Isle of Wight Clinical Commissioning Group

OPERATIONAL PLAN 2013-2014

Version	Date	Author
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1 Introduction & Executive Summary

The Isle of Wight Clinical Commissioning Group (CCG) has undertaken a three-stage planning process:

Stage 1	Consultation and 'refresh' of the Isle of Wight Clinical Commissioning Group Strategy 2013 – 2015
Stage 2	Development of the Operational Plan 2013 – 2014
Stage 3	Development of the Delivery Plan 2013 - 2014

Clinical Commissioning Strategy	Operational Plan	Delivery Plan
Sets out the CCG strategic clinical priorities for the next two years	Sets out the operational plans and priorities in terms of corporate, QIPP, finance, contracting, quality and delivery	Sets out the important outcomes, targets and milestones for QIPP and other key areas and will be used to ensure delivery of the strategy

The 3 documents need to be read together to gain an overall picture of the strategic direction and the plans of how to get there.

This document, the *IOW CCG Operational Plan 2013-2014*, reflects the national requirements in *Everyone Counts: Planning for patients 2013/14* (Department of Health); and the CCG Executive priorities and requirements in delivering the strategy.

The key messages are:

Corporate

- The CCG is making good progress in setting up its governance structures and business processes
- Statutory requirements and duties will be fulfilled
- The vision and values will be embedded through a behaviours framework

Quality, Innovation, Productivity & Prevention (QIPP)

- QIPP is at the centre of the performance and management process and the CCG is leading significant transformational change.

- The QIPP programmes are long term conditions (LTC), frail older people, mental health, unscheduled care, planned care, children, medicines management.

- Considerable service development will continue to take place in 2013/14 to deliver changes from 2014/15 onwards.

Contracting

- The CCG will use a range of market management strategies to procure services. Most development will be undertaken on a collaborative basis but

other mechanisms such as competitive tender and Any Qualified Provider (AQP) will also be used.

- The commissioning intentions reflect the strategy and have been published to providers. The CCG will operate under payment by results (PBR) rules where applicable using national contracts.

Finance

- The CCG is aiming to achieve financial balance in 2013/14, but there are major financial risks with specialist commissioning and continuing healthcare.
- Planning assumptions are consistent with the planning guidance and local analysis of need. There will be flat or very marginal real growth.
- There is non-recurrent investment in health services to aid the transformation programmes.
- Transition support through a risk sharing agreement has been agreed with the Isle of Wight NHS Trust.

Quality

- The focus will be on service improvement, patient safety, improving the patient experience and improved health outcomes.
- CQUINS have been developed that improve quality and support service developments in line with the strategy.
- *Innovation, Health & Wealth* (Department of Health (DH), 2011) will continue to be actively implemented by the CCG.
- The CCG will work with partners to improve safeguarding on the Isle of Wight.

Delivery

- Performance management and delivery of the strategy and plans will be undertaken by the CCG Clinical Executive, overseen by the Governing Body.
- A risk analysis has been undertaken to ensure there are mitigating actions to minimise risk.

2 OVERVIEW OF THE LOCAL HEALTH SYSTEM

2.1 National context

The planning framework *Everyone Counts: Planning for patients 2013/14* issued by the NHS Commissioning Board in December 2012, sets out three objectives:

> *" **Balancing change & continuity**: 2013 sees widespread change at a time of increasing pressure and the best confidence we can provide patients and the public is that local health services are delivering change and not reacting to it.*
>
> *Making **assumed liberty** a reality through creating time and space for CCGs to drive local health priorities within a framework driven by Health & Wellbeing Boards.*
>
> ***Balancing annual requirements with the longer term**: the best indicator we have of future quality improvement is current delivery and we need to assure ourselves the health service is sufficiently robust to deal with the challenge of increasing demand when limited resource growth is likely to be a future feature for several years."*

The key messages which are conveyed are:

- empowered local clinicians delivering better outcomes
- increased information for patients to make choices
- greater accountability to the communities the NHS serves

The NHS outcomes framework will now inform NHS planning. Commissioners must ensure NO indicator within the national NHS outcomes framework or CCG outcome indicator set deteriorates and planning should be based on maximising health gain for the population.

2.2 Local context

Strategic Context

Figure 1: Isle of Wight Local Context

The Isle of Wight is the largest off-shore community in England and Wales, with a population of approximately 140,000. The Island has a single NHS Trust working towards Foundation Trust status and a Unitary Local Authority.

Service Performance

The CCG Clinical Commissioning Strategy sets out where we are now in relation to performance and benchmarking to other areas. The CCG in shadow form has been a high performing organisation, delivering financial balance, facilitating innovation and meeting national targets for service delivery. The CCG will continue to be a high achieving organisation and will aspire to be in the top 10% of performing CCGs.

The CCG has considered a wide variety of reports to compare our service to other areas and to look for QIPP opportunities and inform the strategic direction. A summary of our key outcome performance messages is set out in **Appendix 1**.

Health Needs

Section 4 of the CCG Clinical Commissioning Strategy gives an overview of health needs on the Isle of Wight and a comprehensive analysis is set out in the Joint Strategic Needs Assessment (JSNA). In summary the key points are:

- The population of the Isle of Wight shows an ageing demographic profile with significant levels of chronic disease. This has major implications for health and social care needs as people are living longer but in poorer health.

- Life expectancy is higher compared with England but there are health inequalities with a 10:1 year 'gap' between electoral wards with the best and worst life expectancy.

- The major causes of poor health and premature death are circulatory and respiratory disease, and cancer. Lifestyle is a significant contributory factor and preventable causes of poor health and health inequality include smoking, alcohol misuse, physical inactivity and obesity.

- Mental health and wellbeing is influenced by levels of physical health and vice versa.

- Children live in poverty and levels of indicators associated with poor health outcome in the longer term are high. Strong multi-agency working through the Health and Wellbeing Board will be needed to address this.

2.3 Isle of Wight CCG Vision, Aims and Values

Our vision

Commissioning high quality, sustainable and integrated services

Our Aims (our long term goals)

We aim to:

- Work with partners to improve health and wellbeing for patients, carers and communities
- Ensure that when patients need healthcare, their experience is positive
- Ensure that when the need arises, our patients will access high quality, safe services
- Ensure the healthcare we commission is effective, efficient and financially sustainable
- Reduce the difference in life expectancy and burden of disease that exists between our most advantaged and most disadvantaged communities
- Embed patient and public involvement in our work
- Ensure our practice members value their role within the CCG

Our Values (what we believe in)

- Our approach to commissioning is **clinically-led and patient focused.**
    - We **maximise access to local services** in the context of commissioning **best clinical care**.
    - We **empathise** with those that suffer through ill health, working hard to reduce that suffering.
    - We **embrace change**, looking for innovation and scientific advance which will benefit our providers and our community
    - We believe that **prevention** is as important as cure
- We **involve and listen** to our communities knowing they have the capacity to understand and participate in making decisions about their healthcare.
- We are **accountable** for the decisions we make.
    - We conduct ourselves with **integrity, honesty, candour and fairness**.
    - We have the **courage** to make difficult decisions
    - We are **respectful** to all people
    - We **encourage efficiency** and **minimise bureaucracy**

2.4 CCG Objectives 2013/2014

- To develop and implement our Clinical Commissioning Strategy, making improvements to patient outcomes.
- To demonstrate measurable improvements in the quality and safety of our commissioned services and the primary care services delivered by our members.
- To meet the financial targets set for us by constructively challenging and supporting our providers, suppliers and members to work with maximum efficiency.
- To work constructively with providers and partners for the wellbeing of our patients and communities.

2.5 Strategic Priorities

The strategic priorities are summarised below:

Long Term Conditions

Aim: To improve the quality of life for people suffering from long term conditions (LTC) and support them to manage their condition and avoid complications which require hospital admission.

- Commission a range of self help programmes and ensure information & advice is readily available
- Use risk stratification tools (ACG) to target use of resources effectively to reduce non-elective admissions
- Develop an integrated model of care with more effective care coordination / case management to ensure services meet needs and take forward the My Life: A Full Life programme
- Care pathway redesign – focus on heart failure, chronic obstructive airways disease, chronic pain and children's diabetes. Improve assistive technology as part of pathway redesign
- Improve services and outcomes for children with life-limiting illnesses and disabilities
- Increase psychological support for people with LTCs

Mental Health

Aim: To incentivise service redesign to deliver outcomes based care driving a shift from institutionalised to community based care.

- Redesign adult mental health services to deliver better outcomes linked to unit costs (payment by cluster)
- Facilitate the shift from acute hospital provision to community services, resulting in a reduction of beds, length of stay & readmissions
- Improve the mental health rehabilitation care pathway

- Reduce costs of mainland specialist placements and support individuals to return to the Isle of Wight
- Learn from the pilot facilitating urgent access to advice and support through the urgent care coordination centre and agree permanent improvements
- Improve the pathways and increase the capacity for assessments for children with autistic spectrum disorder

Dementia

Aim: To support people and their carers to live independently with dementia by improving quality and access to care.

- Improve diagnosis rates to ensure individuals with dementia and their carers are getting access to services and support.
- Redesign of inpatient services with new facilities for assessment and treatment, and the creation of community outreach services that will support people in their own homes or care homes.
- Reduce anti-psychotic drug prescribing
- Achieve the 10 quality standards for dementia across all CCG-commissioned services.
- Improve end of life care and ensure more choices are available in care provision
- Redesign memory services to ensure increased therapeutic support and commission the Third Sector to deliver community support

Frail Older People

Aim: To ensure vulnerable frail older people are treated with dignity and respect in the most suitable environment to ensure the best clinical and personal outcome.

- Develop a care pathway for frail older people with complex needs to ensure rapid diagnosis & appropriate treatment & care
- Support nursing & residential homes to develop further the quality of provision to enhance quality of life & prevent avoidable admissions to hospital
- Anticipatory care planning for the last year of life
- Enhance & target more effectively the falls prevention service
- Improve partnership working to identify unmet need and give proactive support to those at risk
- Develop locally based integrated rapid response teams

Urgent Care

Aim: To commission the best quality services through an integrated healthcare system that is simple to use, delivers the best outcomes and delivers care in the most appropriate settings.

- Develop rapid access ambulatory care assessment clinics as an alternative to admission
- Support ongoing development of the urgent care coordination centre and use of NHS 111

- Review of Patient Transport Services to realign it with modern service delivery and care pathway.
- Further development of reablement services to reduce non-elective admissions and readmissions
- Improve the range of alternatives to hospital provision on a 24/7 basis with Crisis Response Services
- Develop & implement major trauma pathway to ensure seamless transfer through mainland specialist centres and more locally based services
- Ensure better coordinated discharge is delivered by providers
- Implement improved IT systems which enable integration of patient records and improve patient safety through information sharing
- Review out of hours and the walk-in centre to ensure best value for money

3 CORPORATE PLANS

3.1 CCG organisational development

The CCG is now in its first year of operation, having made good progress with the Organisational Development (OD) plan it outlined while in shadow form. The next phase, therefore, seeks to ensure that the organisation makes the next steps in terms of governance, business processes to support commissioning and fulfilling its statutory duties. It takes the concepts used to support the authorisation process forward into practical application, making a reality of the promises that were made.

The OD plan will be refreshed in the first quarter of the financial year, taking the opportunity to review where the organisation has made progress and planning in more detail what needs to happen next to support clinical leadership, staff and the Governing Body.

Work to embed the CCG vision and values will continue, with an emphasis on embedding a behaviours framework alongside business process so that we know not only what we are doing but how we are going to go about it.

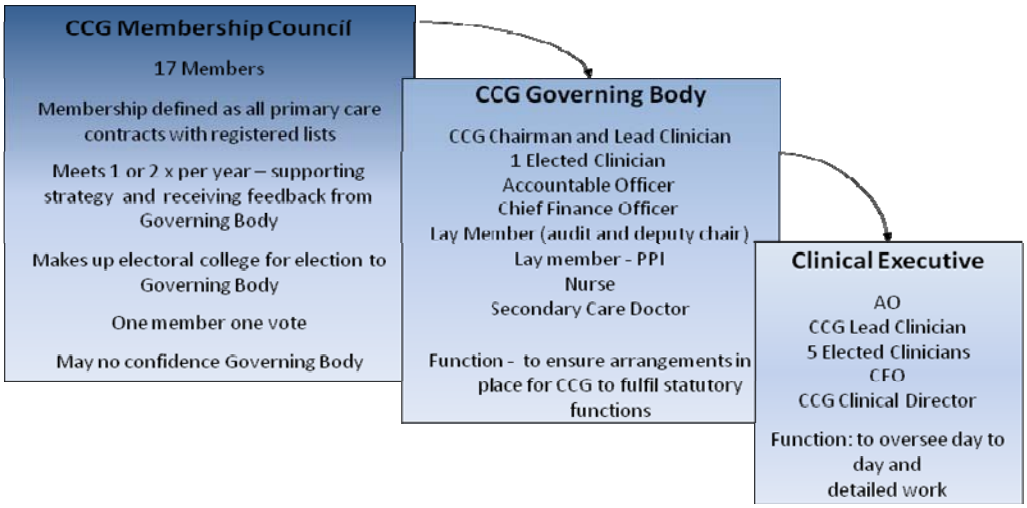
As the assurance process that will be undertaken by the NHS Commissioning Board becomes clear, the OD plan will be amended to take account of national priorities and must do actions.

3.2 Governance Arrangements

As part of the authorisation process, the CCG has outlined its governance arrangements which came fully into force on 1 April 2013. The Governing Body takes on the responsibility as overseer of the CCG working with its subcommittees and alongside the Membership Council.

A key factor in the new governance arrangements is the creation of a membership council which ultimately holds the organisation to account and in which each member practice has a voice.

Figure 2: CCG Governance Arrangements for 2013/14

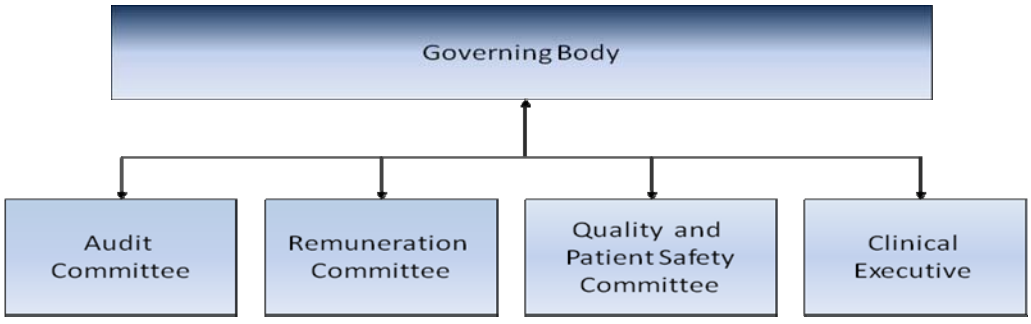


The Director of Public Health is an advisor to the Clinical Executive.

The Governing Body is underpinned by four formal sub committees which will undertake more detailed decision making and assurance work. The work of these committees will develop in the coming year as a full cycle of business is undertaken.

Figure 3: Governing Body sub committees

Governing Body sub committees



3.3 Commissioning support

For 2013/14 the CCG has a service level agreement (SLA) in place with NHS South Commissioning Support Unit (CSU) for the provision of the following support services:

- Business Intelligence
- Financial Services
- Communications
- Information, Management & Technology (including Information Governance)
- Governance & Risk Management
- Human Resources, including Health & Safety, Occupational Health

- Procurement
- Quality (Infection Control)
- Contracting (mainland contracts)

Where appropriate, NHS South CSU is sub-contracting with the Isle of Wight NHS Trust to support delivery. This will enable them to provide a locally based service with an excellent understanding of the Isle of Wight health system.

The CCG's Chief Finance Officer will work with the CSU's Isle of Wight Account Director and Account Manager to ensure that the SLA is delivered to the agreed quality and standard.

Local Counter Fraud Services will be provided under a hosted service arrangement by North Hampshire CCG.

3.4 Support to the Isle of Wight NHS Trust

Supporting the Isle of Wight NHS Trust to become a Foundation Trust by April 2014 is a key priority. The Trust requires financial support above tariff in certain services where the Island diseconomies of scale lead to higher costs.

Work is also being undertaken with Monitor to examine how consideration of this can be reflected in tariff.

3.5 Developing the workforce

A workforce development plan for both the CCG Clinical Leads and Executive Board members has been developed. This focuses on supplementing core clinical skills with the managerial and project skills required for commissioning. Items which are being covered include developing skills in negotiating, managing difficult relationships and conflict, as well as the acquisition of knowledge associated with pathway development, procurement and contracting.

A workforce development plan has also been developed for CCG commissioning staff. This will focus on embedding new culture and behaviours as defined by the CCG Governing Body. It will also look at how staff become intelligent customers of commissioning support services to support clear delivery of the CCG objectives.

3.6 Health & Wellbeing Board

The CCG Chair and Chief Officer sit on the Health & Wellbeing Board (HWB). The CCG is actively involved in its development. It is meeting bi-monthly and is an Isle of Wight Council sub-committee. The Joint Health & Wellbeing Strategy based on the *Marmot Report* has been extensively consulted on and the final strategy was published in March 2013. The priority areas are:

- Ensuring Children and Young People have the best possible start in life
- Helping and supporting people to prepare for old age and to manage long term physical and mental health conditions and disabilities

- Enabling people to make healthy choices for healthy lifestyles
- Building and sustaining economic growth for the Island and supporting improved employment opportunities
- Making the Isle of Wight a better place to live and visit

3.7 Partnership working with the local council

The CCG is working closely with the Isle of Wight Council to ensure services are either jointly commissioned or that our commissioning is closely aligned. Our focus is on:

- Working collaboratively to maximise the use of joint resources
- Giving full commitment to the delivery of the My Life: A Full Life programme
- Maximising benefit and cost effectiveness of reablement services to prevent admissions, reduce length of stay and prevent readmissions to both hospital and long term care
- Delivering the Joint Health & Wellbeing Strategy priorities as applicable to CCG Commissioning
- Working with the Isle of Wight Council to ensure, following the transfer of Public Health to local authorities, that the core offer is agreed and delivered
- Improving safeguarding for children & adults

The National Commissioning Board is transferring the NHS Support to Social Care Grants direct to local authorities in 2013/14. In 2013/14 the grant is £2.7m. The CCG will work with the local authority to agree the plan and monitor delivery.

The following are the key areas where development will take place

- Enhanced Hospital Discharge – additional care managers within the hospital and increased care packages
- Crisis Response services – GP direct access beds in nursing and residential homes, and assistive technology equipment
- Improvements to the Mental Health rehabilitation pathway – increased social work support and housing related support
- Rapid Response and reablement – night worker response
- Carers Support – continuation of joint post of carers commissioner
- Stroke Support – continuation of support for family care worker and communication support
- Equipment Service – increase to baseline budgets
- Falls Prevention – funding for the Falls Prevention Coordinator and training

3.8 Emergency Preparedness

Under the *Civil Contingencies Act 2004* the NHS needs to be able to respond to emergency situations. The CCG is developing its arrangements in line with the Wessex Area Team (Commissioning Board). New on-call arrangements will be in place from April 2013 and these will link both with the Wessex Area Team and local health care system.

3.9 Third Sector

The CCG is working closely with the third sector both to inform its strategic plans and to deliver its strategy. A number of initiatives have already been agreed for 2013/14, where grant funding has been made available to take forward strategic priorities.

Figure 4: CCG Third Sector grants

Initiative	Funding
Funding to support the coordination and access to services in café clinics for people with LTCs, support to Age UK, the Blind Society & Action on Hearing Loss	£34k
Employment support Continuation of employment support to help people with mental health needs into work – funding to OSEL	£70k
Dementia support Support for service users & their carers for the Memory Clubs including volunteer support. Funding via Age UK	£180k
My Life: A Full Life Support to the Third Sector to deliver the transformational programme with integrated working across all sectors. Funding via Community Action Isle of Wight	£500k
Daisy Bus Funding to support purchase of a minibus to assist travel to Portsmouth Hospitals. Funding via Wessex Cancer Trust.	£50k

3.10 Prisons

The CCG will participate in the Prison Partnership Board to ensure the needs of prisoners are reflected in emergency care commissioning where it will continue to have responsibility. This includes A&E, ambulance services and GP out of hours.

3.11 Clinical Networks & Clinical Senates

The CCG will actively participate in clinical senates when they are formed. This will provide a forum where collective knowledge on clinical issues can be shared and inform pathway redesign and service change.

The CCG will also actively participate in clinical networks when established, these are:

- Cancer
- Children & Maternity
- Cardiovascular
- Mental Health / dementia / neurology

4 QIPP PLANS

4.1 Overview

In response to the NHS financial challenge, the Department of Health established the Quality, Innovation, Productivity & Prevention (QIPP) programme as the guiding principle to help the NHS deliver its quality and efficiency commitments. This is often known as the quality and productivity challenge. QIPP is at the centre of the planning and performance management process and the QIPP programmes, which incorporate five CCG strategic priority areas, are aimed at delivering system-wide transformational change and efficiencies. The QIPP model identifies the productivity challenge in terms of finance, activity and workforce, and also identifies the differential impact on both the commissioner and provider positions. Delivery of the QIPP programmes is crucial to achieving our financial and non-financial targets.

4.2 Long Term Conditions (LTC)

Aim: to improve the quality of life for people suffering from LTCs, and support them to manage their condition(s) and avoid complications which require hospital admission.

- My Life: A Full Life programme (MLAFL) – this is a programme of interrelated projects that will promote proactive integrated care across organisations. The Isle of Wight CCG, the Isle of Wight Council and Isle of Wight NHS Trust are signed up to the programme, and it will fully involve primary care and the Third Sector. The project scope is being fully developed following a series of stakeholder workshops but the initial project will focus on three areas:

  - Self help – people will be enabled to promote their own health and wellbeing, supported by self care and self management support
  - Crisis Response – people at times of crises will have the right support as soon as possible, to enable the individuals to live within their communities for longer
  - Integrated locality working – people with long term conditions and frail older people will be supported by a locality approach based on GP practices

  A CQUIN has been developed to support the implementation.

- Risk Stratification – the ACG risk stratification tool is being fully evaluated and consideration is being given to its relationships with Eclipse. It is being used to identify resources required, resources available and gaps in provision for each ‘resource user band’

- Care pathway redesign – there are clinical leads in a number of LTC specific areas who are either reviewing whole pathways, aspects of pathways, or ensuring redesign work that has already been undertaken is embedded in clinical practice. Where appropriate assistive technology will be introduced to increase efficiency.

- Chronic Fatigue Syndrome – a pathway needs to be developed for this small group of patients who currently have difficulty accessing appropriate services
- Asthma – pathway to be revised and disseminated
- Brain injury – commissioning arrangements need to be clarified between specialist and the CCG and a new pathway agreed
- 'Keeping Moving' project – this is a review of podiatry, orthotics, splinting, community pain management, wheelchair and falls service to consider how they can be better integrated for patients who require multiple services. A CQUIN has been developed to facilitate this.

- Heart failure – this is the full implementation of the pathway redesigned and agreed in 2012/13, ensuring cardiac rehabilitation, full implementation of NICE guidelines and Community Nurse support.

- Rehabilitation – the full implementation of the service completed in 2012/13 will be fully evaluated with a view to further reduction in acute rehabilitation beds and enhancement of the commissioned service.

4.3 Frail Older People

Aim: to ensure vulnerable older people are treated with dignity and respect in the most suitable environment that can ensure the best clinical and personal outcomes.

There are four projects within the programme:

- Early intervention – early recognition of possible deterioration of frail older people, to support continued independence and self care in the community.

- Anticipatory care planning – to ensure independence and choice toward the end of life, we wish to offer people an anticipatory care plan. This will ensure choice and respect of wishes so that ultimately wherever possible people are able to plan how they wish to live their life to the very end. This is one of the CCG local priorities to be measured by the National Commissioning Board. It is an acute hospital CQUIN to encourage Advanced Care Planning and difficult conversations in acute settings. It is also a CQUIN on our care home contracts.

- Falls Prevention – Falls Prevention is the responsibility of the local authority from April 2013, but is a key element of our joint working. A falls pathway will be developed together with a comprehensive falls strategy.

- Service Coordination & Crisis response – this links to the My Life: A Full Life programme and is a combined project with the local authority to ensure crisis / rapid response services are in place.

4.4 Unscheduled Care

Aim: to commission the best quality services through an integrated health system that is simple to use, delivers the best outcomes and delivers care in the most appropriate place.

- Mainland repatriation – the pathways and financial flows are not always clear for people who are admitted to mainland hospitals and then subsequently admitted to St Mary's Hospital as part of the same episode. This will be reviewed to ensure pathways are clear and funding follows the patient.

- Clinical variation – a review will be undertaken of non-elective areas of variation by GP practices. Guidelines will be reviewed and new pathways developed where appropriate.

- Emergency Care Review – this is a major review of 111, the walk-in centre / out of hours GP services and the development of the Urgent Care Coordination Centre 'the hub'. These services are interdependent and have been an exciting development. However their cost effectiveness needs to be considered and there is a nation expectation that 111 should be tendered. This needs 'testing in the Island context'.

- Patient Transport Service – this will be reviewed to clarify eligibility criteria with the intention of making it a more efficient service.

- Intravenous therapy at home – this service will be extended during 2013/14 on a pilot basis to improve access at home and tin care homes. It will be supported via a CQUIN.

- Readmissions – by working with the local authority to ensure social workers on all the acute wards, our aim is to improve discharges and reduce readmissions.

4.5 Mental Health

Aim: to incentivise service redesign to deliver outcome based care, driving a shift from institutionalised to community based care.

- Payment by clusters – 2013 will see a significant expansion in the scope of payment by results. In mental health the use of clusters of care for contracting for adult mental health services will become mandatory in shadow form and prices will be agreed locally by commissioners and providers with risk sharing agreements in place. On the Island this requirement is being used as an opportunity to redesign our adult mental health services to deliver better outcomes linked to unit cost. The 21 clusters now have new service specifications based on NICE guidance.

- Redesign of the mental health rehabilitation pathway – Currently patients are not able to move smoothly through the rehabilitation and recovery pathway due to a lack of capacity and appropriate provision. The local provision needs to be determined for more complex patients currently in mainland units in

various parts of the country. The CCG also plan to use the funding the NHS gives to support for social care to increased availability of private landlords where former mental health patients will be accepted. Multidisciplinary team support will also be developed to support people in new environments.

- Redesign of dementia services – Dementia is a key strategic priority and the CCG will continue working with the Isle of Wight Council and will publish its Dementia Plan which sets out progress being delivered against the National Dementia Strategy. In 2012/13 the Dementia Toolkit was deployed, the new national service specifications were implemented and the national dementia CQUINs was applied across all appropriate contracts. The CCG is committed to delivering the 10 quality standards for dementia and is working across providers with a whole-systems approach. A key part of the programme is the redesign of the inpatient assessment and treatment services and the creation of an outreach service. Resources will be invested to support expansion of the Dementia Intensive treatment service. The aim is to support people in their own home environment whether it is nursing, residential or peoples own homes. A new unit is planned on the St Mary's site and due to concern about the current environment temporary accommodation will be made available in the interim.

- Medically unexplained symptoms – patients with medically unexplained symptoms can get passed around various medical and psychiatric services. A new pathway will be developed to give GPs clarity of referral and reduce inefficiencies in the system.

4.6 Planned Care

Aim: to improve the quality of services for patients by putting patients at the centre of decision making and developing an outcomes approach to service delivery.

Fundamentally the message is 'right care, right place, right time'. The overall objective of the planned care programme is to maintain the achievement of targets; address contract hotspots and variation in activity against benchmarks; and manage demand. The areas of focus can be grouped into three areas:

- System efficiency
  - Focus on areas of clinical variation
  - Reducing GP referral variation
- Pathway focus
  - Service review ophthalmology
  - Dermatology improved pathways
  - Pathway redesign schemes led by CCG clinical locality group
- Diagnostics
  - Endoscopy review including improved phlebotomy service in primary care
  - Pathology manage demand and contain costs

4.7 Children

Aim: to redesign the children's acute and community pathways to ensure an integrated system that will deliver improved health outcomes for children.

- Integrated acute and community service – The intention is to increase capacity within the community nursing services so there are clear alternatives to hospital admission and care is delivered predominantly in the community.

- Autistic Spectrum Disorder – The care pathway has been redesigned across paediatrics, psychology, child and adolescent mental health services (CAMHS) to improve access to diagnosis and then ongoing treatment and support. This will be implemented in 2013/14.

- Development of services to support children with life-limiting conditions – The palliative care outreach project has undertaken a gap analysis into services which support children with life-limiting and life-threatening conditions. The service requires investment so that children and their families feel better supported to manage care at home. A joint initiative is being developed with the hospice to support respite for children and young people.

- Development of community physiotherapy services for children with a neurodisability

4.8 Medicines Management

Aim: to achieve quality prescribing and best value.

The medicines management team, working with primary care, have been hugely successful in ensuring high quality cost effective prescribing. The Isle of Wight prescribing position is now 15th nationally. This work will continue in 2013/14.

- Traditional medicines management activities will continue such as scriptswitch.

- Focus on secondary care prescribing and the impact it has on primary care prescribing budgets. The aim will be to develop incentives which contribute to more cost effective prescribing along a whole pathway of care.

- Partner software companies Eclipse Solutions and BMJ information to develop nationally valued safety and medicines management software and continue to implement locally.

- Evaluate and develop strategy to improve benchmarked position against a number of Medicines and Prescribing Centre key therapeutic topics.

Figure 5: Final delivery milestones for QIPP plans

	Long Term Conditions final delivery milestones	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	End state descriptor 2015/16
A	My Life: A Full Life phase 1 plans implemented									Improvement in average health status score for people aged 18 & over reporting they have an LTC
B	Risk stratification being widely used to target use of resources & identify gaps in service									Increase in the proportion of people feeling supported to manage their LTC
C	Care pathways redesigned & implemented (CFS, chronic pain, asthma, brain injury & keep moving project). Where appropriate assistive technology will be used									Reduced serious deterioration in people with ambulatory care sensitive conditions
D	Heart failure pathway fully implemented									Improved functional ability & ability to work in people with LTCs
E	Implementation of phase II of the rehabilitation strategy leading to further reduction in beds									Overall reduction in non-elective admissions for people with LTCs
										Care is fully integrated increasing efficiency across service
	Net savings £000s				(374)				155	

	Frail Older People final delivery milestones	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	End state descriptor 2015/16
A	Early intervention schemes identified and in place									Improved quality of life / care for residents in care homes
B	Crisis response services in place									Reduction in preventable non-elective admissions
C	All frail older people are offered anticipatory care plans									End of life is supported with dignity & choice
D	Training programmes & risk tools widely used across all services leading to reduction in fractures from falls, strategy in place & being implemented									Reductions in fractures relating to falls
										Increased access to multiagency assessment
										Older people supported to live indepdently
	Net savings £000s				114				126	

	Mental Health final delivery milestones	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	End state descriptor 2015/16
A	Adult MH services to deliver better outcomes linked to unit costs & the full implementation of payment by cluster - shadow year									Full compliance with the NICE quality standards for dementia
B	Rehabilitation care pathway improved with no delayed discharges. Housing & care support in place									Outcome focused services where delivery is based on NICE guidance & payment by cluster (Improvement in HONOS indicators)
C	Dementia service redesigned to reduce acute beds & increase community support service									Cost effective services when benchmarked against comparator areas
D	New care pathway in place for medically unexplained symptoms									
	Net savings £000s				0				TBC	

Unscheduled Care final delivery milestones	2013/14				2014/15				End state descriptor 2015/16
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
A New pathways agreed for patients returning from the mainland									Alternatives to hospital admission are in place with a reduction in non-elective admissions Improved access to diagnostics / treatment / advice to prevent deterioration in condition leading to hospital admission Clear access to services via the urgent care coordination centre
B Reduced clinical variation in access to unscheduled care									
C Emergency services reviewed and agreed services in place									
D Patient Transport Services in place with new eligibility criteria									
E Improved access to community IV antibiotic services									
F Reduced readmissions with crisis response services									
Net savings £000s				461				247	

Planned care final delivery milestones	2013/14				2014/15				End state descriptor 2015/16
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
A The healthcare system is more efficient through a reduction in clinical variation									Healthcare system is efficient Healthcare resources are used to maximum effect The Isle of Wight CCG is a high performing CCG when benchmarked against other CCGs Best practice is widely adopted Outcomes are improved Improved access to services More cost effective services Improved access to diagnostics Improved pathways enable efficient use of services
B The Dermatology pathway is improved and fully implemented									
C Ophthalmology service recommissioned									
D Service reviewed - demand effectively managed for endoscopy service									
E Pathways for pathology service - cost effective and in place									
Net savings £000s				509				271	

Children final delivery milestones	2013/14				2014/15				End state descriptor 2014/15
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
A Integrated community services in place to support children with chronic conditions									Children cared for in community settings where appropriate Respite services readily available for parents Effective chronic disease management
B Improved ASD services in place									
C Outreach service in place supporting children with life-limiting illnesses in the community - local respite service in place									
D Holistic service in place for children with a neurodisability									
Net savings £000s				6				(76)	

Medicines Management final delivery milestones	2013/14				2014/15				End state descriptor 2015/16
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
A Eclipse live supports increased patient safety									Patients with hypertension will be on optimum therapy Cost effective prescribing across care pathways Safe & effective prescribing in primary care
B Improved benchmarked position against MPC key therapeutic topics									
C Effective prescribing within primary care & savings targets achieved									
Net savings £000s				1,885				900	

5 FINANCIAL PLANS

5.1 Overarching financial assumptions

The 2013/14 financial plan is based on the CCG's funding allocation for the services it is responsible for commissioning.

The plan delivers savings of £4m and surplus of 1% £1.9m.

Overarching financial assumptions

The financial assumptions are consistent with the 2013/14 planning guidance "Everyone counts: Planning for Patients 2013/14" and its associated technical guidance.

For 2013/14 the CCG will have two funding allocations, one for programme spend (to purchase healthcare) and one for the running costs of the organisation. In addition to this, the National Commissioning Board will provide the CCG with a delegated, ring-fenced budget for General Medical Services Information Technology (GMS IT).

The following are the key financial planning assumptions for 2013/14:

- Deliver a 1% surplus
- Growth in programme allocations of 2.3%
- Non-recurrent headroom of 2%, to fund non-recurrent transition/change related expenditure and support the management of risk in-year
- Set aside a 0.5% contingency
- Running cost allocation of £3.5m

Financial modelling for contracts

The Acute contract values have been calculated using the 2013/14 Payment by results tariffs and forecasting the likely demand for services.

The national provider efficiency requirement for 2013/14 is 4%. This will be offset against estimated provider cost inflation of 2.7%, giving a net adjustment of -1.3%. This has been applied to non-PBR element of Acute, Community, Ambulance and Mental Health Contracts.

Prescribing assumptions have followed the national guidance with a net 5% growth including local population growth.

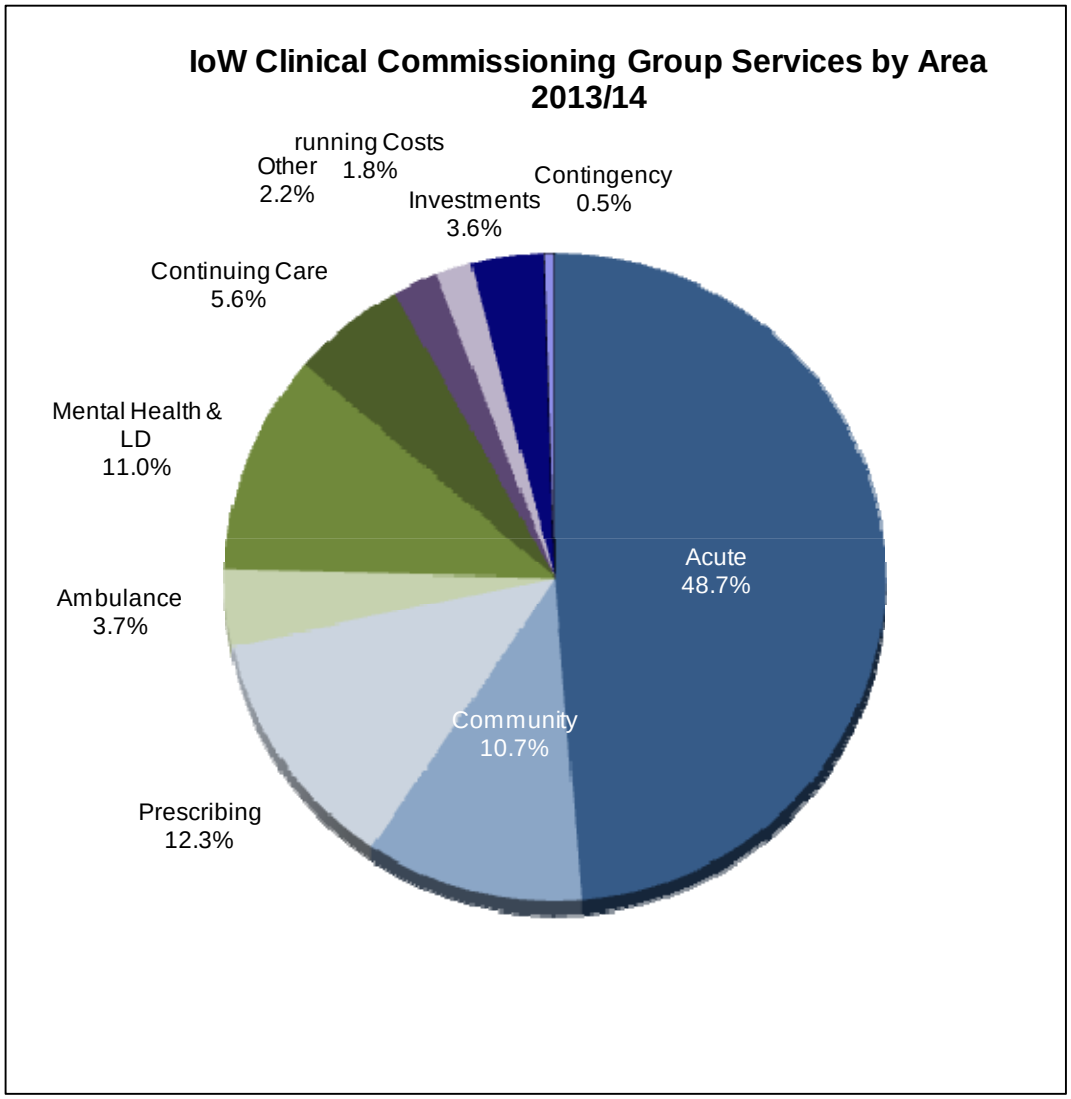
5.2 Source & application of funds

The table below takes the assumptions and known factors from Section 5.1 and applies them to the current CCG baseline allocation. This identifies the level of challenge there is in the system. The CCG will be investing to deliver service transformation, but also has opportunities for saving as set out in the QIPP programmes.

Figure 6: Productivity Challenge – summary financial model

IOW CCG				
Financial Model Summary	**%**	**Recurrent £000**	**2013/14 Non - Recurrent £000**	**Total £000**
Resource:				
Baseline - Programme		189,062		189,062
Baseline - Running Costs		3,494		3,494
Growth in allocation	2.30%	4,348		4,348
Social Care funding			0	0
Local allocations assumptions		135	0	135
Surplus brought forward			1,940	1,940
Total Resources		197,040	1,940	198,980
Application:				
Baseline		(191,061)	2,050	(189,011)
2% Headroom			(3,868)	(3,868)
Contingency	0.50%	(967)		(967)
Inflation	2.70%	(6,748)		(6,748)
Population & Demand		(1,307)		(1,307)
CQUINs				
QIPP investments		(999)		(999)
Cost pressures		(1,380)		(1,380)
Investments		(1,382)		(1,382)
Demand & Inflation Pressure		(12,783)	(1,818)	(16,651)
Tariff efficiency	-4.00%	4,552		4,552
QIPP Challenge		4,063	0	4,063
Total QIPP Opportunities		8,615	0	8,616
Total Applications		(195,228)	(1,818)	(197,046)
Surplus		**1,812**	**122**	**1,934**

Figure 7: Percentage expenditure as Commissioning Services 2013/14



5.3 QIPP opportunities & challenge

The CCG has a number of QIPP transformational programmes as set out in section 4.

Figure 8: Table of QIPP savings & investments

Savings by Programme	2013/14 Recurring Savings £000	Investment £000	Net £000	Use of 2% Headroom Non - Rec £000	2013/14 Savings Non - Rec £000	2013/14 Total Savings £000
Unscheduled Care	(337)	0	(337)	310	(388)	(725)
Children and Young People	(17)	11	(6)	0		(17)
Frail Older People	(114)	0	(114)	0		(114)
Long Term Conditions	(363)	837	474	250		(363)
Medicines Management	(2,191)	137	(2,054)	0		(2,191)
MH LD	(100)	0	(100)	40		(100)
Planned Care	(553)	14	(539)	30		(553)
Total	**(3,675)**	**999**	**(2,676)**	**630**	**(388)**	**(4,063)**

5.4 Running costs

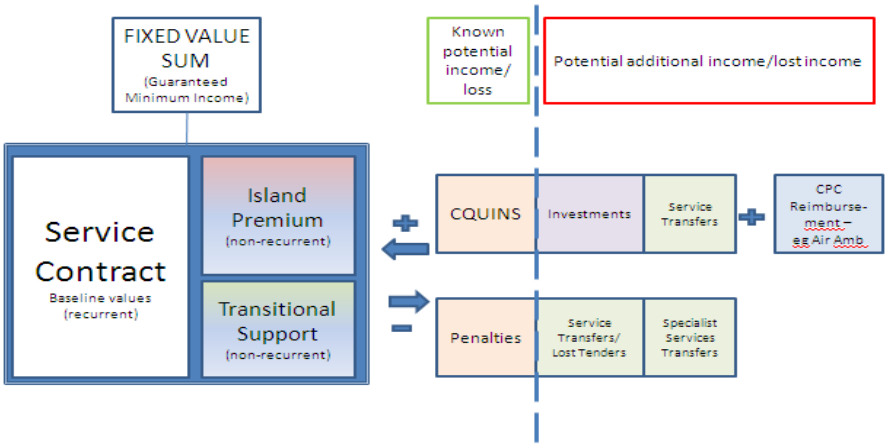
In line with national planning guidance the CCG has an allocation of £25 per head of population for its running costs. Based on the most recent population figures this provides a budget of £3.494m. The majority of this is spent on employing CCG support staff, the CCG Clinical Executive and Governing Body, clinical leads and purchasing support services from NHS South CSU.

5.5 Transitional Risk Share Framework Agreement

The Isle of Wight CCG has agreed a system-wide risk sharing strategy for the main contracts between the CCG and the IOW NHS Trust (provider). The aim is to reduce and manage the risks to both the commissioner and provider which are inherent in a small, isolated, disproportionately elderly rural population, where immediate market opportunities are limited by distance and size of catchment area, and where the main provider can suffer from diseconomies of scale in providing same services.

The proposal is for tariff-based contracts, in line with the Everyone Counts Planning Guidance, and the CCG commissioning intentions, within a formal Risk Share Framework Agreement (RSFA), which is system-wide and supports the transition of the main provider on the Island as it works towards Foundation Trust status. The RSFA comprises three components: service contracts for acute. Ambulance, community and mental health services; small isolated island population payment (Island Premium), and Transitional Support funding, creating a guaranteed minimum income for the provider, but against which contract levers such as penalities would still apply.

Funding outside the Service Contracts is non-recurrent and the aim is for the provider to achieve its Foundation Trust Long Term Financial Plan and achieve Cost Improvement Plans in order to operate sustainably within contract values.


FIXED VALUE SUM
(Guaranteed Minimum Income)
Service Contract
Baseline values (recurrent)
Island Premium
(non-recurrent)
Transitional Support
(non-recurrent)
Known potential income/ loss
Potential additional income/lost income
CQUINS
Investments
Service Transfers
CPC Reimburse-ment – eg Air Amb.
Penalties
Service Transfers/ Lost Tenders
Specialist Services Transfers

5.6 Specialist Services

The funding associated with the transfer of responsibility for specialised services commissioning to the National Commissioning Board is still being finalised. The National Commissioning Board is working to ensure that this has a net nil financial impact on Clinical Commissioning Groups.

6 CONTRACTING PLANS

6.1 Market Analysis and Procurement Plans

A more sophisticated approach to provider and market management has been developed on the Island over the past three years.

The CCG will continue to employ the range of strategic sourcing options available.

Approach	Purpose
Competitive Tender	Consolidation and diversification of provision
Collaboration	Vertical, horizontal and diversification of provision
Any Qualified Provider	Diversification of provision & increased choice

The requirement for healthcare providers to register with the Care Qualities Commission has supported the approach to strategic sourcing, providing commissioners with a healthcare provider market resource, providing intelligence on the providers in the local/regional/national/market, their capabilities, performance and quality ratings. This information will be used as part of the CCG market management and negotiation strategies. The development of the Directory of Services linked to 111 and NHS Pathways provides further market intelligence for commissioners to determine where there are gaps in the market, or over-utilisation. This intelligence will be used to intervene where demand/supply shows imbalances and commissioning interventions could improve patient experience and access.

Procurement Approaches

The CCG will seek to encourage vertical and horizontal alliances where they can deliver integrated services along care pathways and across localities. IW commissioners have a strong history of partnership and collaborative working, and in the Island context this is an important method of ensuring delivery of services.

Where services have not met required standards, or there has been a desire to either increase diversification or consolidation of the market, competitive procurement exercises have been undertaken (for example, physiotherapy, intermediate care, and dermatology, primary care walk-in centre).

The following services are subject to review in 2013/14 where an analysis will be undertaken whether or not to competitively market the service:

- Patient Transport Service
- NHS 111 / hub / walk-in centre / GP out of hours
- Mental Health Rehabilitation beds
- Musculoskeletal physiotherapy
- Dexa scans
- GP local enhanced services

Any Qualified Provider (AQP)

The Isle of Wight Primary Care Trust has undertaken three AQP procurement exercises in 2012/13:

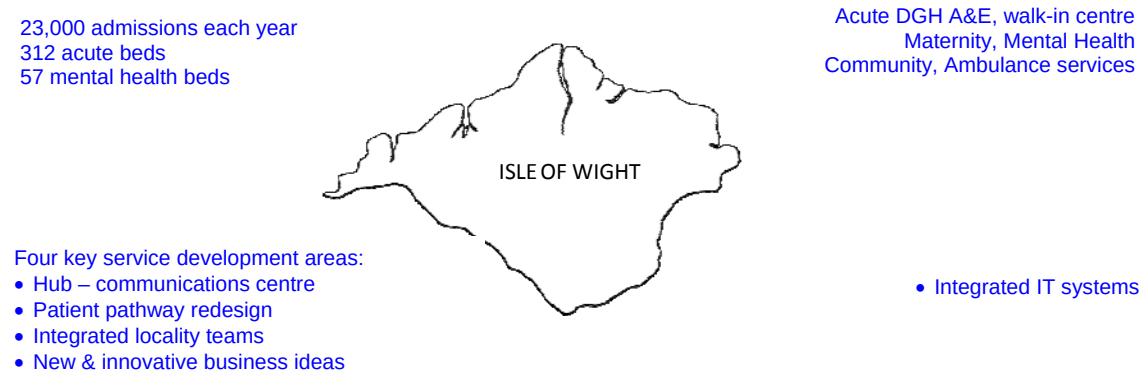
- Weight Management Tier 3 – resulted in one provider
- CAMHs Tier 2 – resulted in three providers
- Termination of Pregnancy – stopped, as choice reduced

The size of the Isle of Wight, the diseconomies of scale and the barriers to new market entrants make it difficult to manage the market via AQP, unless there is already an established market. Very careful market analysis needs to be undertaken before implementing this process; however it will be used where appropriate. An extension to the AQP type domiciliary care contracts will be undertaken this year.

Provider Landscape

The biggest provider for CCG commissioned services is the IOW NHS Trust. The provider is working towards becoming a Foundation Trust, March 2014 pipeline.

Figure 9: Isle of Wight Provider overview



Health system Risk Share Agreement

The CCG has agreed to enter into a Transitional Risk Share Agreement with the IOW NHS Trust on a non-recurrent basis for 2013/14 to support the provider's clinical transformation as part of its application to become a Foundation Trust. This will include support for diseconomies of scale and, importantly, system development incentives that encourage the Trust to work with other organisations to manage demand and reduce activity flowing into the hospital (see section 5.5).

6.2 Contracts and Future negotiating strategy

Contract terms 2013/14

Unless agreed with the SHA (such as tendered services) all contracts in 2012-13 will be one year contracts in the NHS Standard contract(s) format which has been revised for 2013/14. This will ensure that national contract levers can be utilised and imposed to develop the healthcare system. Nationally specified penalties if imposed will be reported to the SHA on the Penalty tracker. ?

The detail of the contracting strategy is set out in the CCG Commissioning Intentions, including full implementation of PBR rules and tariffs where applicable, and local prices/cost pool reviews for baseline values. The CCG will ensure that all contract agreements are based on a reasonable cost of care basis and do not unfairly disadvantage or advantage any one provider.

The aim is to sign contracts by 30 April 2013; however there are risks due to the issues with specialist services. Service Development and Improvement Plans for each contract area will be included where appropriate to include Commissioning Intentions to be delivered in year and counting and coding changes agreed to be actioned in year.

The Isle of Wight will continue to be Associates to the mainland contracts, working closely with Commissioning Support South Contracting Team to ensure that local requirements are included in contracts and that monitoring and application of contract levers is applied in line with contract terms. This is especially important for the Island commissioners in ensuring that 18 weeks RTT is achieved for our patients.

Contracts will be monitored through the monthly SLA performance meetings. This is supplemented by officer-level meetings where detail is discussed. Quality is currently monitored through the Clinical Quality Review meetings, there are plans to incorporate this within the SLA meetings during 2013/14.

A new high-level SLA meeting will be held monthly with directors of the CCG and Trust Directors, to address issues not resolved at lower levels within our organisations.

The NHS Standard Contract requires all NHS providers to submit data sets that comply with published information standards.

Community Care & Mental Health

A list of key community metrics have been developed and agreed to evaluate the overall performance of community services. Further development of this will be supported by the continued implementation of the Isle of Wight NHS community information system in 2013/14.

The roll out of the new information system all includes mental health & child health systems. The new systems will greatly improve data for contract monitoring and inform demand planning for future years.

Although the baseline has been agreed for the community contract in 2012/13, the mental health contract baseline has still to be agreed. An external piece of work has been commissioned to cost the service ‘bottom-up’ in line with revised service specifications for payment by clusters. There remains a significant risk to the CCG and NHS Trust as the Trust reported gap is £1.7m.

Contract Provider Overview

Commissioned Services	2013/14 Value £m	Comments
Acute:		
NHS IOW	79.9	
Southampton	4.5	
Portsmouth	2.8	
Other	9.1	
Ambulance:		
NHS IOW	7.0	
Community:		
NHS IOW	17.6	
Physiotherapy I/S	0.4	
Continuing care	11.0	
Other	3.0	
Mental Health:		
NHS IOW	18.5	
Special placements	2.4	
Other	0.8	
GP-led Health Centre	2.2	
Other Healthcare (various Providers)	1.2	
Prescribing	24.2	
Investment - including 2% headroom/contingency	8.0	
Total	**192.7**	

Contract Transfer

The PCT has been working to ensure all contracts are transferred to the correct successor body, where appropriate for 2013/14.

6.3 Commissioning Intentions

The following is a summary of the commissioning intentions. The full document can be found on the CCG website.

Key focus	Key intentions
Planned care	
Maintaining achievement of national access targets; addressing contract hotspots; diagnostics planning	CCG pathway reconfigurations; pathology, ophthalmology & endoscopy reviews
Unscheduled care	
Improved access to urgent review; avoiding hospital admissions; major trauma	NHS 111/Hub/GP Out of Hours reviews; reducing clinical variation (pathways); crisis response; reablement
Long Term Conditions and Frail Older People	
Integrated community management; self-management; improving case management; managing acute episodes	MLAFL programme, ACG risk profiling; rehabilitation strategy phase II; assistive technologies; personalised care plans; self support; pathway redesign (e.g. heart failure); anticipatory care plans
Mental Health	
Redesign to deliver improved outcomes & payment by cluster; better integration for LD services; shift from institutionalised to community based care	Improvement to the rehabilitation pathway; implementation of the revised dementia pathway including enhancements to the outreach team; re-provision of the acute treatment and assessment unit for dementia
Ambulance	
Non-conveyance system integration; maintenance of target achievement	Integrated call centre; PTS efficiency; workforce development
Maternity & newborns / children	
Reducing hospital admissions; improved services for children with chronic & life-limiting illness; resources targeted at vulnerable expectant mothers; improve ASD services; safeguarding	Development of a virtual hospice for children; ensure implementation of the new service specification for ASD/ADHD; improve children's safeguarding
Other	
Primary care; cancer; medicines management; continuing healthcare	Review and re-commission LESs; phlebotomy re-commissioning; ECLIPSE development; personal budgets for continuing healthcare extended; improve cancer pathways e.g. skin

6.4 Choice

The CCG priority to improve quality of patient experience is facilitated by creating and commissioning effective and informed choice for patients in terms of provider, location, or treatment. This includes choices already in place such as choice of GP practice, choice of elective care, non-elective care, long terms conditions. The CCG will continue to promote choice through a range of communication mediums, and the measure awareness of choice through the Patient Experience Survey.

Choice of hospital and consultant

The demography of the Island means that patient choice is primarily centred around offering choice of appointment in terms of date/time, and location, rather than a wide range of providers (of hospital care). This is because the Island patient population has an older age profile and patient preference is to receive treatment locally rather than travel to the mainland. Whilst a choice of mainland providers is available at GP consultation and commissioners have in place contracts (including ISTC and AQP in the independent sector) with a range of regionally local elective care providers, historical referral patterns suggest that the priority for improving patient experience for the Isle of Wight rests in developing services locally.

Isle of Wight NHS provider offers booking by Choose and Book (CAB) and choice of consultant is already accessible via the CAB and Directory of Services published on the internet 1 April 2011. Improvement in the usage of CAB continues to be a priority with ambitions to increase the number of services available through the CAB system as well as working towards making community and mental services available.

The CCG will continue to work with the Isle of Wight Council and ferry operators to ensure continuation of subsidised travel schemes for patients travelling to the mainland, where they choose to have treatment on the mainland, or where is no clinically safe choice of treatment option for them on the Island.

Choice of healthcare

In recognition of the geographical impact on patient choice, the CCG strategic drivers reflect the intention to offer choice to patients through the provision of integrated care, especially for long term conditions, frail elderly, mental health (especially dementia). This is supported by the strategic priorities to develop assistive technologies, improved case management, and to develop the workforce so that healthcare staff ensures patients are fully involved in decisions around their healthcare and understand the choices they have (e.g. end of life). The delivery actions are included in the CCG Commissioning Intentions, e.g., café clinics, pathways to support patients with multiple conditions, and the use of personalised care plans.

The development of the Single Point of Access model for unscheduled care including the integration of the NHS 111 call service within the urgent care coordination centre, and the Beacon-Walk-In Centre integrated with St Mary's Hospital A&E Department, provides a wider range of responses

Personal Health Budgets

The CCG is developing plans to implement Personal Health Budgets for Continuing Healthcare (CHC) funded patients by 2014/15. Where patients become continuing healthcare funded, and they already have a Personal Budget with the Isle of Wight Council then the CCG supports continuation of this care package via a third party, which is the Advocacy Trust. Patients under CHC transitional funding (leaving hospital) are given a choice of nursing homes to ensure that they can be located close to relatives. Patients also benefit from the Any Qualified Provider type Domiciliary Care Provider choice of eight qualifying providers on the Island.

6.5 Demand Plans

Detailed activity plans have been developed for all major contracts based on projected growth in demand utilising a locally developed modelling tool. These plans will form the basis of the contracts in 2013/14.

Due to the size relative to other contracts additional focus has been placed on the Acute demand plan with the IW NHS Trust. In order to ensure agreement the plans for this contract have been developed in conjunction with the Trust.

The plans have been developed at service line level for each point of delivery and are based on or take account of the following factors:

- Starting point was the forecast outturn at Month 7
- Make an adjustment for predictions of demographic growth at 1%
- Adjusting demand at a service line level using a trend forecasting model that has been developed and used during 2012/13 to forecast year end position
- Input and advice from service managers at IW NHS Trust
- Adaptation for local issues (e.g. growth in waiting lists)
- Inclusion of local commissioning intentions, known service changes and delivery of national and local targets.

The Activity Plans reflect Payment by Results (PBR) rules and requirements where applicable and/or agreed local prices. The majority of local prices have rolled over from 2012/13 with a tariff adjustment of -1.5%.

A further complication to demand planning this year has been the new commissioning arrangements. However work has been done to split the demand plan between relevant Commissioner for example specialist taking account of both minimum and maximum take.

For the IW NHS Trust the split is based on a range of agreed assumptions as well as the output from the Specialist Commissioning Identification Rules exercise. For other contracts the relevant provider has provided details of how the demand should be split between commissioners.

Figure 10: Activity trajectories 2013/14

Activity	i) Elective FFCEs	ii) Non-elective FFCEs	iii) First Outpatient attendances	iv) A&E attendances
2013/14 Total	10363	12896	38874	39484
2012/13 Forecast Outturn	9815	12724	37694	39175
Forecast growth in 2013/14	5.6%	1.4%	3.1%	0.8%

7 QUALITY PLANS

7.1 Overview

Everyone Counts: Planning for Patients 2013/14 outlines the incentives and levers that will be used to improve services from April 2013. It supports local clinicians to deliver more responsive health services, focused on improving outcomes for patients, addressing local priorities and meeting the rights people have under the NHS Constitution. The CCG will strive to ensure that every patient, for whom it commissions a healthcare service, receives healthcare that is safe, effective and that the patient's experience of their healthcare is a positive one. The CCG understands that in order to achieve this for their patients, they must also take other significant documents and learning into account.

Recent reports such as *Transforming Care: a National Response to Winterbourne View Hospital*; the *Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry* (Francis) and *Compassion in Practice* are acknowledged to be key quality drivers both for commissioners and providers of health and social services. The CCG Board will be responsible for ensuring that recommendations from these reports are implemented under the work plan of the CCG's Quality and Patient Safety Committee. Mechanisms are also in place to monitor the compliance with recommendations within commissioned services, through integrated contractual meetings where quality is a standing agenda item.

As a result of the Winterbourne View Review the CCG is a part of the concordat and as such will continue working through the required programme of action during 2013/14. To date placements for people with learning disabilities have been reviewed and funding has been made available for advocacy support for patients and their carers.

7.2 Ensuring that people have a positive experience of care

During 2012/13 the CCG has worked with the Isle of Wight Council on the tender process for Healthwatch Isle of Wight. The CCG's significant involvement reflects the importance it places on patient feedback and patient engagement and involvement in commissioning health services.

Patient feedback through for example, complaints, incidents, Serious Incidents Requiring Investigation and satisfaction surveys provide vital information on the health services the CCG commissions. This data and the learning from investigations will continue to be monitored through Contractual meetings and the CCG Quality and Patient safety Committee. Data from the CCG Outcomes Benchmark Support Pack suggests that the level of patient satisfaction on the island is in line with the national benchmark and in some areas, General Practice and A&E, exceeds the national benchmark.

The CCG will continue to strive to improve levels of patient satisfaction through various systems and processes. It will build upon its early involvement with newly appointed Healthwatch Isle of Wight and SEAP Independent Complaints Advocacy Service. The CCG will also continue to drive the implementation of the Friends and Family Test (FFT) Question within relevant commissioned services. Both Commissioners and Providers are being incentivised to ensure that FFT is rolled out in accordance with the national timetable and that there is demonstrable improvement in patient experience in 2013/14.

The CCG has also agreed to develop a CQUIN scheme to support 'Compassion in Practice' to strengthen a culture of good quality 'customer care' and a safeguarding CQUIN scheme in response to a recent Ofsted report on child safeguarding and associated risk highlighted in the Isle of Wight Quality Handover Document.

7.3 Overview

Treating and caring for people in a safe environment and protecting them from avoidable harm

Risks to patients and or quality of services will also continue to be logged on the CCGs risk register. Two key patient safety issues have been logged; safeguarding and infection prevention and control.

Safeguarding

In response to a recent Ofsted report of safeguarding arrangements for children on the island, the CCG recognises that it must play a full part in ensuring robust arrangements are in place for both children and adults in the services it both commissions and as a member organisation.

The CCG will be an active member of the Local Safeguarding Children's Board and Local Safeguarding Adults Board, in order to address the local issues and improve safeguarding processes. The CCG will continue monitoring contracts in line with section 11 of the Children's Act, and will ensure appropriate clauses and monitoring of all contracts including learning from incidents.

For 2013/14 it has developed a safeguarding CQUIN that particularly focuses on the partnership working of midwives and their role in identifying and targeting vulnerable families with the aim of preventing safeguarding cases from occurring.

Infection Prevention and Control

The CCG is aware of the requirements to monitor incidence of infections both in commissioned services and in the wider community. The CCG has historically worked closely with the Isle of Wight NHS Trust to promote a health economy wide approach to infection control and it is currently in discussion with Public Health Isle of Wight to develop a partnership approach to infection control. It has also agreed an infection control CQUIN scheme for Care Homes on the Island.

Trajectories for Clostridium Difficile have been set for 2013/14 with the input of the Infection Control Nurse Specialist from SHIP Cluster. The CCG threshold has been nationally set at 29 cases and for the Isle of Wight NHS Trust 12 cases. Monitoring of these thresholds, including zero tolerance of MRSA will be monitored through the CCG Quality and Patient Safety Committee and through contractual meetings and or Clinical Quality Review Meetings. Currently MRSA bloodstream infections are subject to a Serious Incident Requiring Investigation process, and investigation reports are shared with commissioners to close. It is proposed that this will continue and providers will be expected to use the toolkit for Post Infection Reviews as part of the SIRI review. This will be written into the 2013/14 contract as a quality indicator

7.4 Duty of Candour

The CCG fully supports openness and transparency with patients, their families and their carers, when care or a lack of care provided results in patient harm.

The Duty of Candour will be contractually enforced where a provider fails to inform the patients and or their family/carer of a patient safety incident that has resulted in moderate or severe harm or death of the patient. It is proposed that every investigation report, arising from a serious incident requiring investigation (SIRI) will be scrutinised as part of the current Commissioner Review process, to ensure the Duty of Candour has been undertaken by the provider.

7.5 Quality Account

The Isle of Wight NHS Trust's Quality Account will be scrutinised and monitored to ensure their published plans for improvement to the quality of care and safety of services commissioned are achievable and delivered. The aim is also to ensure that all providers have a systematic approach to improving dignity in care for all patients, and that staff are appropriately trained. The CCG will continue to have robust contract monitoring arrangements through the Contract Review meetings.

7.6 Key areas of focus

CCG Quality Premium Local Priorities

These local priorities are in addition to the national quality premiums which will require the CCG to work together to improve quality and outcomes.

	Indicator Definition (please specify the local measures chosen) max 4000 characters	Numerator	Denominator	Measure
Local Priority 1	The proportion of patients with a Read code of heart failure across primary care who are being prescribed appropriate first line treatment as per NICE clinical guidelines 108 to include ACE/ARB therapy and a licensed beta blocker. (Rationale: one of our key LTC pathway improvement areas for 2013/14, currently significant levels of sub-optimal treatment).	254	508	50%
Local Priority 2	The number of people in the last year of life with an anticipatory care plan in place. (Rationale: in line with strategic intent and work with Frail Older People & EOL, should reduce inappropriate hospital admissions and support choice and independence).	200	1800	11.1%
Local Priority 3	A proportion of the hypertensive population managing their own condition through an IT self-monitoring scheme. (Rationale: in line with strategy for supporting self-management and increase in use of assistive technology. Reducing poor outcomes in under 75s from cardiovascular disease).	300	2,000	15%

Local areas of focus

Primary Care will continue to be an area of focus, driving continuous quality improvement in practices so that patients only go into hospital if it will secure the best clinical outcome. This will include further development of peer review and audit at locality level, along with a programme of work to reduce unwarranted variation. As part of this work we will support practices and localities to create, pilot and spread new pathway and service improvements in line with the CCG Clinical strategy and develop quality and productivity indicators to enhance the quality and outcomes framework. One of the roles of the CCG's Clinical Effectiveness Committee will be to review proposals from primary care to ensure that pilots and pathway developments are in line with national and CCG objectives and best practice guidance.

Summary Hospital Mortality Index (SHMI)

In the past the Isle of Wight has been an outlier and therefore a significant amount of audit work has been undertaken. Monitoring of this statistic will continue through contractual meetings with exception reports reported to the CCG Clinical Executive and Governing Body.

7.7 The NHS Outcomes Framework

The Outcomes Framework sets out the improvement against which the CCG will be measured and held to account. There are five domains derived from Lord Darzi's definition of quality: patient safety, clinical effectiveness and patient experience. The framework is also intended to support equality in healthcare. The measurements set out in the Outcomes Framework are listed in the delivery plan, to ensure there are clear actions to deliver improved outcomes.

Over and above the nationally mandated outcomes framework quality indicators, for example, the CCG will focus on the areas shown in the following table.

Figure 11: Outcomes Framework

Outcome Framework Domain	Outcome Framework Improvement Area	Isle of Wight CCG Commissioning Intention 2013/14	Quality Indicator
Preventing people from dying prematurely	Reducing premature mortality from the major causes of death	Develop diagnostics commissioning strategy; specific focus on endoscopy Implementation of NICE guidance; pathway for elevated BNP to consultant and ECHO, additional community HF nurse specialist	Reduced <75 mortality from cancer; Achievement of cancer targets; Increase 1 & 5 year survival from colorectal cancer; Increase 1 & 5 year survival from lung cancer; Reduced <75 mortality from cardiovascular disease
Enhancing quality of life for people living with long term conditions	Reducing time spent in hospital by people with long-term conditions	Scope service development opportunities for My Life: A Full Life Programme with key stakeholders Increased access to assistive technology Community chronic pain service	Reduced admissions to hospital; improved case management; patient access to timely and relevant care Patient independence; reduction in community and acute support Improved service for patients: reduction in secondary care costs
Helping people to recover from episodes of ill health or following injury	Improving recovery from injuries or trauma Reducing emergency admissions & readmissions	Consolidation of full year effect of community rehabilitation programme Roll out of further self-help programmes and improved access to information and training for patients; psychological support for managing LTC	Reduction in admissions to hospital and length of stay Improved patient experience Reduced reliance on medical professionals
Ensuring that people have a positive experience of care	Improving the experience of care for people at the end of their lives Improving the healthcare for people with a mental illness	Development of anticipatory care plans in the community Evaluation of NHS 111 pilot; further development of integrated directory of services and capacity management system Improve dementia diagnosis rates including early diagnosis rates	People enabled to die in a place of their choice Achievement of planned care, A&E and access targets; improved access for patients Improved patient and carer experience
Treating and caring for people in a safe environment and protecting them from avoidable harm	Reducing the incidence of avoidable harm	Development of clinical software to share with IoW NHS Trust to enable patient medication information to be accessed by primary and secondary care clinicians Strengthen contract monitoring and placement reviews in CHC	Reduction in medication related patient safety incidents Reduction in patient safety incidents and referrals to safeguarding

7.8 Commissioning for Quality & Innovation (CQUINS)

The CQUIN framework was introduced in April 2009, a national framework for locally agreed quality improvement schemes, to reflect quality: safety, effectiveness, patient experience and innovation.

In 2013/14, 2.5% on top of the contract value of provider contracts will be linked to the achievement of CQUINS.

Clinical leads from the CCG and commissioners have come together to identify areas for improvement that would benefit from an incentive scheme. These ideas have been presented to the CCG Executive Strategy meeting where final agreement on the outline CQUINS for acute, community, ambulance and mental health & learning disability contracts was reached, as tabled below.

In 2013/14 CQUINS have been developed, with the aim of addressing quality on a health care system wide basis, for example compassionate care in response to the Francis report, others have focused on issues specific to the Isle of Wight, for example, children's safeguarding. Some national CQUINS have been stretched,

such as reducing the age of dementia screening from 75 to 65 years of age, the success of last year's dementia screening programme.

Where possible CQUIN schemes have also been developed, such as the infection prevention and control CQUIN in care homes, to reduce community acquired infections being transferred into the acute hospital setting.

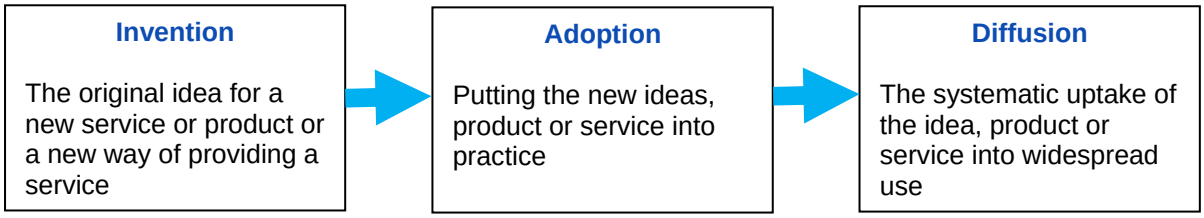
Figure 12: Isle of Wight CQUIN schemes

Contract	I O W CQUIN Schemes 2013/14 - Proposals	National (N) Regional (R) Local (L)
Trust-wide	• Compassionate Care - Francis Report and Compassion in Practice; review and analysis of reports, implementation of relevant recommendations and measuring the outcome of the recommendations and impact on patient safety and patient experience	• L
Acute	• *High Impact Innovations – Achieve 50% of pre qualification criteria; 3 million lives, IOFM, International and Commercial activity, digital first, carers for people with dementia to improve quality and productivity of care • Patient Experience – Friends & Family Test Question (Inpatients, ED). Phased expansion of F&FT to other service areas, improving response rates and improved performance on the staff F&FT in staff survey • VTE – risk assessment and RCAs on cases of hospital associated thrombosis • Dementia – screening, risk assessment, referral for diagnosis of eligible patients 75 years+, clinical leadership and staff training, support for carers – monthly audits • NHS Safety Thermometer – Pressure ulcers; improvement trajectory set against 12/13 baseline • AMBER Care Bundle - care planning and 'difficult conversations'; integrating skills of palliative care team with ward teams • Ambulatory care – rapid access to diagnostics and results for ambulatory care sensitive conditions – to be defined • OPHIT – Extending provision of IV care in non acute setting (avoiding non elective admissions and facilitating early discharge); building on 12/13 scoping CQUIN to develop pathways and extend treatments available • Medical Outliers – 'Right Place First Time' reducing numbers of patients placed as outliers; adopting recommendations from Emergency Care Intensive Support Team Review • Safeguarding children – Midwives identifying additional needs early, use of CAF and referrals to HVs (Maternity) • Paediatric Patient Experience – PREM (ED, Inpatient, Day Cases) • Preventing readmissions of full-term babies to children's ward and NICU; reduce length of stay on maternity unit (Maternity) • Digital first – including remote follow-up and secondary care letters to GPs	• N • N • N • N • N • N • L • L • L • L • L • L • L
Community	• *High Impact Innovations – Achieve 50% of pre qualification criteria; 3 million lives, International and Commercial activity, digital first to improve quality and productivity of care • Patient Experience - Friends & Family Test Question (Inpatient stroke and rehab beds) Phased expansion of F&FT to other service areas, improving response rates and improved performance on the staff F&FT in staff survey	• N • N

	• VTE – risk assessment and RCAs on cases of hospital associated thrombosis (Inpatient Stroke and Rehab beds) • Dementia – screening, risk assessment, referral for diagnosis of eligible patients 75 years+, clinical leadership and staff training, support for carers – monthly audits (Inpatient Stroke and Rehab beds) • NHS Safety Thermometer – Pressure ulcers; improvement trajectory set against 12/13 baseline • 'Keeping Moving'; Community Service/pathway redesign; multidisciplinary approach to supporting patients to remain mobile and independent • 'My Life; a Full Life' (Community nursing – understanding current role and planning for integration to support My life; a Full life) • Assistive Technology Development; Strategy and implementation plan for rolling out assistive technology and building upon COPD pilot 12/13 • Psychology for Long Term Conditions; exploring use of psychological interventions within GP practices to help achieve productive behavioural change for staff members and patients with LTC	• N • N • N • L • L • L • L
Ambulance	• *High Impact Innovations – Achieve 50% of pre qualification criteria; International and Commercial activity, digital first to improve quality and productivity of care • Ambulance Service Public Campaign; promote greater awareness and understanding of service and different components 111, 999, PTS to enable patients to understand how the service responds and what patients can reasonably expect. • Awareness of patients with cognitive impairment (i.e. dementia and LD) – staff training for adaptive communication, pain assessments • Patient Transport System – improving quality and robustness of data and information to ensure commissioners can monitor and evaluate the quality and effectiveness of the service	• N • L • L • L
Mental Health & Learning Disabilities	• *High Impact Innovations - Achieve 50% of pre qualification criteria; 3 million lives, International and Commercial activity, digital first, carers for people with dementia to improve quality and productivity of care • NHS Safety Thermometer – Pressure ulcers; improvement trajectory set against 12/13 baseline • Dementia – screening, risk assessment, referral for diagnosis of eligible patients 75 years+, clinical leadership and staff training, support for carers – monthly audits • Mental Health Emergency Hub – maintaining and evaluating MH integration in the hub and exploring how technology can be utilised to widen modes of access by patients • Learning disability self assessment framework - developing a resource tool to support and improve self assessment and reporting • Supporting service quality and accreditation (Royal College of Psychiatrists); The College Centre for Quality Improvement (CCQI) aims to raise the standard of care that people with emotional or mental health needs receive by helping providers, users and commissioners of services assess and increase the quality of care they provide	• N • N • N • L • L • L

7.9 Innovation, Health & Wealth

The CCG welcomed the publication of *Innovation, Health & Wealth* (DH, December 2011), which is in line with CCG values. As a CCG we will continue to seek opportunities to improve outcomes and increase efficiency through the adoption & implementation of new innovations and best practice. We will also actively share the good practice which is taking place on the Isle of Wight so that others can learn from our experience.



Through the pre-requisite High Impact Innovation CQUIN in 2013/14, the CCG aims to support the Isle of Wight NHS Trust in taking forward developed business cases for scoping assistive technology in the management of long-term conditions, child in a chair in a day and the Whzan telehealth. We will also continue to encourage our providers to be affiliated with Academic Health Science Centres and work with the Local Health Innovation & Education Cluster (HIEC) to ensure alignment of innovation work streams.

The CCG will develop a culture of innovation through:

- Prioritising the adoption and spread of innovation and good practice
- Making innovation integral to everyone's job through induction, education and training programmes, and competency frameworks
- Executive level leadership of, commitment to, and accountability for investing time, resource and effort to innovation
- Responsibility to ensure that arrangements are in place throughout the organisation to champion research, innovation and adoption, and spread of proven innovation is central to commissioning plans
- Seeking out and adopting best practice, and recognising the legal duty to promote innovation, which will be integral to the CCG authorisation process
- Ensuring that all NICE Technology Appraisal recommendations are incorporated automatically into relevant local formularies in a planned way that supports safe and clinically appropriate practice

8 DELIVERY PLANS

8.1 Delivery of system reform

Delivery of the operational plan and delivery plan will be monitored quarterly by the Governing Body and CCG Executive Board. A quarterly report will be produced which sets out progress against targets and milestones. All investments will require business case approval before new services can commence or be procured. New business processes are being developed to streamline activity, cut out unnecessary bureaucracy, but ensure clear accountability for delivery.

Monthly performance reports on finance, activity and quality will continue to be presented to the CCG Executive and bi-monthly to the Governing Body, highlighting areas of good and poor performance. Monthly SLA meetings will also continue with key providers.

QIPP programmes will be subject to robust programme management arrangements which are overseen by steering/working groups. There will be a system of internal performance management where leaders will be held to account for their work programmes and targets. System-wide issues will continue to be discussed and highlighted to the System Reform Board. The clinical leads are all in place to drive forward strategy and delivery of the QIPP programmes. The clinical governance framework is in place to assure on quality and patient safety.

Figure 13: Clinical governance

The clinical governance framework will be further developed and embedded across all commissioned services and with CCG members in the next financial year.

8.2 Risk Management

The successful delivery of the CCG strategy and operational plan is subject to a variety of risk factors. A robust risk management process within the CCG is being used to ensure risks are identified and mitigation strategies are implemented.

Figure 14: Key risks

Principle Risks	Severity	Likelihood	Mitigating actions
Financial			
• Lack of clarity regarding commissioning for specialist services. Financial transfers do not always tie up with service specification requirements. Financial transfers to specialist greater than expected leading to CCG funding deficit	High	Medium	Workshops held to clarify responsibility & identify funding & activity streams. Letters sent to SHA expressing concerns and response indicate planning assumption should be zero change and that in-year adjustments will be made
• Insufficient commissioning funds to support Island Premium or level of transitional support required by IOW NHS Trust as they move towards foundation status leading to system instability	Medium	Medium	Risk sharing agreement to be negotiated
• As commissioning is shifted to other parts of the NHS, pathways may not be joined up and cost shunting may occur	Medium	Medium	Relevant delivery boards hold system to account. Continued engagement and joint working across care pathways and use of contractual frameworks
• Provision for continuing healthcare retrospective reviews may be insufficient for actual liability	Medium	Medium	Discussions with auditors as to what is reasonable in terms of provision when a significant number of claims still need to be processed
• Mental Health SLA baseline costs are not agreed and the gap between current SLA value and projected provider costs is £1.7m	Medium	Medium	External review of costs of services required. Possible risk share agreement to be put in place
• Keeping running costs within target may adversely impact on capacity to deliver robust governance and transformational change	Medium	Medium	Ensuring value for money from commissioning support unit. Consideration of buy/ share/procure to deliver most cost effective options
• Commissioning strategies and plans produced through QIPP are not affordable for the local health economy & will not close the economy gap in funding, making IOW NHS Trust financial position worse	High	Medium	Process in place to ensure opportunities are assessed for strategic alignment risk profiling & delivery
Delivery			
• There is a capacity risk with the CCG trying to deliver large scale QIPP transformational projects	Medium	Medium	Short term additional capacity may need to be bought in for specific projects
• Partners (IW Council & providers) may lack capacity to implement agreed schemes within timescales & significant slippage occurs, also impacting on ability to deliver investments & slippage	Medium	High	Contracting levers used to support implementation, including use of CQUINS to incentivise transformational change. Section 256s with the IW Council have clear performance requirements

Risk management is an integral part of the governance arrangements. There is a system of internal control underpinned by an assurance framework which enables the Governing Body and CCG Executive to be properly informed about principle risks to the achievement of objectives. The Risk Register is reviewed monthly by the CCG Executive Board and bi-monthly by the Governing Body.

8.3 Opportunity management

The CCG will continue to seek out opportunities for QIPP innovation and capitalise on them by using business intelligence to identify best practice and test/adapt for local implementation.

Opportunities	Actions to ensure opportunities are maximised
Central support to CCGs from the Commissioning Support South (CSS) will improve sharing of innovative schemes and good practice which will benefit all CCGs	CSS to ensure process is in place to capitalise on the potential to exploit the large volume of data it will have access to
With GPs involved in all aspects of commissioning there is the opportunity to have genuine clinical leadership driving QIPP programmes	CCG development to ensure a strong focus is placed on active clinical leadership in the local environment
Increased access to commissioning support and advice via CCS	CCG to be clear on support available via prospectus
Joint working with other CCGs and networks to share resources and aid learning	Active membership of networks & collaborative working with other CCGs where appropriate

8.4 Enablers

Communications and engagement

The Isle of Wight CCG has developed its communications and engagement strategy, with the aim of demonstrating that it meets all the requirements of authorisation, including statutory requirements.

'*No decision about me, without me*' is at the heart of the government's bill and this is being driven forward from the outset of the CCG.

Objectives for 2013/14 include:

- Continuing to develop capacity and capability to deliver the communications and engagement agenda including working with the Commissioning Support South to embed new processes and ways of working
- Embedding systems to engage all GP members, including practice managers and other health professionals in the work of the CCG.
- Developing a strategic approach to stakeholder engagement, which when implemented makes consultation part of everyday work
- Continuing the development of our key relationships both on and off island
- Ensuring best practice in communications and media handling

- Developing core materials for ongoing two-way communications, including a web presence

Health Informatics

The Isle of Wight CCG will work with the Isle of Wight NHS Trust, Isle of Wight Council, Primary Care providers, the NHS South CSU informatics team and other Commissioning partners to continue to develop local and relevant information solutions for the Island. During 2013/14 we will work to develop a comprehensive IM&T strategy for commissioning, a key part of which is to better understand the CCG's role in relation to IT investment (including GMS IT) & the development of island-specific systems.

System-wide Leadership:

- To inform our IM&T strategy, we will review our data collection/sharing and tools to support good patient management such as the ACG risk stratification tool and Vision360.
- We will work with our local trust to support the infrastructure improvement programme underway (ISIS) which will to support the delivery of safe and high quality care to patients.
- We will lead and promote the introduction of innovative solutions which support improved patient care e.g. the integration project in the trust and new technologies in primary care.

Internal:

- We will continue to develop our IT capability to support new working practices of the CCG while assuring good information governance. This includes remote working solutions and standardised desktops
- We will work with NHS South CSU to support them in developing a robust, responsive support service for CCG and GMS IM&T
- We will work with partners to support the roll out of integrated business tools to enable easy collaboration (SharePoint, video conferencing etc.)

Information to support patients:

- We will work with partners to support the national programme to make basic health personal health information available to patients by 2015.
- We will work with partners to support the roll out on-line systems to allow patients to choose and manage their appointments
- We will work with partners to develop and publish Information about local services and health outcomes to support patients to make decisions about their care.

Information to support clinicians:

- Whilst we review our current IM&T systems and develop our strategy, we will continue to invest in Vision 360, ACG and the Eclipse system as our prime ways of sharing information across clinicians within different organisations. We will further develop our systems and processes to provide assurance to patients that the information shared is used appropriately.

Information to support decision making:

- We will promote the ongoing use and development applications such as dashboards and scorecards that can drill down to patient level data to support development and monitoring of care pathways.

- We will develop specifications to secure a robust business intelligence support function for the CCG
- Through the OD programme we will equip our commissioners and clinical leads with the necessary skills to request and interpret data to support good decision making

Capital planning and estates

From 1st April 2013, non-estate capital planning will become the responsibility of the National Commissioning Board. The CCG does not anticipate having any non-estate capital requirements during 2013/14.

All commissioning related estate will transfer to NHS Property Services on the 1st April 2013. This organisation will hold and manage the lease for the CCG's accommodation. For 2013, NHS Property Services has a capital requirement of £130,000, to fund the fit out costs of the CCG's new accommodation, which is due to be completed during late June 2013.

The CCG will support capital planning and estates in the following ways during 2013/14:

- Developing carbon reduction strategies
- Engaging GPs, practice manager with key stakeholders in devising local plan to improve the quality of the built environment for our patients
- Supporting major/complex business cases for local healthcare premises
- Supporting the delivery of major strategic service redesign/rationalisation projects on time, budget and quality
- Ensuring that our plans shape the future development of the health infrastructure
- Building our relationships between provider-owned health estate and those owned by NHS Property Services
- Understanding and establishing the CCG's role in GP premises development and future investment in GP infrastructure

Appendix 1

NHS Isle of Wight CCG
Summary spine chart

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

This CCG is in the Coastal & Countryside cluster

Outcome Indicator	CCG and cluster distribution
1a Potential years of life lost (PYLL) from causes considered amenable to healthcare	
1.1 Under 75 mortality rate from cardiovascular disease	
1.2 Under 75 mortality rate from respiratory disease	
1.3 (proxy indicator) Emergency admissions for alcohol related liver disease	
1.4 Under 75 mortality rate from cancer	
2 Health related quality of life for people with long term conditions	
2.1 Proportion of people feeling supported to manage their condition	
2.3i Unplanned hospitalisation for chronic ambulatory sensitive conditions (adults)	
2.3ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	
3a Emergency admissions for acute conditions that should not usually require hospital admission	
3b Emergency readmissions within 30 days of discharge from hospital	
3.1i Patient reported outcome measures for elective procedures – hip replacement	
3.1ii Patient reported outcome measures for elective procedures – knee replacement	
3.1iii Patient reported outcome measures for elective procedures – groin hernia	
3.2 Emergency admissions for children with lower respiratory tract infections	
4ai Patient experience of GP services	
4aii Patient experience of GP out of hours services	
4aiii Patient experience of NHS dental services	
5.2i Incidence of Healthcare associated infection (HCAI): MRSA	
5.2il Incidence of Healthcare associated infection (HCAI): C Difficile