent care services for all, we acknowledge the following challenges:

- Below average GP recruitment and retention within primary care. Data produced by the Health and Social Care Information Centre, Census of 2012, reveals an England average figure of 0.74 full time GPs per 1,000 patients. NEE is below the national average at 0.63 full time GPs per 1000 patients
- A local acute Trust (CHUFT) in a turnaround situation which will have an impact on their ability to support the NEE CCG 5 year strategic plan
- Variation in accessibility of primary care and community services within NEE. This is clear from the varied use of other urgent care services along with patient feedback and satisfaction surveys
- Patient GP satisfaction rates – national GP patient access surveys from December 2013 show NEE to be lower in specific questions around ‘recommending your surgery to new people in the area’, ‘the doctor involving you in decisions about you’ and ‘the ease of making an appointment at your surgery’

- Above average hospital admission rates measured against peers within the East of England
- Variable performance in meeting the ED four hour waiting target
- Public are unclear about which service to access and when to access appropriately
- Variable performance in ambulance targets
- Increasing demand from local care homes on community, primary and secondary care services
- Lack of data sharing technology and arrangements for a cohesive and integrated healthcare system
- Lack of alignment of various contracts held by the CCG to ensure an integrated system
- The reliance on the new models of community care to support the urgent care demand
- Lack of integration with the social care system for people requiring multiple assessments and the need to reduce delays in support services provision

The current urgent care system will not meet the local challenges or the projected increase in demand. The CCG must therefore transform and deliver an integrated system of urgent care services that are simple to use and respond to and meet the needs of the NEE population; an urgent care system that provides access to rapid help and advice; an urgent care system that prevents and reacts quickly to any arising patient crisis.

To achieve this aim, the following key themes have been identified as the primary focus and are based on feedback from the many public events and discussions held in NEE over the past 12 months:

a) Improving self-care
b) Improving system access, focussing on primary care access
c) Improving flow into the hospital through ED
d) Appropriate flow on discharge and improving care options and access within the community
e) Improving data flows between services and providers

1.3 Public and Patient Feedback

The CCG and all stakeholders are continuously seeking public and patient feedback and views on services to ensure continual improvement. Messages from a number of sources have been collated and included to ensure patient views drive system designs and changes to meet user demands and expectations. These sources include:

- The Big Care Debate
- 2012/13 Acute Inpatient Survey
- 2012 ED Survey
- National GP Patient Survey

The Big Care Debate

The Big Care Debate was the NEE CCG's response to NHS England's Call to Action[7] and was an intensive educational, communications and engagement exercise that included people across NEE in a discussion to help achieve the vision for the CCG and inform healthcare strategies for the next five years.

Overwhelmingly the resulting message from the public is that access to GP appointments is the single biggest point of comment and concern with 86% of responses related solely to wanting easier and improved GP access and access to GPs during evenings and weekends. There was also an overriding view that GPs are pivotal to providing healthcare and represent the gateway to preventing other services from being overloaded.

From a range of engagement methods the feedback highlighted some major themes which are interlinked and point strongly to person centred care including:

- Access issues within primary care
- A push for self-care and the need for health care professionals to be better educated to promote self-care to patients for managing conditions
- Access to education materials, information on services and pathways
- The obvious duplication and waste in the system
- The timeliness of being seen for an emergency within ED
- Duplication of paper work between services

[7] The NHS belongs to the People, A Call to Action: NHS England, 2013

- Timeliness of discharge from secondary care when a patient is ready to go home

Acute Inpatient Survey
Between September 2012 and January 2013, a questionnaire was sent to 850 recent inpatients at each Trust. Response was received from 387 patients (46%) at Colchester Hospital University NHS Foundation Trust.

The areas explored were: the emergency/A&E department; the waiting list and planned admissions; waiting to get a bed on a ward; the hospital and ward; doctors; nurses; care and treatment; operations and procedures; leaving hospital; overall views and experiences. The resulting trust scores are compared with all other trusts in England.

For Colchester Hospital University NHS Foundation Trust the majority of indicators (55/57) in this survey were rated 'about the same' as other trusts.
Source: 2013 North East Essex CCG JSNA Patient Voice

Emergency Department Survey
During 2012, a questionnaire was sent to 850 people who had attended an NHS emergency department between January and March 2012. Responses were received from 270 people at Colchester Hospital University NHS Foundation Trust.

The areas explored were: travel by ambulance; reception and waiting; doctors and nurses; care and treatment; tests; hospital environment and facilities; leaving the ED department (if not admitted); overall views and experience. The resulting trust scores are compared with all other trusts in England. For Colchester Hospital University NHS Foundation Trust all the indicators (37/37) in this survey were rated 'about the same' as other trusts.

No indicators showed the Trust to be performing better or worse than other Trusts.
Source: 2013 North East Essex CCG JSNA Patient Voice

The National GP Patient Survey
This survey explores areas relating to: accessing GP services; making an appointment; waiting times; last GP appointment; last nurse appointment; opening hours; overall experience; managing your health; your state of health today; demographic characteristics. The GP Patient Survey aims to assess patients' experiences of access and the quality of care received from their local General Practices. The results cover the period July 2012 to March 2013. The percentages presented have not been tested for statistically significantly different values from the comparator figures.

In the overall experience of GP surgeries domain, 86% of NEE respondents reported a good experience. The result is comparative to the national figure of 87%.

In the 'opening hours' domain, 79% of NEE respondents reported to be satisfied with current opening hours. The result is comparative to the national figure of 80%.

In the 'making an appointment' domain, 78% of NEE respondents reported their overall experience of making an appointment as 'good'. The result is above the national figure of 76%.
Source: 2013 North East Essex CCG JSNA Patient Voice

Patient feedback from each of these sources has been aligned with the priorities of both commissioners and providers of services to demonstrate how patient priorities are shared by all and are reflected across the system:

Aligning Priorities

PATIENTS	PROVIDERS	COMMISSIONERS
A Positive Experience	Process, organisational culture and leadership	Value, Need and Outcome for patients
Be 'Joined up' and responsible for my care	Network and integration between service providers	Commissioning of Quality services that at productive and efficient
Help me understand the urgent and emergency care system	Education, Publicity and consistency for the population	Improve the consistency of service times and access points and improve the understanding of services available
Let me access it appropriately	Patient Navigation and Care Planning	Embed the use of NHS 111 and ensure a simple system with fewer access points
Assess and treat me promptly and in the right place by the right person	Reduce ED attendances and resulting zero day length of stay admissions	Enhanced community assessments, case managements and capacity within primary and community settings, including the use of technology
Admit me to hospital only when necessary	Case Management and case planning, with improved access to the correct setting in a timely manner	Improved LTC management and proactive case management
Make my stay in hospital short, safe and effective	Integrated assessments and treatments between the appropriate specialists, reduced hospital admissions, improved hospitals systems and cultures and improved discharge processes with appropriate community support for these patients upon discharge	Improved LTC care within the community, improved End of Life Care, reduction in non-elective stays and focus on hospital discharge over 7 days.
Try to care for me at home, even when I'm ill	Develop and integrate community and primary care services	Provision of reablement and intermediate care, extended community teams working in an integrated way, risk stratification and self-care

The outcomes of patient and public feedback has been built into the priority areas, the four overarching aims and the 13 individual projects to ensure all patient needs are considered and catered for using a systematic and consolidated approach.

2. Quality Assurance

Quality is at the heart of everything we do; by having a quality focus built around the patient we will ensure that our residents are seen at the right place, the right time, by the right person, first time.

NEE CCG will ensure that all people experience better care and are treated with compassion, dignity and respect whenever they come into contact with the NHS.

The CCG and Essex County Council share four quality ambitions which will provide a focus for all commissioned services, as follows:

- *Mutually beneficial partnerships between patients, their families and those delivering health care services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision making.*
- *There will be no avoidable injury or harm to people from health care they receive and an appropriate clean and safe environment will be commissioned for the delivery of health care services at all times.*
- *The most appropriate treatments, interventions, supports and services will be provided at the right time to everyone who will benefit and wasteful or harmful variation will be eradicated.*

- *Foster a partnership approach with social care providers to provide joined up high quality patient care and outcomes*

The CCG will strive to ensure that the high quality healthcare they commission is provided on the basis of its on-going commitment to equality of experience and outcomes to everyone in NEE, no matter whom they are or where they live.

3. Aims and Objectives

The primary aim and objective of the urgent care strategy is to deliver high quality care in the right place, at the right time, first time, whilst working to manage demand in the current climate.

To do this, service transformation is required to ensure demand is managed at all levels of the system.

The following key aims have been generated by the stakeholder workshops for focus and delivery by the new system:

Aim 1: To reduce unplanned hospital admissions/re-admissions by 3.5% by the end of 2015, with a continuous reduction of 1% over the next 3 years

Aim 2: To reduce ED attendances by 10% by the end of 2015 from the current baseline in April 2014, with a continuous reduction of 2% over the next 3 years

Aim 3: By April 2016, 100% of patients requesting a same day consultation receive this

Aim 4: By 2020, 80% of patients will hold electronic health records

Many people experience a variety of health and social care needs throughout their lifetime. The spectrum of care they need may range from information on self-management to acute or urgent care. With the CCG moving towards outcomes based commissioning we aim to ensure that outcomes are achieved, based specifically on patient need, from the healthcare system in North East Essex.

4. North East Essex Urgent Care System

4.1 Urgent Care

Urgent Care is defined as the range of healthcare services available to people who need medical advice, diagnosis and/or treatment quickly and unexpectedly. In practice this means that people, whatever their need, wherever they reside, get the best possible care from the correct people, in the right place, at the right time, first time.

There are many levels to our current urgent care system in NEE The different levels have interdependencies between them and we will need to work with all providers to construct an integrated system that works smoothly and ensures patients are seen in the correct place, to begin addressing the system challenges highlighted in this document.

The Care Closer to Home (CC2H) work programmes and services will play a key role in the future success of the urgent and emergency care system and in successfully meeting the four aims with delivery of the 13 key projects highlighted in this document.

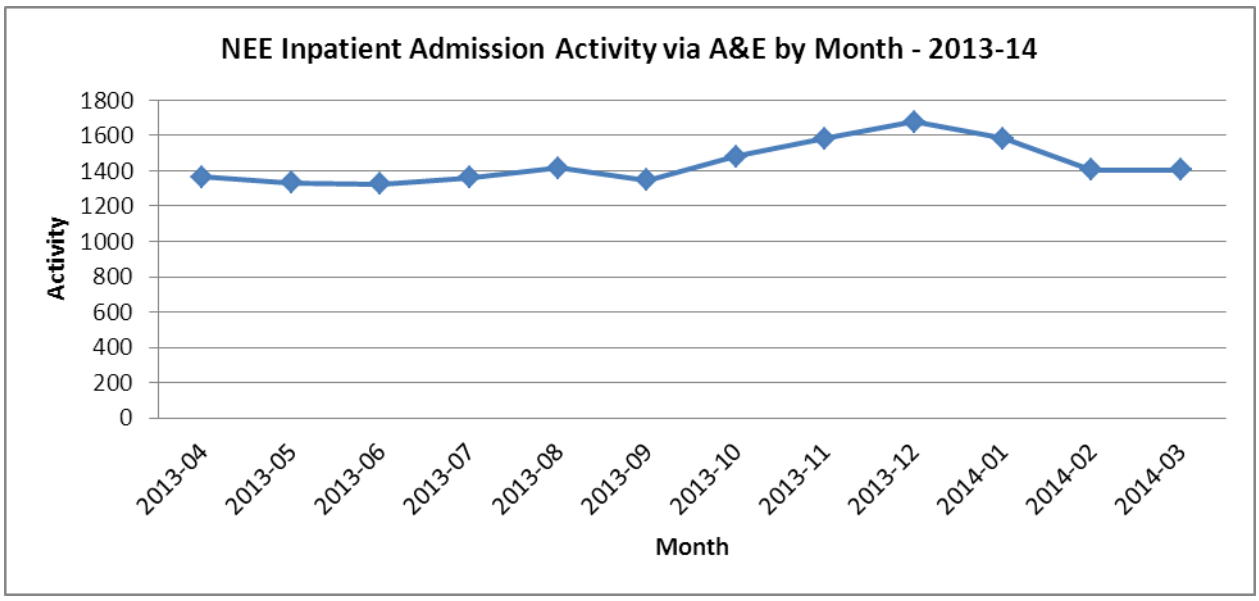
Appendix 1 shows the current urgent care landscape and the levels and relationships within the current urgent care system.

4.2. Level 4: Local Acute Admissions into Hospital

The population of North East Essex is serviced by one acute hospital situated in Colchester and two community hospitals situated in Clacton and Harwich.

There are an average of 4,500 hospital admissions per month, with a large proportion of these admitted through ED.

FIGURE 5: Number of admissions per month via ED *(April 2013 – March 2014)*



Summary of findings: Inpatient admissions continue to rise due to the increase in ED demand within NEE

Table 1 shows the most common admission cause via the ED department:

TABLE 1: Inpatient Primary Diagnosis *(April 2013 – March 2014)*

Inpatient Primary Diagnosis Activity by Patients Admitted thru ED - 13/14	
Primary Diagnosis	Grand Total
Urinary tract infection, site not specified	839
Lobar pneumonia, unspecified	713
Fracture of neck of femur: closed	414
Unspecified acute lower respiratory infection	382
Chest pain, unspecified	343
Tendency to fall, not elsewhere classified	338
Chronic obstructive pulmonary disease with acute lower respiratory infection	321
Syncope and collapse	311
Cerebral infarction due to thrombosis of cerebral arteries	279
Gastroenteritis and colitis of unspecified origin	275
Atrial fibrillation and flutter	274
Congestive heart failure	262
Other chest pain	260
Poisoning: 4-Aminophenol derivatives	259
Other and unspecified abdominal pain	228
Cellulitis of other parts of limb	195
Other and unspecified convulsions	190
Cerebral infarction due to embolism of cerebral arteries	188
Asthma, unspecified	185

Pneumonia, unspecified	181
Constipation	179
Acute myocardial infarction, unspecified	176
Pain localized to other parts of lower abdomen	175
Angina pectoris, unspecified	175
Pertrochanteric fracture: closed	165
Acute tonsillitis, unspecified	164
Unstable angina	159
Epistaxis	143
Headache	139
Viral infection, unspecified	134

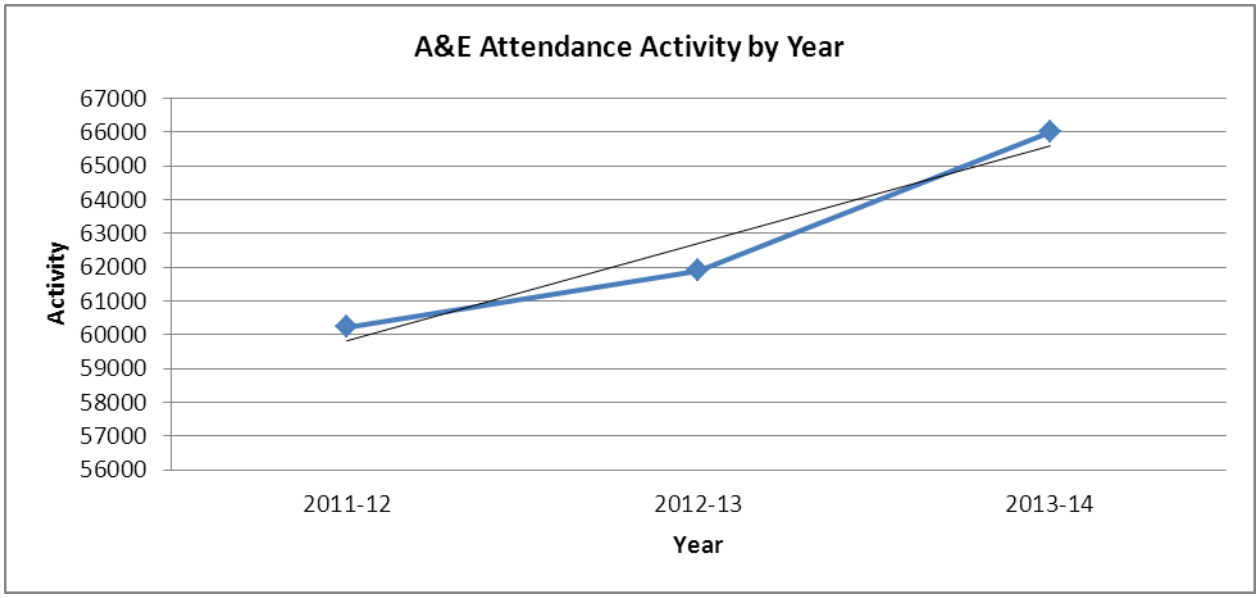
Summary of findings: Large numbers of patients continue to attend ED inappropriately and continue to be admitted for conditions such as headaches and constipation which could be diagnosed and treated within primary care.

Many LTC patients are admitted via ED which could be reduced with improved access to routine primary care appointments for monitoring, self-care and education.

4.3. Level 3: Emergency Department

Figure 6 shows the total number of NEE resident ED attendances between 2011 and 2014:

FIGURE 6 – ED Attendances *(April 2011- March 2014)*



Summary of findings: ED attendances have begun to increase at a faster rate over the last year showing the need for system changes to deal with the demand. This increase could be linked to poor general practice access, lack of patient education or patient convenience and choice

Table 2 shows the annual emergency department cost to North East Essex CCG by year:

TABLE 2 – ED Costs *(April 2011- March 2014)*

ED Activity	Costs		
ED Band	2011-12	2012-13	2013-14
Any investigation with category 5 treatment	£ 23,700	£ 20,619	£ 4,977
Category 1 investigation with category 1-2 treatment	£ 1,074,840	£ 1,150,812	£ 287,898
Category 1 investigation with category 3-4 treatment	£ 253,470	£ 247,146	£ 50,694
Category 2 investigation with category 1 treatment	£ 1,930,830	£ 1,734,150	£ 390,940
Category 2 investigation with category 2 treatment	£ 1,090,992	£ 1,102,654	£ 358,071
Category 2 investigation with category 3 treatment	£ 197,210	£ 223,860	£ 53,300
Category 2 investigation with category 4 treatment	£ 951,872	£ 1,043,890	£ 357,230
Category 3 investigation with category 1-3 treatment	£ 174,332	£ 193,848	£ 72,980
Category 3 investigation with category 4 treatment	£ 97,650	£ 144,060	£ 61,320
No investigation with no significant treatment	£ 419,340	£ 492,594	£ 113,390
Unknown (coding)			£ 6,344,192
	£ 6,214,236	£ 6,353,633	£ 8,094,992

Category levels increase with more serious accidents.

Summary of findings: Coding within ED continues to be inconsistent but we are able to see the increasing cost of ED as an urgent care resource

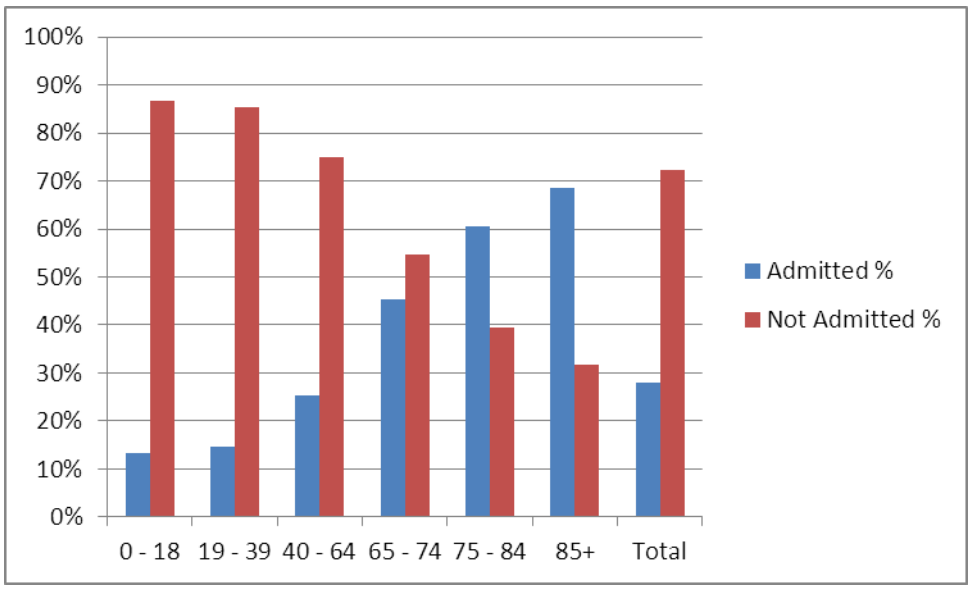
Table 3 shows, based on these ED attendances, the number admitted, by age:

TABLE 3 – ED Admissions *(April 2013 – March 2014)*

ED Activity				
2013-14	Attendances (Admitted)	Attendances (Non Admitted)	Total	Admitted %
0 - 18	2075	13434	15509	13%
19 - 39	2629	15278	17907	15%
40 - 64	3941	11714	15655	25%
65 - 74	2665	3230	5895	45%
75 - 84	3647	2389	6036	60%
85+	3425	1581	5006	68%
Total	18382	47626	66008	28%

Figure 7 below shows the proportion of patient attendances admitted and not admitted:

FIGURE 7 – Attendances Admitted Vs Not-Admitted *(April 2013- March 2014)*



Summary of findings: Although the 19-39 age range show the highest activity for ED attendances, it is clear that, as the age increases so does the proportion of those admitted. 70% of those aged over 85 attending ED result in an admission, with many of these as a result of poor LTC management.

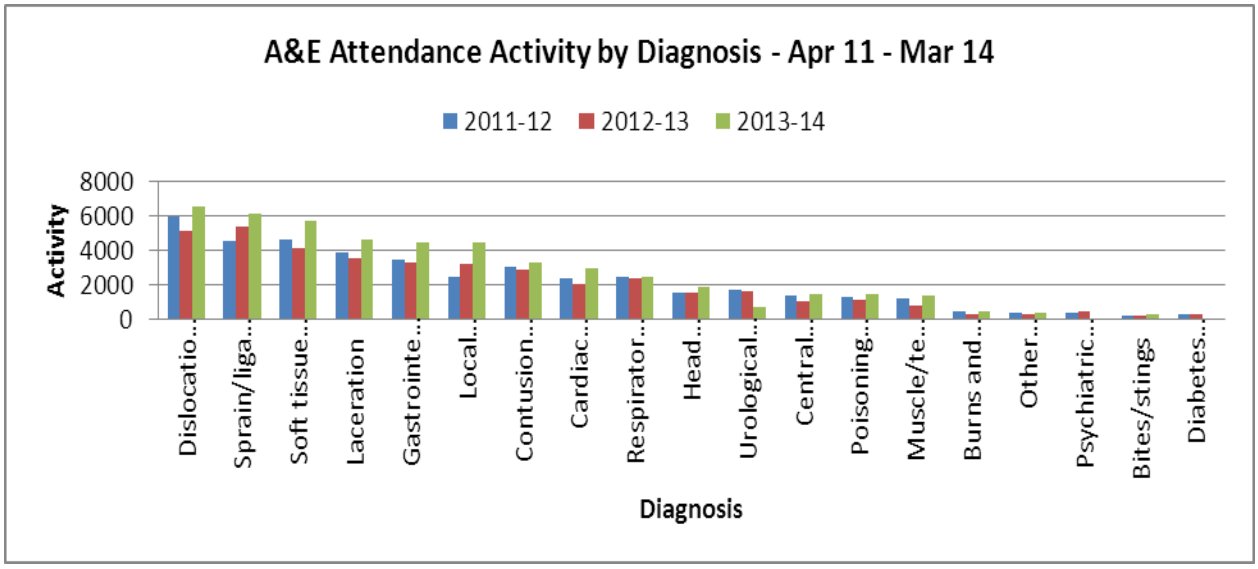
Table 4 shows the proportion between Major ED attendances and Minor ED attendances

TABLE 4 – ED Attendances, Minor Vs Major *(April 2011- March 2014)*

	2011/12	2012/13	2013/14
Major	39199	38641	10798
Minor	21030	23251	55210
Total	60229	61892	66008

Figure 8 shows the minor ED attendances by condition for 2013/14:

FIGURE 8 – Minor ED Activity (*April 2011- March 2014)*



Summary of findings: The number of minor ED attendances continue to rise with the number of major ED attendances decreasing. This may be due to the change in secondary care coding and levels of upgrade from minor to major following booking. This appears to be a national trend across the country with patients citing the primary reason for attending ED for minor conditions is that they were unable to access other health services within a timely fashion.

4.4. Level 2b: Primary and Community Services

Linking with the CCG Care Closer to Home Strategy, the main focus is to provide increased care within the community and to avoid people attending ED where clinically inappropriate. Services in the community include community nursing, rapid response teams with case management and risk stratification of people with complex needs.

Work on demand and capacity mapping, and providing improved ease of access through the commissioning of Single Point of Access systems is being addressed within the CC2H Strategy.

All urgent care services will be required to work in integration with primary and community services to ensure safe and efficient services are in place for patients before and after their discharge from hospital.

4.5. Level 2a: Primary and Community Services

Minor Injuries Units: Clacton and Harwich

Table 5 shows activity for 2011 to 2014 for North East Essex patients within the Minor Injuries Units:

TABLE 5 – Minor Injury Units Activity (*April 2011- March 2014)*

MIU Activity		
Year	Harwich	Clacton
2011-12	5371	18605
2012-13	6034	22542
2013-14	5691	24354

Summary of findings: There continues to be increasing demand within the Clacton Minor Injuries Unit due to an increasing population and an increasing population aged over 65 within the area. Harwich MIU activity has remained comparitively stable over the past 3 years.

Table 5 shows attendances to the Minor Injuries Units by days of the week in 2013/14:

TABLE 5 – Minor Injury Units Activity by Day of the Week *(April 2013- March 2014)*

MIU Activity - 2013-14		
Day	Harwich	Clacton
Monday	1016	4125
Tuesday	835	3561
Wednesday	788	3449
Thursday	787	3404
Friday	808	3340
Saturday	800	3378
Sunday	657	3097

Summary of findings: Both MIUs show the highest patient demand on Mondays and lowest demand on Sundays. This will need to be considered when resourcing these services.

Table 6 shows the top presentations at the Minor Injuries Units for 2013/14:

TABLE 6 – Minor Injury Unit Activity by Presentation *(April 2013- March 2014)*

MIU Activity - 2013-14				
Diagnosis	Harwich	Clacton	Total	%
Laceration	930	3354	4284	14.26%
Diagnosis not classifiable	523	3563	4086	13.60%
Soft tissue inflammation	1184	2740	3924	13.06%
Sprain/ligament injury	480	2898	3378	11.24%
Dislocation/fracture/joint injury/amputation*	514	2085	2599	8.65%
Contusion/abrasion*	463	2060	2523	8.40%
Local infection	203	1115	1318	4.39%
Muscle/tendon injury	181	1001	1182	3.93%
Bites/stings	211	782	993	3.31%
Burns and scalds*	186	654	840	2.80%
Ophthalmological conditions	106	640	746	2.48%
Foreign body	123	516	639	2.13%
Dermatological conditions	72	443	515	1.71%
ENT conditions	83	415	498	1.66%
Unknown	67	360	427	1.42%
Head injury*	68	337	405	1.35%

Summary of findings: Similar presentations and conditions occur within both Harwich and Clacton MIUs. With high levels of injuries requiring diagnostics and skin problems requiring pharmaceuticals.

Walk in Centre: Colchester

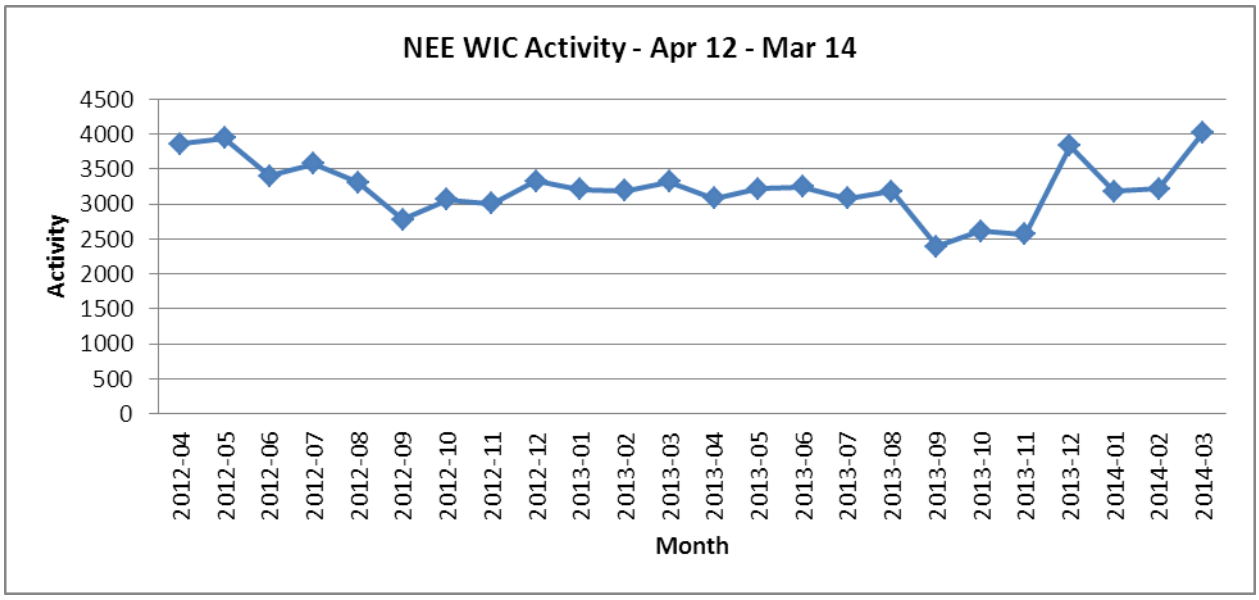
Table 7 shows activity for 2011 to 2014 for NEE patients within the WiC:

TABLE 7 – Walk in Centre Activity *(April 2012- March 2014)*

Year	Total Walk ins
2012/13	42,783
2013/14	55,348

Figure 9 shows the walk in patients by month over the past two years, showing the seasonal trends and peaks:

FIGURE 9 – Walk in Centre Activity by Month *(April 2013- March 2014)*



Summary of findings: WiC attendances have increased in 2013/14 with a steady climb since September 2013 which is indicative of the continuous increase in demand across the overall health system, comibined with the pressure within general practice and the need for additional patient access points.

4.6. Level 1: Patient Self Care

Educating the public to pro-actively manage their health conditions and how to access health services appropriately is an absolute priority and will positively impact on and influence urgent care service provision.

The work needs to include the use of 111 for patient reassurance, advice on self-treatment and sign posting to the correct services.

111 Service for NEE

The NHS 111 service in NEE has received 127,424 calls between November 2013 and May 2014.

It was predicted that 32% of the NEE population would utilise the service, however, local data suggests activity remains under 23%.

In addition, since November 2013:

- 9,031 ambulances were dispatched by the 111 service and an average of 45.1% resulted in the patient not being transported to hospital
- 18,270 calls within NEE have been triaged to the Out of Hours service provided by Care UK
- 1,663 patients have been advised to attend the Colchester Emergency Department.

Pharmacists

There are 62 pharmacies in NEE. Pharmacists are recognised to be an underutilised alternative to general practice consultations for advice on patient self-care and the treatment of minor injuries and illnesses. Pharmacists can also provide support for the management of some long term conditions which represent a major burden on other higher cost services. The system needs to actively engage with this sector to explore how its increased utilisation can shift patient demand and behaviour and lessen GP, WIC and MIU workload.

5. Vision for Urgent Care

The intended outcomes of the urgent care system is one that is able to meet the needs for the NEE population within the resources available, delivering improved quality and patient experience.

The health and social care system needs to work closely together to achieve the CCG's vision of an integrated urgent care system with the following key strategic objectives:

- Consistent, high quality treatment and care within an acute setting, within the community or at home wherever you present and at whatever time of day
- Patients will be managed out of hospital wherever possible with safe thresholds set and consistently applied
- Every consultation will have relevant patient data accessible to the clinician to enable safe advice and treatment
- All partners will recognise their role and will participate in the management of the urgent care system, with plans in place to provide capacity during surges in demand

These objectives combine the views and opinions gained from the public and services users on improving the NEE urgent care system. By successfully meeting the objectives and vision of the urgent care system, NEE will commence achievement of the four aims set out in section 2 of this document.

To facilitate successful achievement of the vision, a number of key projects have been defined as high priority over the next three years.

A review of the four CCG aims and strategic objectives resulted in the agreement of essential actions and the development of key projects designed for successfully achievement.

The projects were then assessed through a prioritisation tool during the stakeholder workshops to reach an agreed work-plan consisting of projects that offer high value for the overall system.

Projects were scored using the template found in Appendix 2 and the results are shown in Appendix 3

Projects evaluated with an outcome of low value were put on hold to ensure those that agree with the over-arching aims defined in section 2 of this strategy are implemented first

The CCG will work with stakeholders to ensure that urgent care priorities are aligned with theirs and result in a clear system wide delivery plan for the next five years.

Urgent Care Programme Plan

5.1 Urgent Care Structure for North East Essex

Supporting;

Aim 1: To reduce unplanned hospital admissions/re-admissions by 3.5% by the end of 2015, with a continuous reduction of 1% over the next 3 years
Aim 2: To reduce A&E attendances by 10% by the end of 2015 from the current baseline in April 2014, with a continuous reduction of 2% over the next 3 years
Aim 3: By April 2016, 100% of patients requesting a same day consultation receive this

This must align with the NHSE Primary Care Strategy for successful implementation.

The (NHSIQ) facilitated workshops have enabled stakeholders to discuss and visualise the possible transformation of the urgent care system structure and how it will be achieved.

Principles of new services include:

- To change the way we work to meet the current, and predicted, increasing levels of demand and population
- To provide services in all areas, including Colchester, Clacton and Harwich and rural localities
- To commission services to work collaboratively
- To improve consistency of services across NEE including the scope of services, times available, appointment methods and availability of services/diagnostics
- To consider the future role of primary care and the transformation agenda
- To consider separating where and when acute conditions and long term conditions are seen and by whom
- To include timely, quality triage in all services from first contact to ensure patients are seen in the correct setting by the correct people, first time
- To consider the future use of the 111 and out of hour (OOH) services and how they will work when the shift to 7 day working and / or extended hours occurs
- To ensure all services are deliverable and within the available budget
- To decommission services that are no longer effective, or evidenced to no longer benefit patients
- To ensure all services provide a good patient experience
- To ensure all services work together to encourage patients to take ownership of their own health
- To empower staff and carers to make decisions, understand risk and direct patients to the most appropriate care setting

Workshop discussions established the advantages and disadvantages of potential urgent care delivery models; for example, a model was agreed in July 2014 with recommendations that the WIC be re-commissioned as an Urgent Care Centre and relocated at the front of ED. The centre will become the main urgent care hub and will triage all attendees before they enter ED to determine if they are in the correct care setting for their presenting condition and will then signpost patients to alternative, more appropriate services as necessary.

Harwich and Clacton MIUs will form spoke models for the Urgent Care Centre working in similar ways with similar scope of service and access. This model will require decommissioning ED minors from Colchester Hospital and this activity will then be included in the scope of the Urgent Care Centres.

Outcomes - *As a patient*:

- *I have access for urgent health issues at a central location*
- *I have access to the right people and right tests in an emergency*
- *I know when and how to use the urgent care system*
- *For patients to feel confident of when to use urgent care services and to feel that their needs have been met on their first attendance*
- *A seamless process from primary care to urgent care pathways*
- *To have consistent access to urgent care services irrelevant of location, day or time*

How will this be achieved?

By combining and re-commissioning the current contracts for the local WIC, the Clacton and Harwich MIUs, NEE OOH Service and the NEE 111 service. The aim is to determine an innovative and integrated way to commission these services to provide a consistent urgent care system that is simpler for patients to navigate.

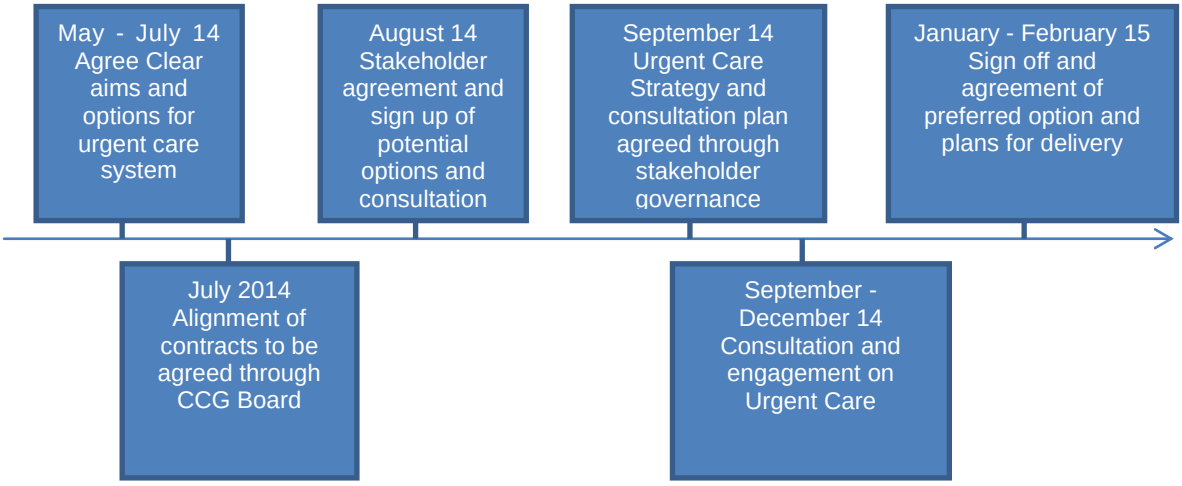
Potential models and options will be designed in partnership with all NEE stakeholders. A full public consultation will take place from December 2014 to ensure all views are taken into account when designing the new system.

System changes may result in potential changes in service location, ways of working and patient pathways, but will ultimately improve services for the NEE population.

In achieving these outcomes the following objectives will also be met:

- To reduce the number of Ambulance conveyances to ED and subsequent hospital admissions for 2 days or less, where patient needs could be met elsewhere
- Increased patient satisfaction on access and experience within the urgent care system
- Reduce the wait time for ED majors

Timescales



5.2 Primary Care Support to Care Homes

Supporting;

Aim 1: To reduce unplanned hospital admissions/re-admissions by 3.5% by the end of 2015, with a continuous reduction of 1% over the next 3 years

Aim 2: To reduce A&E attendances by 10% by the end of 2015 from the current baseline in April 2014, with a continuous reduction of 2% over the next 3 years

Must align with the CCG Care Closer to Home Strategy and NHSE Primary Care Strategy

The number and complexity of individuals residing in care homes is set to rise and is placing an increasing pressure on the urgent care system. Many cases could be managed successfully within the care home environment with the right community care support and co-ordination of services.

Outcomes - *As a Care Home resident*:

- *I will have access to a proactive Primary Care Service that responds when I need them*
- *I will feel satisfied in my experience with Health and Social care where my needs are being met in the right place, at the right time*
- *The Care Home staff will feel empowered and confident in knowing how to access support in order to manage and meet my needs*
- *Care Home staff and I will feel that services are integrated and that I do not have to repeatedly 'tell my story' to different professionals*

How will this be achieved?

Through the commissioning and development of a dedicated service to improve primary care access to care homes providing a standardised approach across NEE for care home residents.

The service will proactively case manage patients with the aim of preventing crisis through engagement with other community services to support the resident remaining in the care home whenever possible and appropriate.

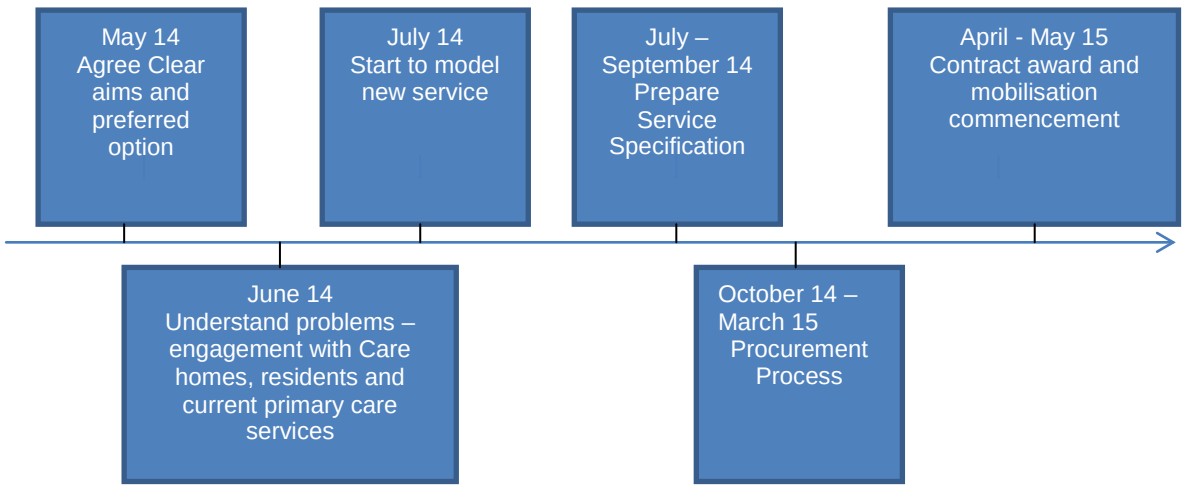
Through adequate reassurance from the service and additional training, the care home staff will be knowledgeable and confident in accessing the correct support, rather than reach to 999 for non -life threatening conditions.

Social Services will play a key role in these changes due to holding care home contracts and monitoring the quality of services within care homes. Health and Social care will need to work together to design services that are going to be fit for purpose and improve the standards for patients residing within care homes.

In achieving these outcomes the following objectives will also be met:

- To reduce the number of ambulance calls from care homes where needs are met within the community setting, particularly in relation to falls
- To reduce the number of Ambulance conveyances to A&E and subsequent hospital admissions for 2 days or less, where needs could be met within a community setting
- To optimize prescribing and to reduce the amount of medicines wastage
- To improve the education and training for care home staff in relation to specific health issues.

Timescales



5.3 Intermediate Care

Supporting;

Aim 1: To reduce unplanned hospital admissions/re-admissions by 3.5% by the end of 2015, with a continuous reduction of 1% over the next 3 years

Must align with the CCG CC2H Strategy

The pressure on intermediate care services in NEE is expected to rise with the increased focus on patients being cared for closer to home rather than being treated in a hospital setting. The increased pressure on hospital beds will require earlier discharge of patients, resulting in an increased number of more complex patients needing treatment in the community.

It is recognised that patients require different levels of care (which include reablement) and the current provision of individually commissioned services along this patient pathway does not facilitate seamless transfers for patients who may require different intensities of care. This therefore creates duplication in the system, confusion for referring clinicians and frustration for patients in accessing a number of services.

Aims for intermediate care service;

- Prevent people staying in hospital longer than they need to by providing rehabilitation at home and to support early and safe discharge from Acute settings to home, to allow patients to reach their optimum level of independence
- Through the use of rapid assessment of individual's patients' needs, planned and focused intensive interventions, to maintain people in their own homes
- Admit patients in crisis to nurse led beds at Cheviots Nursing Home where loss of functional independence is notable to be safely managed within the community, however does not require acute care. These beds will be proactively managed in order to provide. intense rehabilitation
- To provide time limited support up to 6 weeks.
- To provide health prevention and promotion advice to patients at time of assessment; referring to other community services as need dictates.

How will this be achieved?

Intermediate Care is a range of community based services target to facilitate early discharge from acute settings in order to prevent unnecessarily prolonged hospital stays and to prevent inappropriate admission to acute inpatient care. Through the use of rapid assessment of individual's needs, planned and focused intensive interventions the primary aim of the service is to maintain people in their own homes.

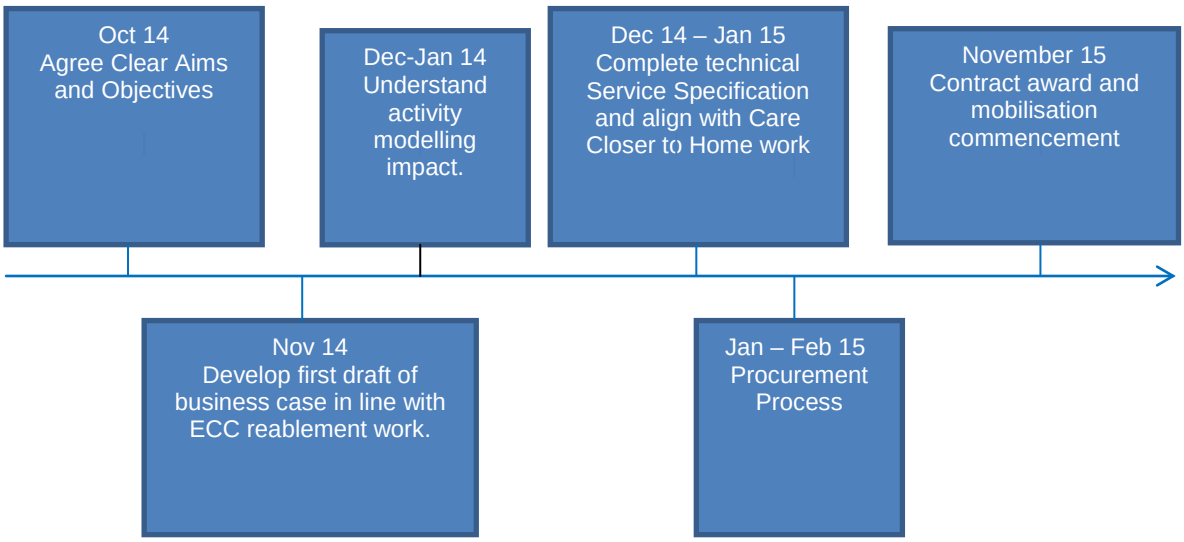
The service will have a number of features that will be central to delivery;

- Rapid Response /Crisis intervention/Early discharge:
  The service will offer a rapid response, which will aim to respond to referrals and arrange short-term care packages within four hours. This service is for patients who require nursing care/support in a crisis, who otherwise would have to be admitted to hospital, thereby avoiding an admission.
- End of Life/ Preferred Priorities of Care:
  To provide care and nursing support so as to allow the dying patient and their family the choice of dying at home or in their own environment. A high quality, co-ordinated and seamless service that meets individual physical, cultural, spiritual and psychological needs and preferences, is offered to patients who appear to be entering the terminal phase of their lives and may be rapidly deteriorating.
- Facilitation of multidisciplinary team input for end of life patients is key to the service delivery. Patients admitted to the service have a clearly identified key worker who is responsible for the case management of the patient on their journey through the service
- Clients who present to the Emergency Department (ED) or minor injuries to facilitate transfer back to the community with appropriate support and follow up:
- Assess and intervene in cases referred by GPs and community matrons where intermediate care support is likely to avoid an admission in the proceeding 2 to 3 days
- The service will be expected to work in conjunction with any other community service in-particular reablement service also being provided to the patient to support and work towards shared outcomes.

In achieving these outcomes the following objectives will also be met:

- Prevention of admission to acute service, residential care or nursing home
- Maximise functional independence potential
- Reduction in length of stay for patients within secondary care

Timescales



5.4 Primary Care Access

Supporting:

Aim 2: To reduce A&E attendances by 3.5% by the end of 2015 from the current baseline in April 2014, with a continuous reduction of 1% over the next 3 years

Aim 3: By April 2016, 100% of patients requesting a same day consultation receive this

Must align to the NHSE Primary Care Strategy

Primary Care plays a key role in the urgent and emergency care system. General practice is just one element of primary care which also includes dental, pharmacy and optometry services.

There are 42 GP practices situated within NEE. Practice patient access systems vary in the number and type of appointments offered and many patients report finding it difficult to access urgent, same day appointments which results in the inappropriate use of the WIC, MIU and A&E. Patients who work also find it challenging to access a GP appointment as not all practices provide extended hours (appointments outside core hours of 08.00 – 18.30) and some still close at lunchtime.

The majority of Big Care Debate responders expressed discontent and concern regarding primary care access and the difficulty in accessing a GP. Coupled with the wide variation of referral patterns and capacity within practices, there is a clear need for general practice to review its skill mix and transform and improve patient access systems to alleviate pressure on the urgent care system. General practice reform and collaboration will also be required to meet the national seven day working agenda and patient expectation.

Patients must also be educated that it is not always necessary to be seen by a GP and a consultation with a nurse practitioner, practice nurse, healthcare assistant or pharmacist is a more appropriate clinical option. The CCG will work with NHSE to ensure there is adequate emergency dental care provision to lessen patient attendance at GP practices or urgent care services for this reason.
This will require further work with dental partners and local optometrists to ensure patients have access to these services which may sometimes be more appropriate than seeing their GP.

Outcomes for Primary Care;

- *Improved access to general practice consultations through the use of technology, including, telephone consultations, Skype consultations and online booking*
- *Extended GP practice opening hours aspiring to 08.00-20.00 hours, seven days a week to give all patients parity of access to face-to-face GP and Nurse consultations when they require them*
- *Responsive primary care provision including home visiting when clinically appropriate*
- *For patients to feel confident regarding when it is appropriate to access primary care and to feel that their needs have been met on their first attendance*

How will this be achieved?

The CCG will work closely with NHSE area team who currently hold and manage primary care contracts. A joint approach between the two organisations, with input from our member practices within NEE, will result in cohesive decision making and commissioning.

A number of research and scoping projects will be undertaken in the next 12 months to determine and agree the best way forward to improve patient primary care access and reduce urgent care activity in NEE.

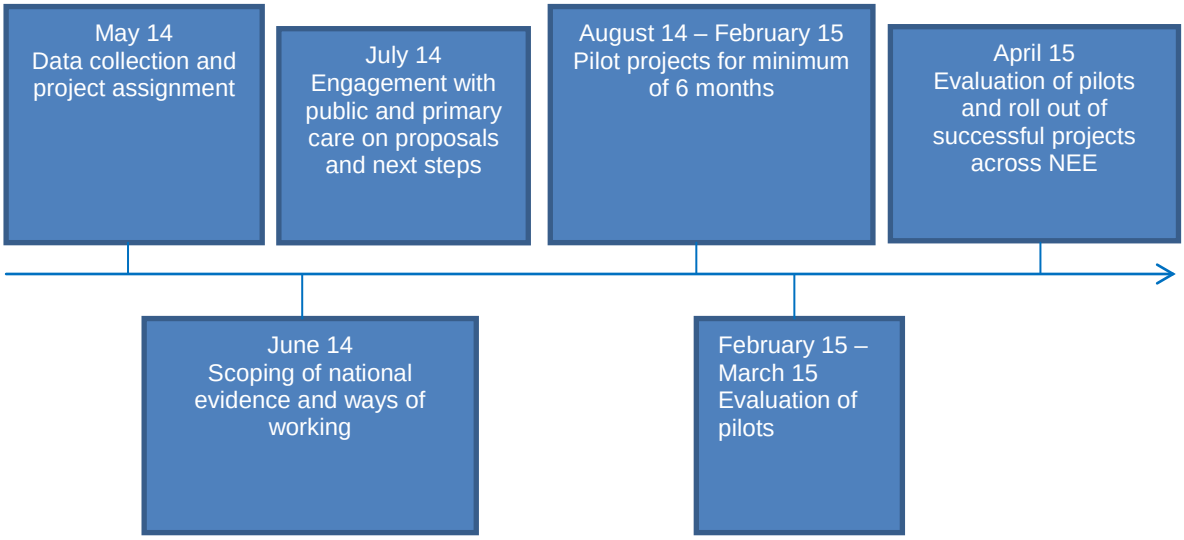
These include:

- Demand and capacity review and service mapping using the primary care data collection work undertaken in 2013/14. The data have been mapped by practice against the use of other urgent care services including A&E, WIC, MIUs, EAU and 111. This data will form the trend analysis benchmark for future capacity and demand work
- A review of national evidence of GP 08.00-20:00 working will be undertaken to establish the resources and capacity required for delivery. This review will be undertaken with GP practices to determine their interest and opinions. An evaluation of the GPPC led weekend working pilot that occurred from 15th February 2014 to 27th April 2014 will also take place to determine its success
- A review of national evidence relating to a Single Point of Access service for GP appointments will be undertaken, to evaluate IT and infrastructure requirements and assess public feedback on the success of the new booking system
- A review will be undertaken by GPs on continuing or discontinuing the option of offering same day appointments, to explore whether resources such as WIC and MIU should take on additional daily demand, and have their contractual scopes changed to meet the activity increase
- Trials will be undertaken with thorough evaluations on the use of technology within primary care, including the use of telephone and Skype consultations and increasing the use of online booking

In achieving these outcomes the following objectives will also be met:

- Increased patient satisfaction with the access and experience within primary care
- Reduction in the use of WIC, MIUs and A&E
- Reduction in the number of minor A&E attendances

Timescales



5.5 Patient Self-Care

Supporting:

Aim 1: To reduce unplanned hospital admissions/re-admissions by 3.5% by the end of 2015, with a continuous reduction of 1% over the next 3 years

Aim 2: To reduce A&E attendances by 10% by the end of 2015 from the current baseline in April 2014, with a continuous reduction of 2% over the next 3 years

Must align to the CCG Care Closer to Home Strategy

Self-care and prevention strategies for children, older people, those with mental health needs, and carers have the potential to impact significantly on the need for urgent and reactive care. Similarly, the evidence that anticipatory care in Long Term Conditions reduces hospital admissions is substantial. Research has shown that supporting self-care can improve health outcomes and increase patient satisfaction resulting in reduction in length of stay in hospital, better medicines management, a reduction in A&E visits and a reduction in hospital admissions.

The system will need to work together, including pharmacies, dentists, optometrists and general practice.

Outcomes – As a Patient;

- *I am educated where possible in managing my conditions at home, myself*
- *My carer or family members are educated where possible in managing my conditions with me*
- *I have options open to me on where and how to access support and education on self-care*
- *I feel more confident and empowered to help myself and manage my illness*
- *I do not need as many health professional interventions*

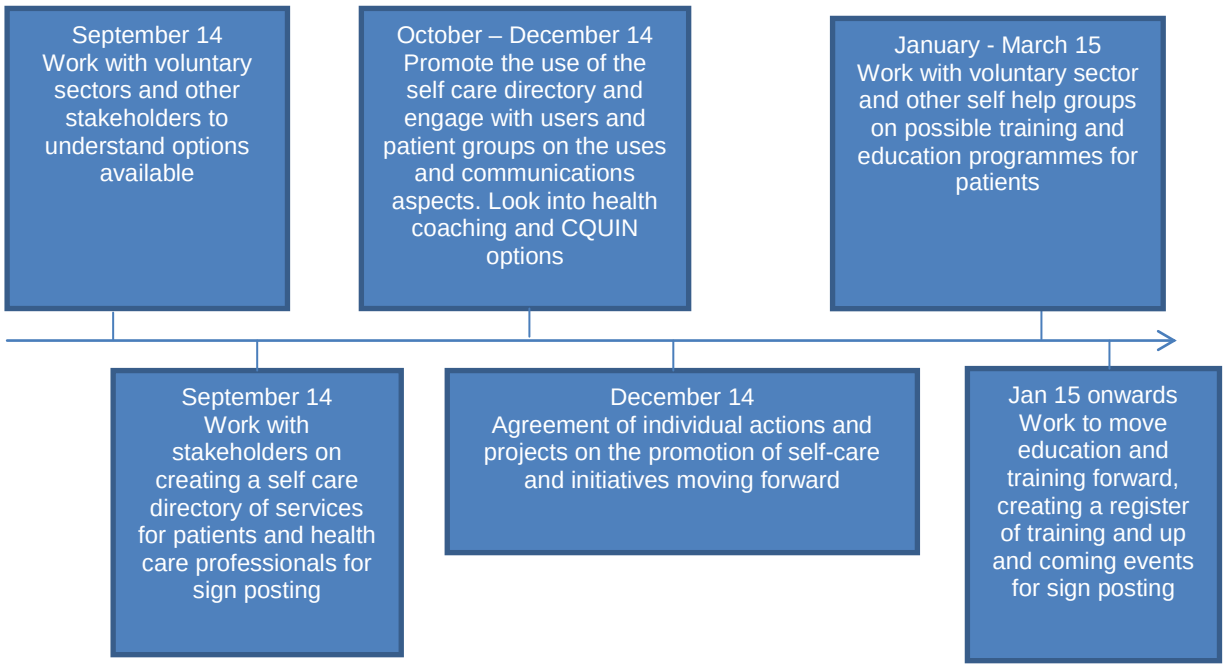
How will this be achieved?

- Educate and support patients to manage their own care where possible
- Utilising pharmacies and their role to promote and encourage self-care
- Initiatives such as Health Coaching for patients and front line clinicians
- Training and education to front line clinicians on supporting patients to support themselves. This would involve work with Health Education England
- Ensure patients work to achieve optimum quality of life and health outcomes
- Review and extend the use of telecare and telehealth where clinically appropriate
- Work with the voluntary sector, support groups and patient groups to develop skills and techniques and a range of options which help reduce anxiety and increase people's confidence in their ability to self-care
- Embed the role of peer support, voluntary sector and community networks in care and support plan
- Support care and nursing homes to have management plans and a skilled workforce to improve self-care needs
- Ensure consistent availability of self-care education and options in all health and social care environments

In achieving these outcomes the following objectives will also be met:

- Reduction in primary care urgent appointments
- Reduction in home visiting
- Reduction in A&E attendances
- Reduction in admissions to hospital
- Increased integrated working between health providers and the voluntary sector

Timescale



5.6 Patient and Public Education

Aim 2: To reduce A&E attendances by 3.5% by the end of 2015 from the current baseline in April 2014, with a continuous reduction of 1% over the next 3 years

Accessing urgent care services can be a confusing process with many patients defaulting to the local ED due to the complexity of our current system. NEE has a range of dedicated and professionally delivered urgent care services for patients who need urgent assistance, however, the current system can be confusing for people to understand what service to access and when. Patients and the public need targeted information and guidance that gives them the confidence to choose the appropriate service when they need urgent care.

Outcomes – As a Patient:

- *In time of requiring urgent care services, I will have the understanding of where to attend that is most appropriate for my need*
- *I will not be passed around the urgent care system – I will have the confidence to have chosen the right route first*
- *I will feel satisfied with my experience of the urgent care service that I access*
- *I will feel assured that local healthcare providers are all communicating the same messages and hence will not be confused*

How will this be achieved?

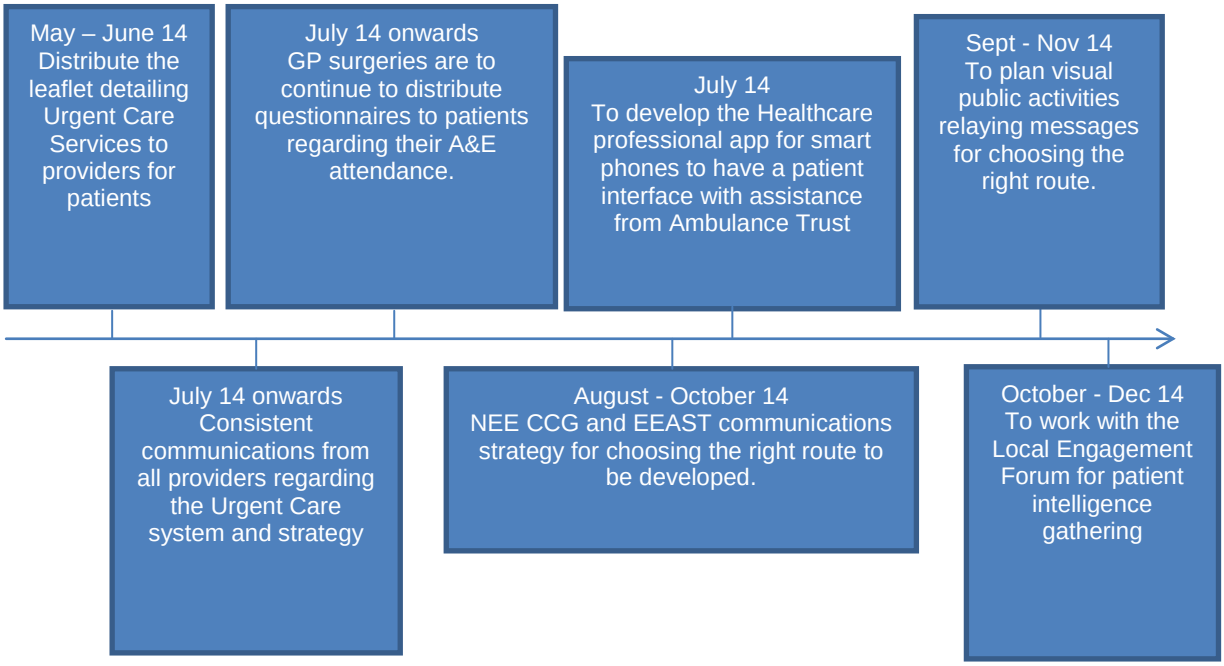
- We have designed, produced and distributed an easy to follow patient leaflet that details all the urgent care services available in NEE and what symptoms, illness or injuries they are designed to treat and manage.
- Interactive and visual public communication activities about choosing the right route for illnesses and injuries will continue to take place twice in year in both Clacton and Colchester town centres.
- NEE CCG will work closely with our Local Engagement Forum consisting of patient representatives to gain intelligence on patient perspectives and to link further with patient groups for their opinions on the urgent care system locally.
- NEE GP surgeries will continue to contact patients, known to have accessed A&E inappropriately, to question and understand the reason for their attendance by using a questionnaire template. Results will be shared with the CCG to inform changes in how we educate patients on urgent care use
- The current NEE CCG Healthcare Professional app for Smart Phones will be developed further for patient use. This will detail services available to patients, opening times and locations to enable them to make swift and appropriate decisions regarding which service to access

- Consistent and targeted communication will occur to ensure the same messages are relayed to our population from all local providers. A communications plan will be developed to educate patients in the appropriate use of the urgent care system
- NEE CCG will liaise with the East of England Ambulance Service Trust (EEAST) to develop a communication strategy that educates and assists patients in choosing the right route when in need of urgent care

In achieving these outcomes the following objectives will also be met:

- To reduce the number of inappropriate A&E attendances and ambulance calls as patients and carers will feel empowered to utilise other services available to them
- To increase the communication and information flows to all patients utilising mobile technology and literature
- Improvements will be made, where necessary to the urgent care system based on the comments, opinions and suggestions received from GP surgeries and their patients, the Local Engagement Forum and service users

Timescales



5.7 Patient Risk Profiling and Risk Stratification

Supporting:

Aim 1: To reduce unplanned hospital admissions/re-admissions by 3.5% by the end of 2015, with a continuous reduction of 1% over the next 3 years

Aim 2: To reduce A&E attendances by 10% by the end of 2015 from the current baseline in April 2014, with a continuous reduction of 2% over the next 3 years

Must align with the CCG Care Closer to Home Strategy and NHSE Primary Care Strategy

A small number of patients account for a large proportion of emergency hospital admissions. Assessment of these patients and pro-active care planning will reduce the likelihood of re-admission and provide the patient with the right community support optimise their healthcare. The Combined Predictive Model (CPM) assists GP's in identifying patients at risk of an emergency admission within the next 12 months based on their previous healthcare service activity.

Outcomes – As a recognised risk profiled patient:

- *I will have more choice over where I am cared for*
- *I will be fully involved in making decisions regarding my care, and if I need to make tough decisions surrounding the end of my life, I will be fully supported in doing so*
- *I understand that my GP is proactively managing my care and will contact me if they feel I require an additional intervention to allow me to continue to manage my disease or disability*
- *My case manager will organise all of my care so I do not need to worry about whom to contact*

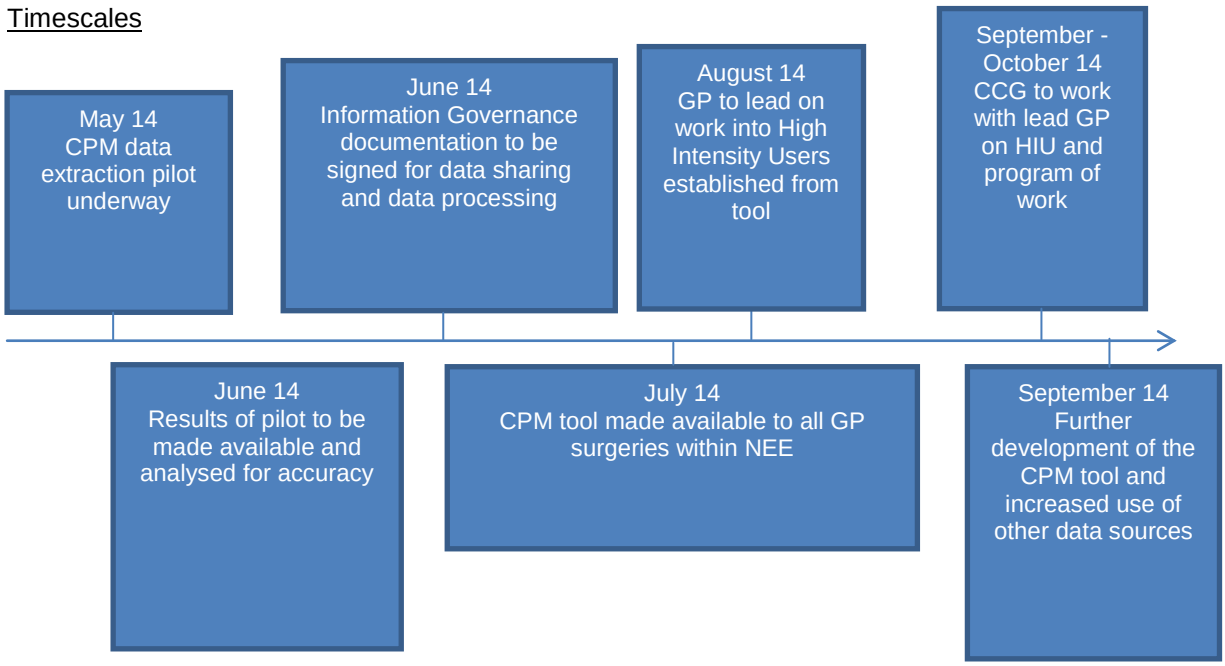
How will this be achieved?

- The use of CPM will assist GPs and other health and social care practitioners to work proactively with patients to identify those at risk enabling them to manage them in a primary care / community setting
- The CCG's expectation is that all GP practices will use the risk stratification information and undertake a multidisciplinary approach to managing patients' conditions, through early diagnosis, reducing the likelihood of admission/readmission to hospital and preventing illness
- Proactively case manage vulnerable patients (both those with physical and mental health conditions) through developing, sharing and regularly reviewing personalised care plans, including identifying a named accountable GP and care coordinator

In achieving these outcomes the following objectives will also be met:

- To reduce the number of unplanned admissions
- To increase care in the community for patients allowing them to receive increased care at home that is managed between the patient, carer and case manager
- To utilise resources more effectively and efficiently for everyone within our population

Timescales



5.8 Patient Care Planning and Case Management [8]

Supporting:

Aim 1: To reduce unplanned hospital admissions/re-admissions by 3.5% by the end of 2015, with a continuous reduction of 1% over the next 3 years

Must align with the CCG Care Closer to Home Strategy

The new unplanned admissions Direct Enhanced Service (DES) requires participating GP practices to identify 2% of their practice populations, who are high risk and are likely to be admitted to hospital, and develop pro-active care management plans for each patient to reduce the need for reactive treatment and unplanned acute admissions.

A forthcoming national requirement is for all patients over the age of 75 to have a named GP and a care plan in place. The CCG will use this directive as a stepping stone to achieve their ambition that 80% of all patients hold an electronic patient record by 2020.

Outcomes – As a patient with my care plan:

- *I will be managed by all health and social care professionals in a proactive way*
- *I will have consistent treatments by all health and social care professionals*
- *I will have more choice and input over where and how I am cared for*
- *My case manager will organise my care so I do not need to worry about what happens next*
- *My case manager is my key contact and so I don't need to worry who to contact with any issues or questions about my care*

How will this be achieved?

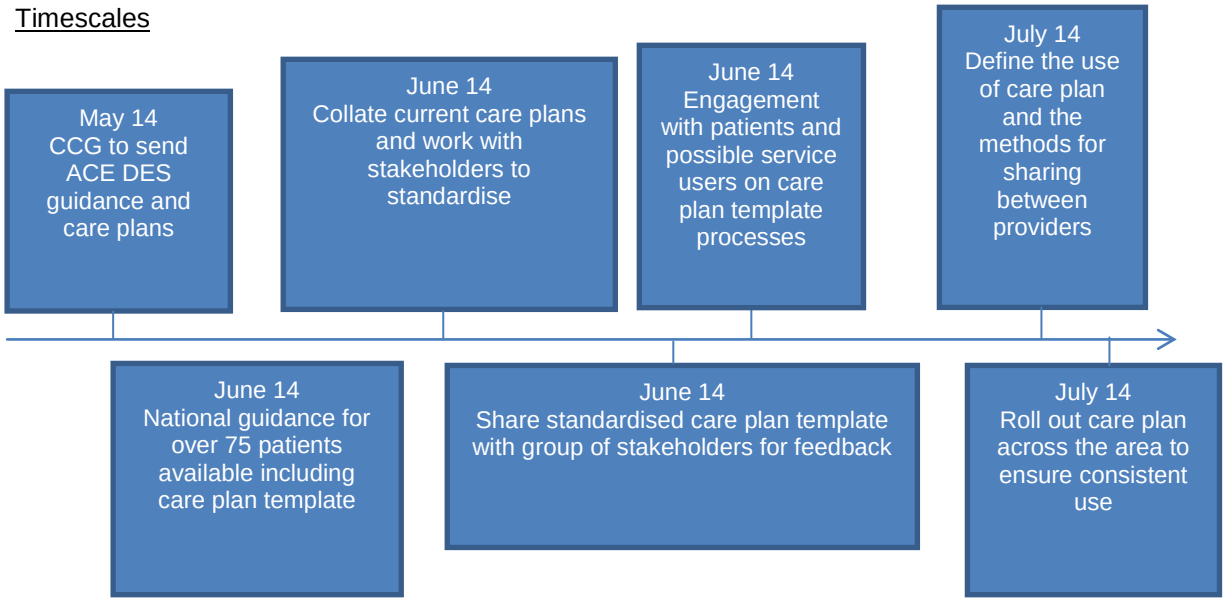
- Work with ACE in combining the current care plan template and case management process with primary care templates for a consistent approach
- Work with stakeholders on the standardised care plan to ensure it is fit for purpose and give feedback for changes and amendments
- Use the combined predictive model (CPM) to identify and pro-actively manage at risk and vulnerable patients. Care plans to be regularly reviewed and updated and a process implemented that allows sharing of patient plans across the system

In achieving these outcomes the following objectives will also be met;

- A reduction in the number of unplanned admissions
- A reduction in the number of re-admissions
- Increased care in the community, along with increased knowledge and ability to self-care at home
- Sharing and integrated working between health and social care professional to create and case manage patients care plans

[8]. Care Planning is a featured 'Core Working Principle' as part of the Care Closer to Home Integrated Community Strategy 2013-2018 therefore post 2014 this project area will be taken forward within that strategy, while still recognising that this work will have a continued impact on the Urgent Care System as outlined.

Timescales



5.9 Patient Care Records and Data Sharing within the Health and Social care system

Supporting:

Aim 4: By 2020, 80% of patients will hold electronic health records
Supporting the national aims of 'Better information means better care'

As we move towards an integrated system of working between providers, both in and out of hours, we will undertake a comprehensive review of the current range of Information Technology Systems that enable the sharing of patient records across providers for consistency, safety of treatment and to offset risk aversion. Research will also be undertaken to determine the benefits of hand held patient records vs electronic patient records. This will be a large and important piece of work that could result in significantly improving a patient's continuity of care within the health and social care system.

Outcomes – As a patient:

- *All providers involved in my care know my past and current treatment and medication*
- *I am not asked the same questions or asked to complete the same form by every different provider I see*
- *I have consistency of care between all providers in all health settings*
- *There is multi-disciplined input into my treatment which all of my care givers are aware of*
- *My information and data is safe and secure, for only my health and social care professional to see*

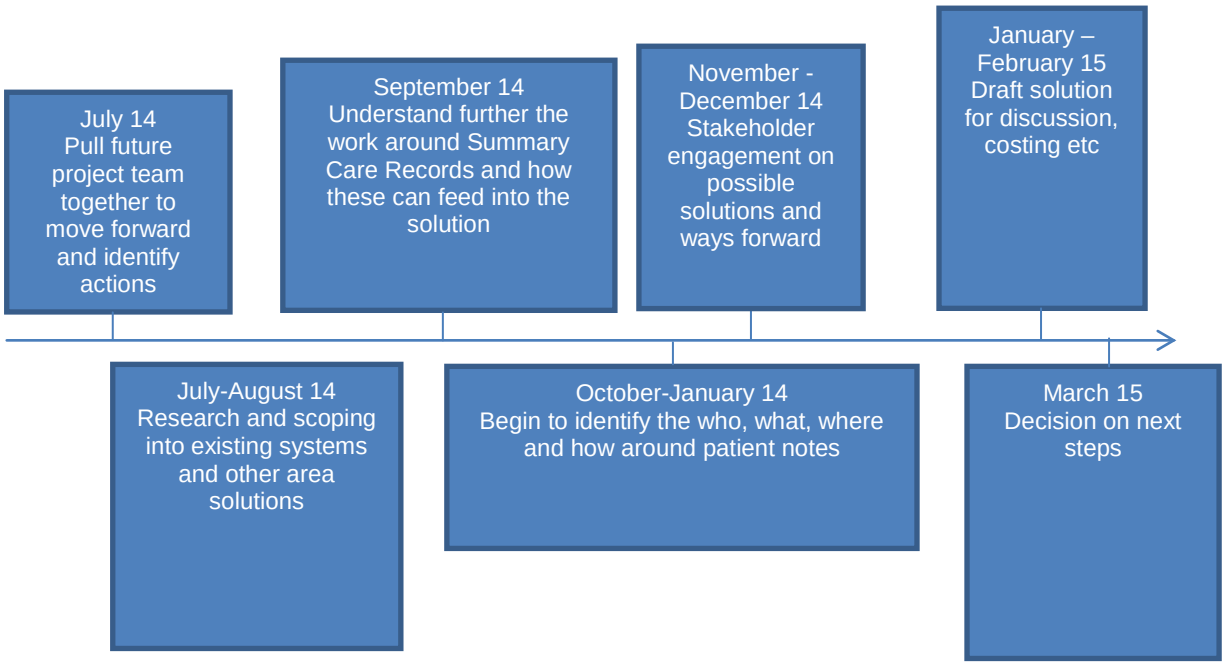
How will this be achieved?

- Research patient data sharing IT systems available and being used in other areas
- Understand who contributes to the patient notes and who would need to be involved in the projects
- Begin the debate on hand held vs electronic records
- Roll out phased implementation to cohorts of patients, for example, first phase - over 75's, second phase - over 65's etc.
- Understand the requirements from patients

In achieving these outcomes the following objectives will also be met:

- Reduction in duplication of services, tests and diagnostics
- Improved quality and safety of the Out of Hours service due to having access to patient records
- Improved integration between service providers
- A smoother more efficient pathway for patients through the health system

Timescales



5.10 Undertaking Continuing Health Care Assessments in the Community

Supporting:

Aim 1: To reduce unplanned hospital admissions/re-admissions by 3.5% by the end of 2015, with a continuous reduction of 1% over the next 3 years

Must align with CCG Care Closer to Home Strategy

Currently Continuing Health Care Assessments typically take place within a hospital setting. Often lack of capacity within the hospital results in a delay in commencing an assessment which can cause an extended stay in hospital and negative health implications for the patient.

It is our intention to provide Continuing Health Care Assessments in the community to give patients greater independence and control and for them to receive timely assessments, closer to home in a positive environment.

Outcomes – As a patient:

- *I am treated within the community and closer to home*
- *My stay in hospital is reduced*
- *My assessment is undertaken in a more timely manner*
- *I am confident and comfortable with the professionals undertaking my assessment*
- *My assessment can be planned around my life*

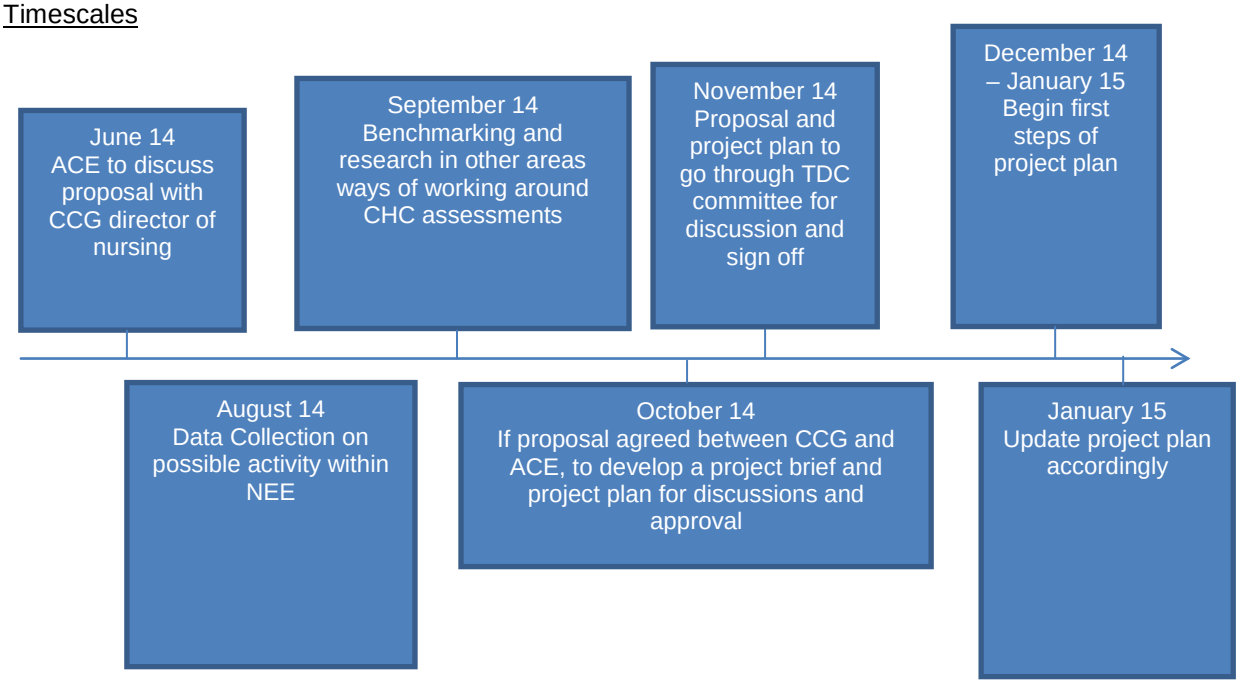
How will this be achieved?

- Understanding resources implications for community health professionals
- Training for community staff
- Process mapping for assessments within the community
- Staffing mapping for assessments within the community

In achieving these outcomes the following objectives will also be met;

- Increased capacity within secondary care settings
- Improved patient experience and satisfaction
- Improved health outcomes from treatment within a community setting in a timely manner

Timescales



5.11 Emergency Care Practitioner Car

Supporting:

Aim 1: To reduce unplanned hospital admissions/re-admissions by 3.5% by the end of 2015, with a continuous reduction of 1% over the next 3 years

Aim 2: To reduce A&E attendances by 10% by the end of 2015 from the current baseline in April 2014, with a continuous reduction of 2% over the next 3 years

The current high levels of call out demand on the ambulance service are increasing and have been exacerbated as a result of the implementation of the 111 service. We need to consider alternative ways of working to ensure that the correct health care professionals are dispatched appropriately to patients in a timely manner. The use of emergency care practitioners (ECPs) could alleviate pressure on the ambulance service and benefit patients.

Outcomes – As a patient:

- *I am seen in a timely manner when called for*
- *I am seen by a health professional with the correct skills to manage my condition/illness/injury*
- *I am seen and treated at home without requiring conveyance into hospital*
- *I have confidence that when I call with a problem that I will be seen*

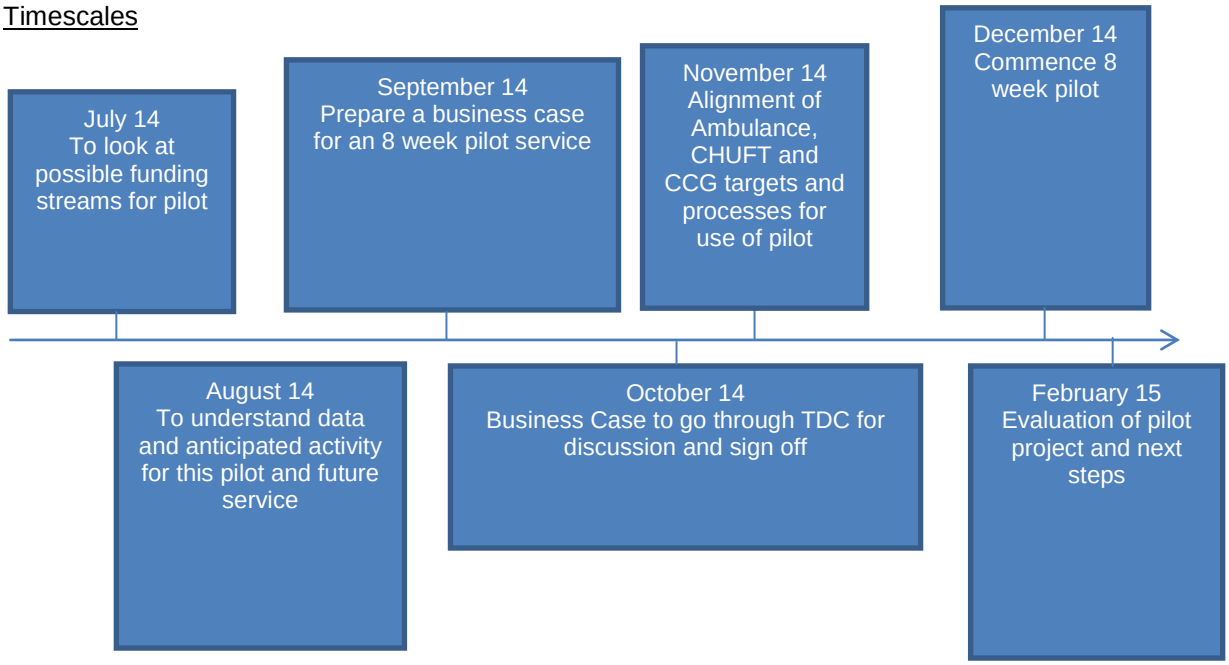
How will this be achieved?

- Understanding funding and resource implications for the area
- Scoping into use of ECP cars in other areas and processes for this. This may involve the training of further ECPs
- Pilot for eight weeks to evaluate the impact and future possibilities
- Align targets of Ambulance service, CHUFT and the CCG to ensure sign up and integrated working for success

In achieving these outcomes the following objectives will also be met;

- Reduction in conveyances into secondary care
- Improved ambulance targets within NEE
- Increased number of patients to be seen and treated on site
- Improve patient experience of the health service

Timescales



5.12 7 Day Working

Supporting:

Aim 1: To reduce unplanned hospital admissions/re-admissions by 3.5% by the end of 2015, with a continuous reduction of 1% over the next 3 years
Aim 2: To reduce A&E attendances by 10% by the end of 2015 from the current baseline in April 2014, with a continuous reduction of 2% over the next 3 years
Aim 3: By April 2016, 100% of patients requesting a same day consultation receive this

Must align with National Strategies and requirements

Many services in NEE are delivered within traditional 'office hours' (09.00 – 17.00 hours) with some already commissioned to provide services over seven days, with extended hours.

National work undertaken by NHSE evidences that variations in service provision, particularly in acute hospitals, has a significant negative impact on mortality, clinical outcomes and patient experience. By taking a system wide approach to identify service gaps and where the public would be better served by providing services over 7 days, we aim to provide integrated, seamless, safe patient care and support that is consistent and accessible every day of the week.

The patient flow from the acute hospital into the community is significantly reduced at weekends compared to activity during the week. The level of patient discharges at weekends needs to be increased and to achieve this we will work with the acute trust to implement the 10 clinical standards developed by NHSE. We will also work with community providers to improve and increase the number of services available at weekends to prevent avoidable admissions to hospital during this period, and to ensure the necessary level of support services and staff are in place to enable patients to be discharged during the weekend.

Social Services play a key role in this work to ensure health and social care integrates to form a cohesive range of services that are available 7 days a week. Social services will need to liaise with other health services to understand how to contract effectively with care agencies to transform the current provision and how patients access services.

Outcomes - As a Patient:

- *My discharge from hospital is not delayed due to services not being available at the weekend*
- *My care in hospital is progressed and not held up due to specialist and services not being available over 7 days*
- *My access to local health care services will be improved to the level where the day of the week is not a limitation*
- *I will not be admitted to hospital unnecessarily due to services being unavailable at weekends*

How will this be achieved?

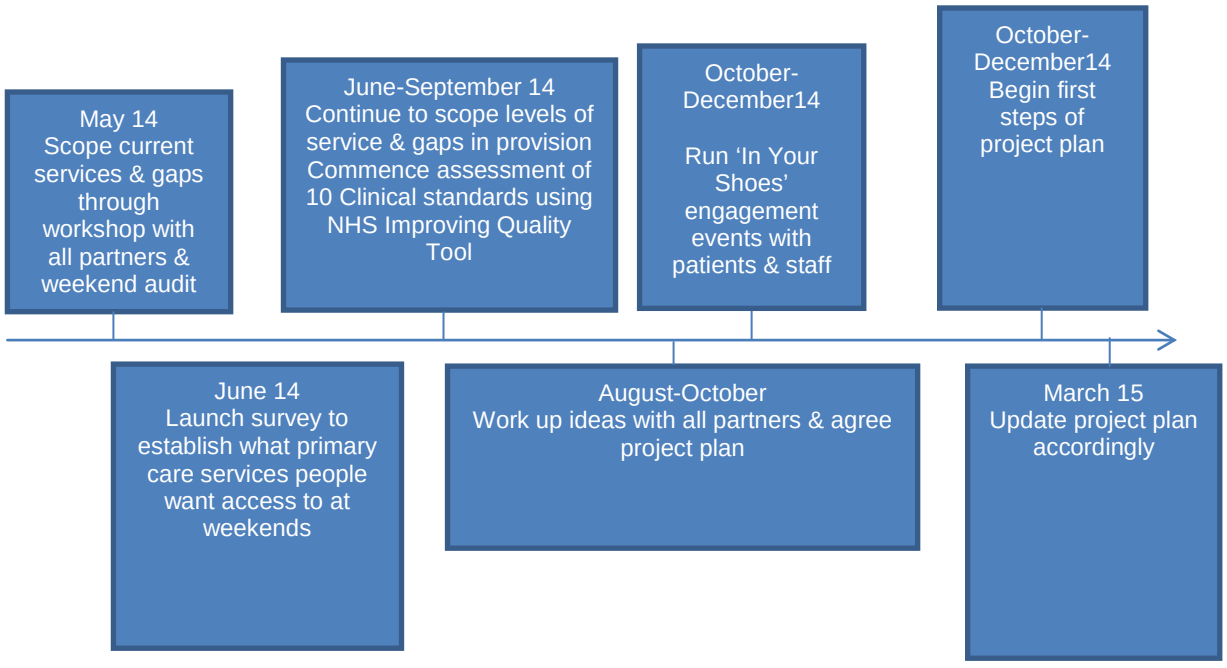
- Work with patients, carers and our partners in the health care system, to create a shared vision for future seven day services
- Implement our shared vision working collaboratively with patients and our partners
- Establish clinically led care pathways which will include services provided by acute, primary, social care and the third sector
- Implement a multi organisational CQUIN to underpin and drive change to implement the 10 clinical standards within the national timeframes - 2016/17

In achieving these outcomes the following objectives will also be met:

- Increased capacity within secondary care settings
- Improved patient experience and satisfaction
- Improved health outcomes from treatment within a community setting in a timely manner
- Implementation of the NHS England's 10 clinical standards within the acute hospital
- Families and carers will have improved support from relevant organisations to help them provide better, sustainable care

Staff working hours and rotas will be improved to ensure that seven day working patterns are sustainable and rewarding and allow staff to retain work life balance.

Timescales



5.13 Mental Health Services

Supporting:

Aim 1: To reduce unplanned hospital admissions/re-admissions by 3.5% by the end of 2015, with a continuous reduction of 1% over the next 3 years

Aim 2: To reduce A&E attendances by 10% by the end of 2015 from the current baseline in April 2014, with a continuous reduction of 2% over the next 3 years

The Clinical Commissioning Group and mental health partners are aware of the increasing demand on urgent care services.

If a person's mental or emotional state gets worse quickly, this can be called a mental health emergency or mental health crisis. In this situation, it is important for them to get help quickly. The overall ambition is to provide proactive and responsive services within community and secondary care services to ensure patients know what to do in a crisis.

By working with patients to improve their longer term care and to plan for urgent situations, there will be improved patient experience, health outcomes and a resulting reduction in the need for ED and in-patient services within NEE.

Work will also be undertaken to ensure that when a crisis does occur, the responsiveness of mental health services are improved.

Targeted schemes of mental health promotion, early intervention and wellbeing initiatives will also be undertaken with a focus on children and young people, at risks groups such as carers, people from BME groups, people who misuse substances and the unemployed. Partnership working with mental health Commissioners and providers of care will continue.

Outcomes - As a Patient:

- *When I have a crisis I know where to access and that the correct healthcare professionals will be there to assist me*
- *I have services to access before I get to crisis. A&E is not the right place for me.*
- *My access to local health care services will be improved to the level where the day of the week is not a limitation*
- *I will not be admitted to hospital unnecessarily due to services being unavailable to me at my time of need*

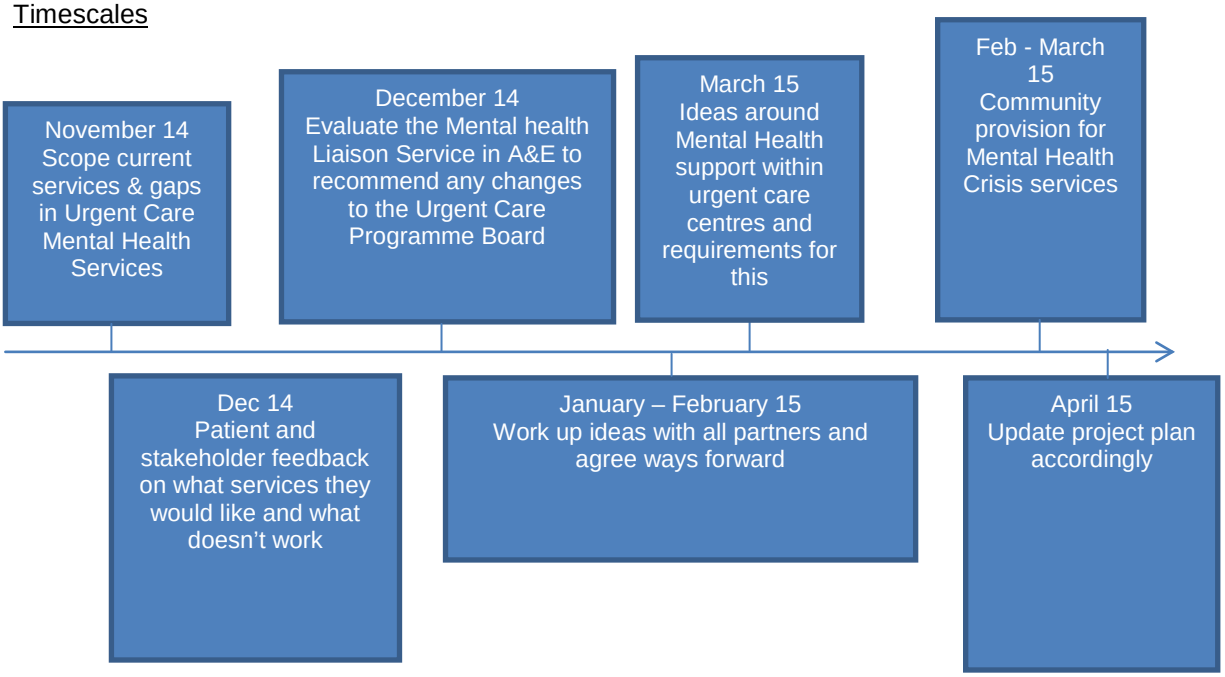
How will this be achieved?

- Work with patients, carers and our partners in the health care system to understand the gaps in services
- Improve the services with additional capacity and expertise for mental health specialists to ensure patients are seen and treated in the most appropriate way
- Consider a separate Mental Health Emergency Department which would be more appropriate for patients

In achieving these outcomes the following objectives will also be met:

- Increased capacity within secondary care settings
- Improved patient experience and satisfaction
- Improved health outcomes from treatment within a community setting in a timely manner
- Families and carers will have improved support from relevant organisations to help them provide better, sustainable care

Timescales



6 Patient & Public Engagement and Communication

NEE CCG cannot deliver its vision of "embracing better health for all" or its values(integrity; person centric; inclusive and delivering health improvements) without close consultation with those that use health services in NEE.

In the process of developing this strategy we set out to understand what is most important to people and what their needs are. We listened to people in a meaningful way and we then used this information to develop and structure urgent care services that are user friendly and truly meet the needs and expectations of the population.

During the strategy consultation stage the CCG were assisted by NHSIQ[9] in facilitating monthly workshops during the period March 2014 to September 2014. All urgent care providers and stakeholders were invited and encouraged to send at least one representative. Representation also included the voluntary sector, patient representatives, Essex County Council, Health Education East of England (HEEoE) and clinical leads.

The workshops allowed open and transparent discussions to take place and for agreements to be formed after an in-depth review and consideration of all service options and possibilities.

Two patient representatives sit on the Urgent Care Programme Board to ensure CCG plans continue to reflect patient interests and that patients remain at the heart of the decision process.

During 'The Big Care Debate, patients informed us of their views on urgent care services and highlighted key themes and areas of service improvement that they wished to see and experience:

- Signposting/information to help me choose services and make healthy lifestyle choices
- 7 day working/longer hours/more access to appointments/location/ named GP/ GP is vital service
- Having plans for my care explained to me
- Improved information sharing/communication between providers in both NHS and Social Care
- Remove duplication
- Improved waiting times
- More confidence in ambulance services should I have an urgent need

[9] NHS Improving Quality: http://www.nhsiq.nhs.uk/improvement-programmes.aspx

- Clear system so I know where to ring and who to see
- Educate me more on long-term health problems and how to combat them
- A reliable GP practice that establishes good relationships and communications
- Shorter waits in A&E. You go there when you have an urgent need and do not want to wait for four hours

Further public consultation will be undertaken to provide a platform for patients to engage in and comment on proposed system changes and to allow the public to be an integral part of the decision making process during the strategy implementation.

The CCG will develop and implement an effective communications plan to engage and inform patients and the public about developments and changes to the urgent care system and how it operates, to enable patients to understand how and when to access it, what they can expect to receive and the benefits of self-care and other information as appropriate.

7 Workforce Planning

The CCG is working closely with Health Education East of England (HEEoE) to ensure that their workforce strategy and work programme aligns with, and is built into, the planning and execution of the NEE urgent care strategy.

The success of the Urgent Care Strategy is predicated on a managed transition of secondary care work into primary care and the community. Improving those services will be necessary and will be largely dependent upon there being a sufficient and sustainable workforce now and in the future to meet increasing patient demand.

HEEoE have met with NEE urgent care providers to ensure that their workforce training and development plans align with provider workforce strategies and challenges. This is to ensure workforce numbers are adequate and providers are equipped with the appropriate competencies to meet future demand as strategy implementation progresses.

HEEoE are leading an Emergency Care Work Stream that has been specifically created to review workforce needs for urgent and emergency care and to assign transformational monies to fund short and long term solutions.

The work stream will carry out age profiling of health care professionals, retirement profiling and vacancy levels in the short term. The profiling will also determine the longer term workforce implications for the health economy in NEE.

HEEoE are working in partnership with local health and social care providers to scope and undertake a number of projects and schemes designed to address current workforce issues and challenges.

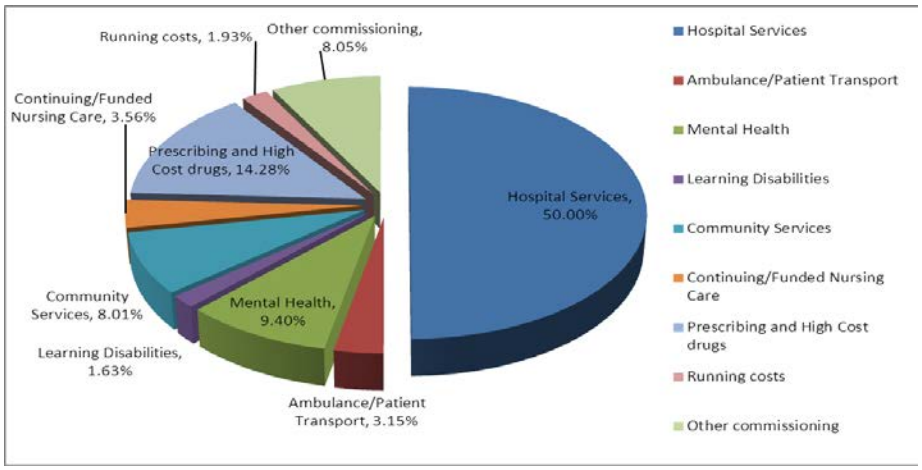
These include:

- Introduction to GP nursing course. There is currently a nurse shortfall both locally and nationally. The CC2H strategy focus is to shift many out-patient specialities to a primary and community setting and there will be a need for an increased number of nurses with enhanced skills to work in multi-disciplinary, multi-agency teams
- Increasing the number of pre-registration student nurse placements to offset long term nurse recruitment problems
- Scoping new ways of working within emergency care over 7 days. This will include the development of a physician assistant role from January 2015. This approach will ensure that all health care professionals are working in their most effective and efficient role to improve quality for the patient
- A primary care workforce and skills audit to inform and assist the urgent care service transition that will be required as the strategy evolves. This may include enhanced GP and Nurse roles and training and new career pathways for the pre-professional workforce (e.g. Health Care Assistants) to ensure the successful delivery of high quality, consistent patient services

8 Financial Overview

It is show below that the CCG spends around 50% of its budget on Hospital Services. This accounts for both elective and Non-elective activity.

In addition to this, urgent care spend is utilised for the commissioning of Ambulance and Patient Transport Services, along with the Walk in Centre, Out of Hours and Minor Injuries Units which are accounted for within the 'Other commissioning' section of the graph.



With activity for urgent services continuing to increase, to stay within the NHS static budget, changes will need to be made.

In order for the CCG to remain clinically and financially viable, the urgent care strategy will be required to deliver QIPP (quality, innovation, productivity and prevention).

This strategy purposely focusses on innovation and integration between all stakeholders in the urgent care system, whilst working closely with the services providing care closer to home to keep people out of hospital when clinically safe.

The commissioning and pathway changes within the urgent care strategy will be responsible for delivering, in part, the CCG's QIPP target over the 5 year period. There is financial leadership and sign up from all urgent care system stakeholders, and those involved in creating the urgent care strategy.

The financial focus will be on:

- Contract alignments for a bundle of urgent care services for efficiency gains
- Reduction in duplications of services within the urgent care pathway
- Risk stratification and predictive modelling to allow provider to flex resources and meet demand in the correct setting
- Collaboration with all service providers
- Decommissioning of ineffective services
- Patient being seen in the right place first time
- Contracting controls to optimise value for money
- Continuous benchmarking and evaluation of activity base-lined within this strategy to learn from peers
- Incentivised commissioning to drive quality and productivity through CQUINS and partnership working

The Urgent Care Programme Board now have the governance in place to monitor the urgent care spend and correlating effect on activity and patient outcomes using the Urgent Care Tracker.
The tracker will provide assurance to the Urgent Care Programme Board members that services within this strategy and that decisions made within the Board have had the desired effect.

The Urgent Care Dashboard, currently in development, will help with the activity and financial modelling and monitoring of these schemes and the overall efficiency of the North East Essex Urgent Care System.

9 Risk Summary

Category	Risk Description	Mitigation and Controls
Contracts	NHSE WIC contract prevents inclusion in transformed service.	Seek early assurance from NHSE on plans for WIC
Contracts	OOH contract cannot be extended to Aug 2015	Take contract/legal advice and develop action plan.
System	Risk that Urgent Care Centre (UCC) replicates current duplication between OOH and 111 services	Stop referring to OOH and 111 and start referring to service outcomes
System	Capacity within the system to meet demand	In-year non-recurrent investment agreed, to alleviate pressures on waiting times and improve access
System	Risk that integration model for UCC excludes potential new providers who could enhance the service	Seek legal advice on constraints of integration model
System	Risk that staff who do not like elements of new contracts (e.g. 7 day working), move to neighbouring providers who do not have this requirement	Liaise with neighbouring commissioners to roll out 7 days working at the same time and pace
System	Risk that an organisation withdraws from the initiative part way through leaving the remaining partners unable to complete the programme without additional delays and costs.	Commitment required from each organisation through a signed MOU
System	Risk that CC2H does not deliver or embed the services that the UCC is dependent upon to implement the new service model.	Programme management to ensure that all programmes are aligned. Workshop for UCC to confirm what its specific dependencies are
Engagement	GPs fail to engage with new schemes that require referral patterns to change and the expected benefits do not materialise as a result	Specific projects will be presented at GP forums to stress the need to comply with new schemes, processes and behaviours, e.g.; Community Beds,
System	Risk of failure to integrate with partners resulting in inefficient costly services which fail to meet the needs of vulnerable service users	Joint meetings for integrated working and shared processes
System	Risk of challenge from providers relating to the procurement of services under the current strategy.	Ensure that commercial rules and procedures are fully adhered to
Quality	Risk that through changes in service provision and providers the quality of current services are compromised	Focus on quality throughout transformation, following CCG vision and values of patient centred focus and continuous improvement
Finance	Possible transitional costs have not yet been identified - not accounted for	To include in overall costing to ensure financial viability. Finance team to be overseeing in projects and programme boards
Engagement	Risk of patients not on board with potential urgent care structures	Communication and engagement plans to be worked up with with consultation with NEE public for feedback and discussions
Finance	Risk we do not align incentives and levers across the system creating an unbalanced commissioning model.	Early identification of required quality and other outcomes so that incentives and levers line up with these across system

10 Programme Governance

The CCG governing body and its sub-committees have all adopted the key principles of:

- *Clinical Commissioning must be focused on individual needs and promote the health and wellbeing of communities, as well as addressing health inequalities.*
- *Clinical Commissioning must work in the spirit of public service, professionalism and selflessness to serve our local population.*
- *Clinical Commissioning should be driven by the health needs of the population, prioritising our commissioning towards work which delivers the greatest improvements in health and the best possible experience for all.*
- *Clinical Commissioning will seek to continually improve quality wherever possible and to embrace innovation to achieve this, within available resources and ensuring value for money.*
- *Clinical Commissioning must be drivers of strong clinical leadership and enablers of clinical empowerment.*

This strategy has been developed based on these commissioning principles and the internal rigor in the authorisation of this strategy is outlined in Appendix 4.

11 Project Plan and Milestones

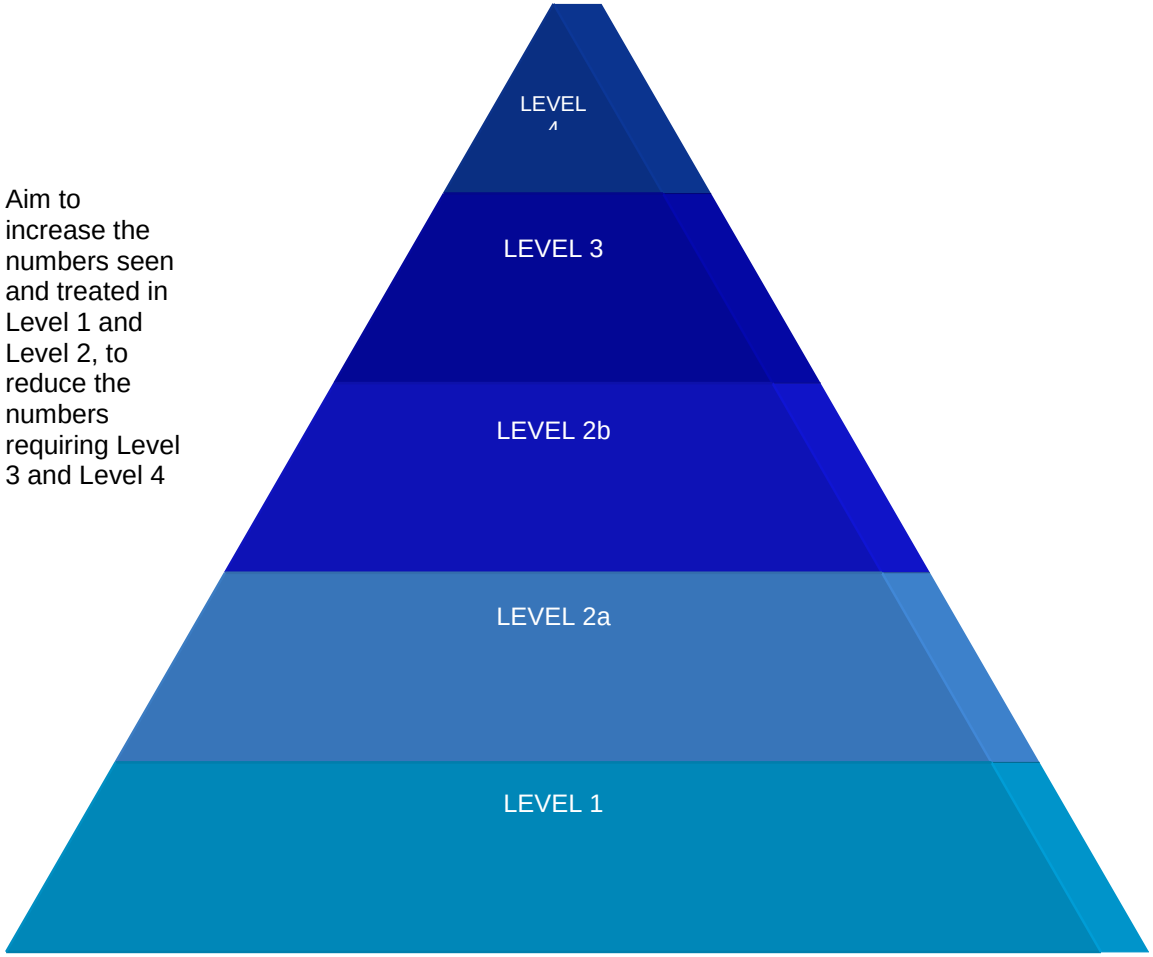
Milestone	Start Date	Completion Date
NHS IQ Workshops	March ‘14	September ‘14
Development of Urgent Care strategy	April ‘14	September ‘14
Strategy to stakeholder boards and signature of Appendix 5	September ‘14	September ’14
Submit to HOSC with the view to consultation for 3 months	October ‘14	January ‘15
Outcomes and measurements of success established	November ‘14	January ’15
Further Stakeholder Engagement following consultation	January ‘15	February ‘15
Agree model of care	February ‘15	March‘15
Detailed planning and mobilisation	February ‘15	March ‘16
Start of Care Closer to Home service	Oct ‘15	
Start of new urgent care service	March ‘16	

12 Glossary of Terms

A&E	Accident & Emergency Department
AQP	Any Qualified provider
BCD	Big Care Debate
CCG	Clinical Commissioning Group
CCTH	Care Closer to Home
COPD	Chronic Obstructive Pulmonary Disease
CQUIN	Commissioning for Quality and Innovation -
ECC	Essex County Council
ECP	Emergency Care Practitioner - Generally come from a background in paramedicine and most have additional academic qualifications, usually at university, with enhanced skills in medical assessment and extra clinical skills over and above those of a standard paramedic, qualified nurse or other ambulance crew such as technicians
ED	Emergency Department
EoE	East of England
EoL	End of Life
GP	General Practitioner
HEEoE	Health Education East of England
IAPT	Improving Access to Psychological Therapies
LETB	Local Education and Training Board
LTC	Long Term Conditions
MIU	Minor Injuries Unit
MSK	Musculoskeletal
NEE	North East Essex
NEL	Non-elective
NHS	National Health Service
NHSE	NHS England
OOH	Out of Hours
QIPP	Quality Innovation Productivity and Prevention
Reablement	Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living
Telecare	Telecare is support and assistance provided at a distance using information and communication technology
Telehealth	Telehealth is the remote exchange of data between a patient at home and their clinician(s) to assist in diagnosis and monitoring typically used to support patients with Long Term Conditions
WIC	Walk in Centre

Appendix 1 – Urgent Care Landscape

Aim to increase the numbers seen and treated in Level 1 and Level 2, to reduce the numbers requiring Level 3 and Level 4



LEVEL 4 – Local Acute Admissions to Hospital

Main Provider – Colchester Hospital University Foundation Trust

LEVEL 3 – Accident and Emergency

Main Provider – Colchester Hospital University Foundation Trust

LEVEL 2a and 2b – Primary and Community Services

Providers of Community Services - ACE, NEPFT, GPPC, CHUFT, CARE UK

Providers of Primary Services – 42 GP practices, Clacton MIU, Harwich MIU and Colchester WIC

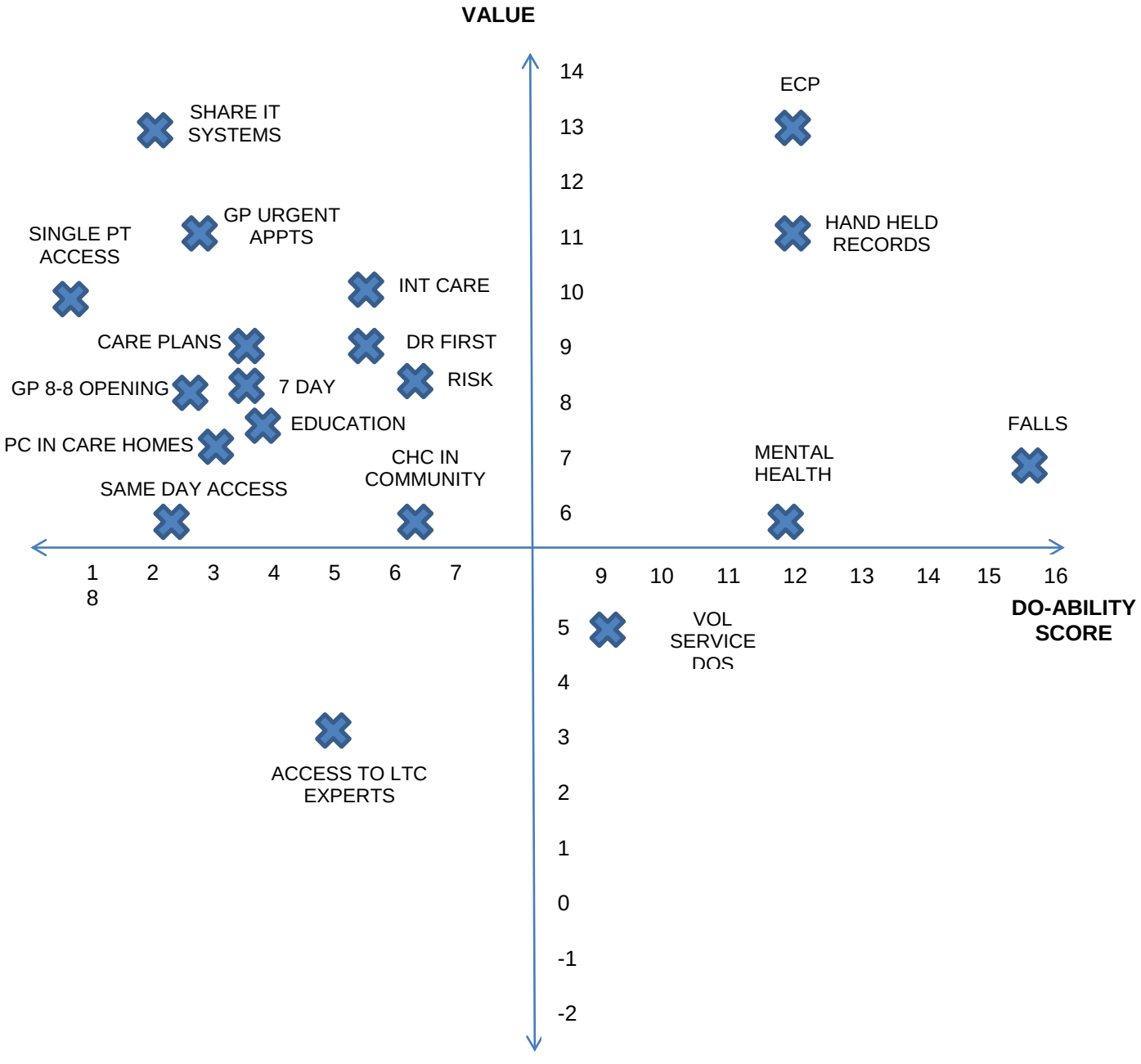
LEVEL 1 – Self-Care

Education and self-management, 111 advise, pharmacy advice and patient education

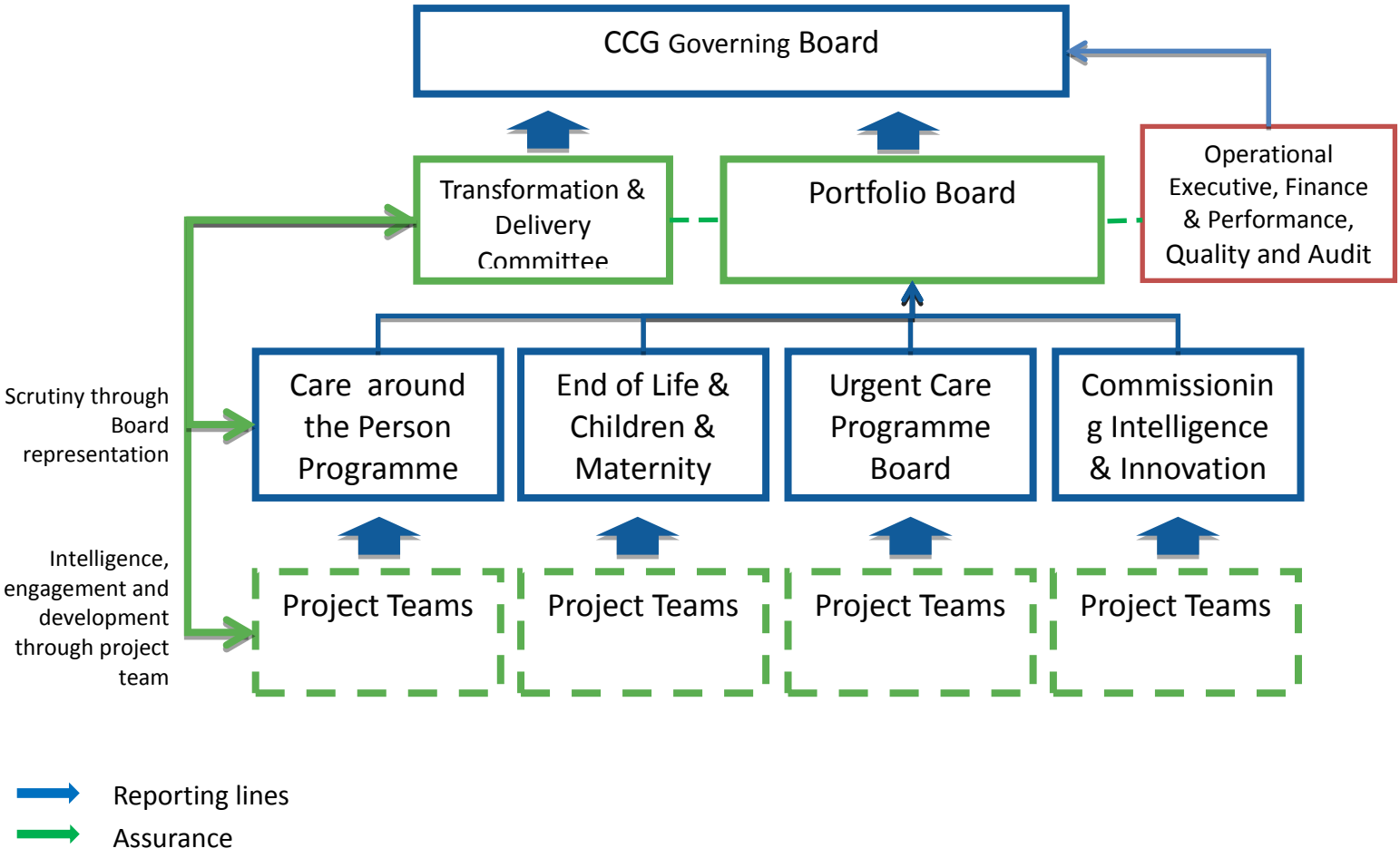
Appendix 2 – Prioritisation Scoring Template

List of interventions	Importance score based on 'value' See score card for ratings guide				VALUE TOTAL SCORE	Evidence of this already being done successfully	Reality of how deliverable it is	DO-ABILITY TOTAL SCORE	Comments e.g. What more information is required
	Improved health outcomes	Increased safety & reliability	Person centred to improve experience of care	Overall cost reduction	**Add up previous columns for total score**	1 – Low evidence 2 – Evidence elsewhere 3 – Evidence locally 4 – Lots of evidence locally & elsewhere	1 – Low confidence 4 – High confidence	**Multiply evidence score by reality score**	

Appendix 3 – Prioritisation Star



Appendix 4 – Urgent Care Governance Structure



Appendix 5 – Signature of Agreement

NHS North East Essex CCG Date Approved: Signature:	Colchester Hospital University Foundation Trust Date Approved: Signature:	Anglian Community Enterprise Date Approved: Signature:
East of England Ambulance Services Date Approved: Signature:	Essex County Council Date Approved: Signature:	Date Approved: Signature:
Date Approved: Signature:	Date Approved: Signature:	Date Approved: Signature: