NHS
Thurrock
Clinical Commissioning Group

Agenda item: 5

THURROCK BOARD MEETING

DATE:

Title of Report:	**Thurrock CCG QIPP and Commissioning report**
Author:	Mark Tebbs, Head of Integrated Commissioning
Presented by:	Dr. Raymond Arhin (GP lead for QIPP) and Mark Tebbs (Head of Integrated Commissioning)
Committees previous consulted:	QIPP Committee
Executive Summary:	The aim of this report is to appraise the Board on: • Performance against the 2014/15 QIPP programme and an update on the planning of the 2015/16 QIPP programme • Key Updates within the commissioning portfolio encompassing Medicines Management, Planned, Unplanned Care, Whole System Redesign, Mental health and Paediatrics work programmes. • Update on CCG performance against constitutional standards and the action plans to support delivery (see Appendix A)
Recommendation to the Board:	Board members are asked to note the report and progress being made within the commissioning portfolio.
Financial Implications:	The QIPP plan forms part of the CCG's financial plan.
Fit with CCG strategy/objectives:	Forms part of the CCG's 2014-15 Integrated Operational Plan
Risks identified:	Failure to deliver the full effect of the QIPP plans and the resultant pressure on the CCG's financial plan. Failure to adequately monitor the provider contracts will adversely offect CCG's commissioning vision.
Resource Implications:	QIPP committee and various provider contract monitoring committees

View of the Patients Carers or the Public and the extent of their involvement:	High level QIPP opportunities discussed at clinical reference group in November
Evaluation Criteria:	
Evaluation Date:	

1) INTRODUCTION

This paper aims to appraise the Board of:

- Performance against the 2014/15 QIPP programme and an update on the planning of the 2015/16 QIPP programme
- Key Updates within the commissioning portfolio encompassing Planned Care, Unplanned Care, Whole System Redesign, Mental health and Paediatrics work programmes.
- Update on CCG performance against constitutional standards and the action plans to support delivery of the standards

2) KEY UPDATES

2.1) QIPP

Performance against 2014/15 QIPP programme

Portfolio	YTD Total Plan	YTD Validated Plan	YTD Actual	%Against Validated Plan	% Against Total Plan
Planned Care	£ 1,710,358	£ 1,686,827	£ 1,628,000	97%	95%
Unplanned Care	£ 619,000	£ 619,000	£ 550,394	89%	89%
Medicine Management	£ 1,140,001	£ 901,819	£ 1,265,137	140%	111%
Paediatrics	£ 363,754	£ 350,888	£ 186,805	53%	51%
Mental Health	£ 873,997	£ 511,664	£ 570,157	111%	65%
Other	£ 537,000	£ 447,000	£ 447,000	100%	83%
Community	£ 369,002	£ 319,000	£ 319,000	100%	86%
Total	£ 5,613,112	£ 4,836,198	£ 4,966,493	103%	88%

The table below shows that 2014/15 QIPP delivery is 103% against the validated plan and 88% against the total plan. Performance remains at similar levels as indicated in the March report.

The performance report, issue log and risk plan were reviewed at the QIPP CORE meeting on the 9th April. The outstanding issues relate to:

Outstanding Issue	Actions to resolve
Ophthalmology drugs savings	Medicine management team meeting with lead commissioners (Southend CCG) to quantify savings.
Formulary Management	Delay in implementation of formulary/pathway has led to the issues with delivery of savings. Savings now being recorded, but probably will not achieve target by end of year.
Lipid Lowering Drugs	Difficult to switch all patients on rosuvastatin. Initial cost savings may not be delivered due to newly identified clinical issues.
Wound Care	Increased costs of wound care Likely that costs of wound care have increased following roll out of project to Care homes.
Care Homes	Medication reviews underway but savings less than expected. Good impact upon quality of prescribing has been reported. To add ScriptSwitch saving recommendations to widen care home.
Diabetes	Delay of formulary implementation experienced in getting agreement around insulin formulary. Diabetes Network met in March and agreed formulary subgroup to formulate ""preferred drug list"" for 2015/16.
Referral management	Although the net GP referral activity is down compared to previous year it hasn't reduced discharge rates as a percentage of the

	referral rates for routine medical specialties. Planned Care lead has liaised with Executives to come up with following mitigating action plan: • Continue with existing project but enhance communications and engagement with practices • Review scope of existing project with the view to draw up an alternative project that will look at referral rates split by specialities • Lead to bring decision and update to next QIPP core in May

Planning for the 2015/16 QIPP programme

The Sustainability Director is supporting the organisation to optimise its delivery of the 2015/16 QIPP plan. The target is to develop a robust QIPP plan 2015/16 by the end of April 2015 (see critical path – Appendix B). It is recognised that the process is behind schedule by approximately 1 month compared to previous years due to the size of this year's challenge, system wide pressures and delays in contract negotiations caused by national tariff negotiations.

The team are working through a 3 stage process of refining and developing business cases. Projects have been categorised as either:

A) Programmed – fully developed business case with robust finances, activity and quality impact assessments which has been through the appropriate clinical governance.
B) Being Developed – the business case is being developed but is not yet robust.
C) Opportunities – ideas and opportunities which are being scoped to develop into full business cases following appropriate clinical review

The table below shows the current status of the Thurrock QIPP plan:

	Programmed	Being Programmed	Opportunities
Number of Schemes	10	29	20

The organisation has established weekly working group meetings to ensure that the deadline for completing business cases is delivered. This will be supported by a system steering group to ensure that the programmes of work are co-ordinated across the SW Essex system.

From a financial perspective the combined programmed and being programmed schemes still leave the organisation with a QIPP gap of £2-3m. This figure has remained constant since the March Board report.

2.2) Planned Care

- **MSK**

The new hub service has commenced from 1st April 2015. The new service will be picking up all the patients already in the system and going forwards will be managing all MSK related conditions within the hub. The hub is expected to streamline patient journey to ensure compliance with 18 week RTT targets. The new provider (Connect) presented a service overview at the April CEG which was well received by the practices. The provider is also down to present some of the clinical pathways that will be incorporated during the course of the year at the May Time to Learn event.

Diabetes network

The diabetes network has been meeting monthly and has now agreed its terms of reference. The initial focus of the group has been three fold; working with public health to establish a good evidence base to underpin the work programme, establishing a separate sub group to review the preferred medicines list and working on System One integration. The group is progressing well.

Ophthalmology

CCG is working with the other South Essex CCGs to develop a shared care glaucoma pathway in collaboration with Southend hospital and community optometrists. The project is expected to improve patient outcomes, ease pressure at the hospital whilst releasing some saving for the CCGs. The proposal has been approved by the QIPP committee

Dermatology

The CCG is working with the Basildon and Brentwood CCG to procure an integrated dermatology model. The proposal to begin the procurement process has been approved by the QIPP committee and a detailed paper will be brought to the Board shortly setting out the detailed service specification and project plan.

LES Procurements

The current phase of LES procurements has now been completed and providers notified. The CCG is working with the CSU to issue contracts in a timely fashion.

As agreed, by the LES task and finish group, the CCG will begin a new round of LES procurements in May to try to increase the uptake of this within primary care. A workshop was held in March to support all providers with any forthcoming procurement. The workshop was well attended.

2.3) Unplanned Care, End of life and CHC

Front door and back door reviews

A&E 4 hour performance continues to be very challenging for the SW health system. The QIPP CORE committee reviewed progress on the 'Front Door' and 'Back Door' reviews. These programmes of work will be fully scoped by the end of April. However, progress is being made on a number of aspects of this programme of work including:

- A&E Improvement Study - The Trust commissioned a review of A&E processes. The review focused on demand and capacity, processes within hospital and output blockages. The key finding was that 39% of ambulance arrivals could have been seen by another service (as judged by paramedic crews).
- Clinical Utilisation Review - The Trust also commissioned a Clinical Utilisation Review which showed that 26% of total bed days examined were used by patients who were ready for discharge/transfer, c70% of discharge/transfer delays were due to "in hospital" processes (waiting for tests, specialty review, etc) and the remaining 30% related to "community."
- Social Marketing Exercise - The CCGs commissioned a piece of social marketing research, examining reasons for A&E attendance. Headline figures suggest that 39% of "minors" patients attended A&E because they perceived there was no alternative service; 22% because they couldn't get a GP appointment.

- Integrated Discharge Team – The Back door workshop concluded that the current discharge process is complex and poorly co-ordinated (up to 33 different discharge pathways). The working group meeting is developing an integrated discharge team which will co-ordinate the discharge process from BTUH. The aim is to make a single organisation responsible for co-ordinating the discharge process.

In summary, there is consensus across the system there is scope for system improvement. The QIPP CORE committee agreed representatives to attend a workshop to discuss the next steps for the front door redesign.

Ambulance

Ambulance performance against the constitutional standards remains challenging across Essex. The CCG have signed the collaborative agreement to formalise the Essex commissioning arrangements. The Quality team are now regularly engaged with the contract and are overseeing the service development plan.

End of Life

The contract value for St. Luke's Hospice has been agreed. This includes the agreement to continue to fund the One Response Service and the Fast Track pilot.

Continuing Health Care

Regular performance meetings are being held with Arden CSU to monitor the management of CHC. A regular agenda item is the QIPP plan and the CSU is being very supportive in

Cancer

The first Thurrock 'Improving Cancer Outcomes' meeting has been organised for the 30th April 2015. The initial meeting will be to review and refine the Thurrock Cancer Action Plan. One of the key areas will be to ensure the consistent delivery of the cancer waiting time standards. Unfortunately, the overall treatment numbers in February have been affected by a reduced number of diagnosed patients in January. BTUH have seen an unprecedented increase in demand on diagnostics due to the dramatic increase in referrals, this has put strain on the current capacity. BTUH has an agreed action plan as part of their original trajectory.

2.4) Children's, young people and maternity

Neurodevelopmental Delays Pathway

The multi-agency Neurodevelopmental Delays all-age Pathway group held its first meeting on 23 March, whereby we had excellent attendance from Thurrock partners. This initial meeting reviewed the terms of reference for the group and agreed to focus on three core areas: ASD, ADHD and Tourette's. The workshop also assisted in mapping services our partners provide to children, young people and families for neurodevelopmental delays. A draft all-age Neurodevelopmental Pathway project plan is currently in development. Monthly meetings have been arranged from 13 May for the rest of the year. The Director from LANC (Learning Assessment Neuro Centre) will be attending the meeting in May to share their best practice and model of delivery.

A plan is currently underway to review our current ADHD 11+ cohort currently known to the CCG. Providers have written to the known families, approximately 28, to undertake a paper

based assessment. To date 10x have been returned. The theme that has emerged is that the majority require local authority support so the group has been expanded to include a wider representation. The first review of cases is taking place on 16 April 2015.

CAMHS procurement

The CAMHS procurement remains on track. The competitive dialogue period has now been completed and the lead commissioners issued the 'invitation to submit final solutions' (The closing date was 10th April). These bids will be evaluated by the expert evaluation panel with the aim that CCGs will be asked for decision in May so that the contract can be awarded in June.

SEND Reforms

The main remaining issue for the SEND reforms remains the Designated Medical Officer (DMO) role. A plan has been agreed with NELFT to review this in year and aim to develop a cost neutral solution by July 2015.

Sickle Cell novation

A project group has been established to review the current sickle cell pathway. The aim of the group is to establish whether the current configuration of services between BTUH and NELFT are delivering the optimum patient outcomes. Providers and commissioners feel there is an opportunity to make the pathway more integrated within the existing resources.

2.5) Whole system redesign and the Better Care Fund

The Better Care Fund section 75 agreement has been signed and the focus has shifted towards delivering the key aims set out in the pool fund. The outputs from the integration workshop are still be finalised. At the same time, the Frailty task and finish group has been meeting to develop the approach to frailty and integrated older people commissioning. The focus is on 2 main streams of work:

- Developing a risk stratification tool for primary care
- Developing the locality based service model

More details information will be provided as the work develops.

2.6) Mental Health and Learning Disabilities

The Board are reminded of the priorities for Parity of Esteem set out within the 'The forward view into action: planning for 2015/16, NHS England, December 2014.' The planning guidance set out new requirements in 2015/16 for commissioners on top of the existing standards.

- Deliver IAPT 15% service coverage and 50% recovery rates
- Improve dementia diagnosis rates
- Deliver the new waiting time targets for mental health:
    - 50% of people experiencing a first episode of psychosis will receive treatment within two weeks.
    - At least 75% of adults should have had their first IAPT treatment session within six weeks of referral, with a minimum of 95% treated within 18 weeks

- Developing adequate and effective levels of liaison psychiatry for all ages in a greater number of acute hospitals.
- Develop the Crisis Care Concordat to set out the actions required to deliver effective mental health crisis care.
- Invest in community child and adolescent mental health services to; improve outcomes for patients and families, reduce the use of expensive out-of-area tier four services, and reduce the incidence of young people being admitted to inappropriate settings.

IAPT Update

The table below shows the CCG performance against the IAPT service coverage target.

CCG	Population	April to March 2014/15			
		Target	Actual	Target	%
Thurrock CCG	20614	3092	2764	15.00%	13.41%

The table below shows the IAPT Recovery rates for Thurrock in Q4.

Performance Indicator	Jan	Feb	Mar	Qtr 4
The Number of people completing treatments	172	168	135	**475**
The number of people who are "moving to recovery" (completed treatment and achieved "caseness" at first session but not at final session) during the quarter	87	80	66	**233**
The number of people who have completed treatment during the quarter who were not at clinical caseness at commencement	7	14	7	**28**
The proportion of people who have complete treatment who are moving to recovery (PHQ13-03/PHQ13-04)	**52.7%**	**51.9%**	**51.6%**	**52.1%**

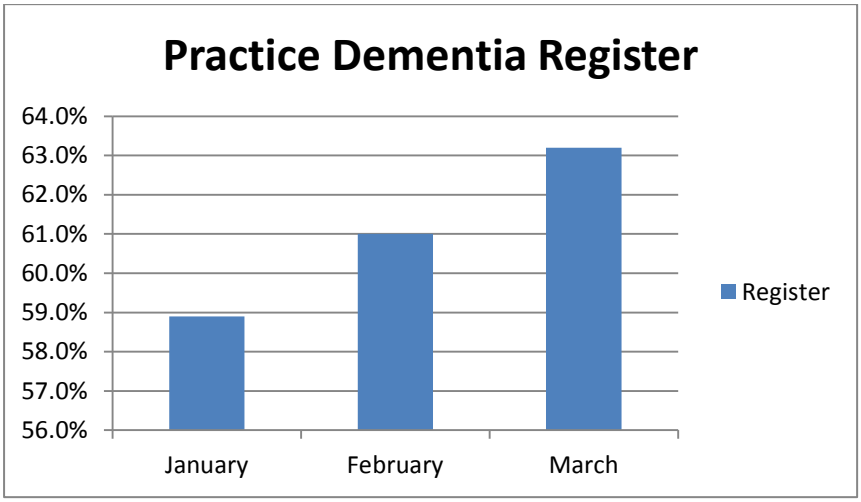
The CCG failed to hit the annual target for IAPT service coverage, despite the focus by commissioners on delivering the recovery action plan. However, the CCG did perform well on the recovery rates indicator. Commissioners continue to meet with SEPT on a monthly basis to ensure a focus on delivery in Thurrock as well as ensuring that the Thurrock perspective is well represented at the contract forums led by Castle Point and Rochford CCG. The Board will be aware that the 15/16 plan for IAPT is to re-procure IAPT using a new service specification. This procurement is at the Invitation to Tender stage.

The new waiting time standards that at least 75% of adults should have had their first IAPT treatment session within six weeks of referral, with a minimum of 95% treated within 18 weeks is incorporated within the existing SEPT contract and within the new specification.

Dementia Diagnosis Rates

The dementia diagnosis action plan has been effective and the table and graph below show the progress made towards delivering the target:

Month	Register
January	58.9%
February	61%
March	63.2%



Thurrock has done well against the national target of 67% in 2014/15 and is ranked 17th out of 61 in England and leading in Essex. Signing up to the Shared Care Protocol has been highlighted as a key contributor to the good performance and the CCG looks forward to the momentum being maintained in 2015/16.

Crisis Care Concordat

The CCG successfully met the deadline for the completion of the crisis care concordat and the subsequent action plan (see Appendix B). There is a SW Essex multi-agency project group overseeing the delivery of the plan. The Board will receive regular updates on delivery against the milestones of the plan.

Winterbourne

The CCG is working closely with LA to ensure that that vulnerable people, particularly those with LD and autism receive safe, appropriate and high quality care. This includes jointly sourcing appropriate community care packages and bespoke housing arrangements to meet all levels of presenting needs. The two Care and Treatment Reviews mandated by NHS E have were undertaken in November and December 2014 with clear outcomes identified to facilitate safe and appropriate discharges. There is a multi-agency project group in place to manage one of the long term patient's discharge process which is scheduled to conclude with a suitable placement in the community on 01/03/2016. This will be a jointly funded package between the CCG and LA. One more patient is due for discharge on 01/05/2015 and LA will fund the community care package. The CCG doesn't currently have any new admissions falling under the Winterbourne remit. There are however 2 cases in the specialist commissioning cohort that are likely to align with the CCG therefore a potential cost pressure

3) Recommendation

The Board are requested to note the content of the report.

NHS
Thurrock
Clinical Commissioning Group

2. NHS Constitution

Ambulance:

Red 1 within 8 minutes (Monthly Cumulative)	Thu CCG	>= 75%		68.1%	68.8%	69.0%	66.9%	66.7%					67.4%
Red 2 within 8 minutes (Monthly Cumulative)		>= 75%		50.8%	53.2%	52.4%	51.9%	53.0%					52.9%
Cat A19 within 19 minutes (Monthly Cumulative)		>= 95%		94.1%	94.3%	94.5%	94.4%	94.6%					94.0%
Ambulance Diverts (Official)	BTUH	Zero	0	0	0	0	0	0	0	0	0	0	0

A&E

Avg. Time to Handover from Ambulance to A&E	BTUH	<= 20 mins											
Time to initial assessment - 95th centile		<= 15 mins	2	2	2	2	3	3	2	3	13	11	13
Time to see a Clinical Decision Maker - Median		<= 60 mins	66	70	65	78	60	63	55	75	80	69	76
Time spent in A&E (Non Adm) - 95th centile		<= 240 mins											
Time spent in A&E (admitted) - 95th centile		<= 240 mins	457	458	452	511	600	484	536	559	705	678	650
4-hour wait		>= 95%	96.42%	95.63%	95.82%	94.88%	93.46%	96.67%	95.37%	94.83%	90.17%	88.53%	88.95%	88.70%
Number of re-attendances within 7 days		<= 5%	2.6%	2.8%	2.9%	2.8%	3.2%	3.2%	3.5%	3.5%	3.9%	3.3%	4.0%
Long Trolley Waits (Over 12 hour DTA)	BTUH	Zero	0	0	0	0	0	0	0	0	0	0	0

Referral to treatment waits: Percentage of patients waiting 18 weeks or less

Admitted (Non Adjusted)	Thu CCG	>= 90%	88.6%	83.6%	82.0%	79.0%	80.9%	79.4%	81.6%	80.3%	82.6%	86.5%	87.2%
Admitted (Adjusted)		>= 90%	91.1%	85.3%	84.7%	81.2%	82.8%	82.9%	83.4%	81.2%	82.7%	89.8%	86.8%
Non Admitted		>= 95%	95.3%	95.9%	92.4%	90.5%	91.6%	89.8%	91.0%	91.3%	93.3%	95.2%	91.9%
Incomplete Pathways		>= 92%	87.5%	84.4%	85.5%	87.4%	92.7%	92.7%	92.0%	92.2%	91.0%	90.7%	90.6%
Waiting >52 weeks (Admitted Stops)	Thu CCG	Zero Patients	0	1	0	2	0	0	0	0	0	0	0
Waiting >52 weeks (Non Admitted Stops)			0	0	1	1	0	0	0	0	0	0	0
Waiting >52 weeks (Incomplete)			1	6	1	2	1	1	0	0	0	0	0

Diagnostics

Percentage patients waiting over 6 weeks	Thu CCG	<= 1%	0.3%	0.1%	0.8%	0.5%	0.1%	0.2%	0.2%	0.1%	0.1%	0.5%
Percentage patients waiting over 6 weeks	BTUH	<= 1%	0.0%	0.0%	0.8%	0.1%	0.0%	0.0%	0.1%	0.0%	0.3%	0.1%

Cancer Waits: Maximum 2 week wait from:

Urgent GP/GDP referral to 1st Outpatient Att.	Thu CCG	>= 93%	93.9%	95.3%	97.4%	97.2%	96.6%	95.7%	95.9%	95.6%	97.3%	96.0%	96.8%
Referral breast symptoms to 1st hospital assess.		>= 93%	98.1%	96.9%	93.5%	97.4%	96.7%	100.0%	96.2%	95.6%	94.9%	88.9%	88.9%

Cancer Waits: Maximum 31 day wait from:

Decision to treat to first definitive treatment	Thu CCG	>= 96%	98.2%	98.3%	96.4%	100.0%	98.2%	98%	100%	100%	100%	98%	100%

Cancer Waits: Maximum 31 day wait from: Decision to treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for:

All cancer patients	Thu CCG	>= 96%	95.6%	97.8%	95.8%	100.0%	100.0%	97.9%	95.9%	95.9%	95.0%	95.5%	95.3%
subsequent treatment: surgery		>= 94%	85.7%	87.5%	87.5%	100.0%	100.0%	100.0%	90.0%	100.0%	77.8%	66.7%	83.3%
subsequent treatment: drug treatment		>= 98%	95.7%	100.0%	96.2%	100.0%	100.0%	100.0%	100.0%	94.1%	100.0%	95.8%	100.0%
subsequent treatment: radiotherapy		>= 94%	100.0%	100.0%	100.0%	100.0%	100.0%	92.3%	93.3%	100.0%	100.0%	100.0%	100.0%

Cancer Waits: Maximum 62 day wait from:

GP/GDP referral to first definitive treatment	Thu CCG	>= 85%	69.0%	71.4%	61.5%	77.3%	65.6%	71.4%	76.0%	80.6%	80.0%	67.7%	61.5%
Ref from NHS Screening Programme to 1st treat.		>= 90%	100.0%	100.0%	87.5%	100.0%	100.0%	50.0%	100.0%	NA	0.0%	100.0%	100.0%

Delivering Same Sex Accommodation

Breaches	Thu CCG	Zero	1	1	0	5	2	0	0	0	2	1	0

Cancelled Operations

Cancelled Elec Ops for non clinical reasons	BTUH	Zero		75		94		82				
Breaches: Cancelled Elec Ops not treated <=28d		Zero		2		3		1				

5. Other Activity and Efficiency

VTE Risk Assessment	BTUH	>= 95%	98.2%	98.8%	99.7%	99.8%	99.5%	99.8%	99.8%	99.9%	99.8%	99.8%	

Other

111 Service

Percentage of abandoned calls	IC24	< 5%	0.31%	0.10%	0.09%	0.07%	0.07%	0.05%	0.16%	0.38%	0.00%	0.20%
Percentage of calls answered within 60 seconds	IC24	> 95%	96.5%	98.2%	97.6%	98.6%	98.4%	98.9%	98.3%	94.4%	96.5%	96.3%

SHMI

				Sep-13		Dec-13		Mar-14		Jun-14
Standard Hospital Mortality Rates	BTUH	Banding >= 2		2		2		2		2

Serious Incidents (Volume / KPIs)

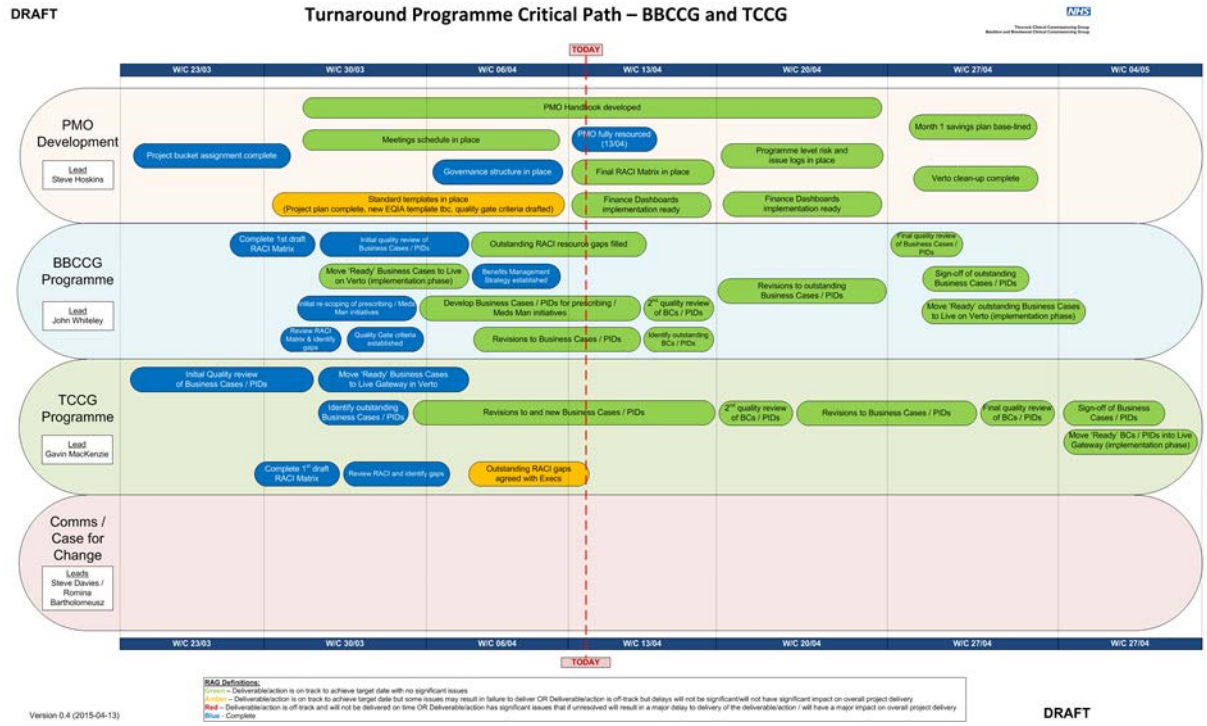
Volume	NELFT			13
% reported within 2 working day from the decision that a SI has occurred		100%		13
Volume of Never Events				0

Improving Access to Psychological Therapies

IAPT Access Target - Monthly	Thu CCG	>= 1.1%	0.7%	0.7%	2.1%	1.0%	1.0%	1.1%	1.3%	1.2%	0.9%	1.2%	1.0%	1.1%
IAPT Access Target - Cumulative	Thu CCG	>= 12.1%	0.7%	1.5%	3.5%	4.5%	5.5%	6.5%	7.8%	9.0%	9.9%	11.1%	12.0%	13.1%
IAPT Access Target - Cumulative Plan	Thu CCG		1.1%	2.4%	3.8%	5.2%	6.2%	7.2%	8.6%	10.1%	10.8%	12.1%	13.6%	15.0%
IAPT Recovery Rate	Thu CCG	>= 50%	50.7%	52.6%	51.1%	50.5%	52.6%	51.1%	50.5%	50.4%	50.4%	53.2%	50.1%	52.1%

Vision Statement: The Health and care experience of the people of Thurrock will be improved as a result of our working effectively together.

Appendix A – Critical Path for QIPP Sustainability Business Case Development



Vision Statement: The Health and care experience of the people of Thurrock will be improved as a result of our working effectively together.

1. Commissioning to allow earlier intervention and responsive crisis services				
No.	**Action**	**Timescale**	**Led By**	**Outcomes**
1.1	Establish baseline data ▪ Street triage pilot • s136 admission • EDS/EDT service • CHRT • A&E Liaison /RAID • Public Health (JSNA) • Ambulance • 111 Flowchart • Telecare ▪ Review quality of existing data	From April 2015	All concordat stakeholders	▪ Improved demographic data on the people using crisis services to inform service development ▪ Improve services for people when in crisis – appropriate setting, readily available, smooth transition between services .Understand the effectiveness of the street triage of the s136 admissions.
1.2	Improve collection of qualitative data around experience of patients by categories defined under the Equalities Act 2010	May 2015	CCGs/LAs	▪ Improved understanding of how patients from diverse communities experience crisis services using surveys. ▪ Understanding the barriers that prevent seeking of services when in crisis
1.3	Collate service users experience "when in crisis", of all stakeholder services .This will provide qualitative data to inform future service delivery.	From July 2015	All concordat stakeholders	▪ Understanding the barriers that prevent seeking of services when in crisis ▪ Improve outcomes for service users in crisis ▪ Improve mental health awareness for stakeholders
1.4	Collect data of people attending emergency department with drug and alcohol problems	From April 2015	BTUH CDAS	▪ Understanding of gaps in service ▪ Appropriate provision of services
1.5	All partners to consider making *'reasonable adjustments'* to enable people who may be marginalised to articulate what they want	From April 2015		▪ All partner services are more sensitive to the particular needs of people experiencing mental health crisis (parity of esteem) therefore leading to reducing A+E admissions
1.6	Update on the Joint Strategic Needs Assessment (JSNA) to include more information on mental health and specifically data on	June 2015	Public Health ECC and Thurrock	▪ Improved useable data at a local level ▪ Identify areas at risk and gaps in provision and uptake of services

	mental health crisis			▪ Improved mental health intelligence around which to plan, commission & provide mental health services & specifically crisis services ▪ Implementation of mental health metrics devised by NHS England
1.7	Extend the established GP Crisis Line to statutory and possible voluntary sector providers	From May 2015	All concordat stakeholders	▪ Clarity over criteria/ thresholds and ways to overcome them ▪ Outcomes-led/ needs-led approach ▪ Age removed as a barrier to accessing appropriate support in crisis ▪ Prevention of some crisis through listening to young carer and recognition of warning signs
1.8	Review the current communications pathway between all stake holders and develop a communication plan to raise awareness of mental health crisis and services available.	May 2015	All Concordat stake holders	▪ Standardised communication between organisations in South West Essex locality ▪ To prevent crisis admissions to hospital ▪ Raise awareness or mental health across all stakeholders ▪ Improved multiagency working and information sharing ▪ Clear and concise pathways of care which are easy to navigate for service users and professionals alike
1.9	Explore the opportunity of enabling the GP Access Numbers to be made available to all emergency services	From May 2015	South West Essex CCGs	▪ Improve responsiveness to mental health crisis ▪ Prevention of crisis admissions ▪ Reduction in s136 admissions ▪ Improved multiagency working and information sharing ▪ Bringing mental health closer to parity of esteem
1.10	Develop an information leaflet for A&E and VSO	From July 2015	All Concordat stake holders	▪ Prevention of crisis admissions
1.11	Review the current model of CRHT service and pathways. To deliver a model of Crisis Service in line with commissioning expectations and specifications	May 2015	South West Essex CCGs/SEPT	▪ CRHT service specification and agreed performance indicators are identified and implemented. ▪ Single point of access ▪ Equitable crisis provision for all ages and mental health issues ▪ Clear and concise pathways of care ▪ Standard response times, referral processes and quality standards to mental health crises ▪ Satisfactory subjective outcomes for people using services via

				patient/carer surveys ▪ possible co-location with other emergency services (Street triage)
1.12	Completion of the Essex wide CAMHS procurement joint exercise between Essex County Council and CCGs	New service to commence October 2015	CCGs CAMHS Commissioners ECC/TBC/SBC	▪ To improve value, access and responsiveness and ensure a safe, appropriate service
1.13	Review of CAMHS and adults transition protocols between child and adult mental health services, taking into account principles and good practice set out in the national CAMHS transition service specification	March 2015	South Essex CCGs and SEPT	▪ Intention to move to all age commissioning for mental health ▪ Integration between health, social care and physical health care ▪ To agree transition protocol to insert into SEPT contract and possible new CAMHS providers from October 2015
1.14	Investigate and understand the issues and need for care and subsequent mental health assessment for people with drug and alcohol problems	From April 2015	SEPT/CDAS	▪ Reduction in inappropriate use of S136 suites ▪ Vulnerable people are assessed in a safe place ▪ Review of resources used by partner agencies 'containing' intoxicated individuals ▪ Improved response to people lacking capacity with MH needs, but not needing the ED
1.15	Review the Psychiatric Liaison Service to consider all age approach and current gaps including hours required within the Mental Health Liaison team to best meet service users needs.	From March – May 2015	SEPT BTUH	▪ Remove age as a barrier to accessing appropriate support ▪ Crises responded to within standardised timescales and quality standards and with approved outcomes ▪ Fewer admissions ▪ Secure ongoing RAID/Liaison funding
1.16	Review current pathway /outcomes following an A&E attendance. To ensure the appropriate pathways and procedures are in place	October 2015	BTUH/SEPT	▪ Increase community support upon discharge to prevent crisis admissions. (IAPT)

1.17	Review current workforce training required across all Emergency Services	From May 2015	Essex Police /British Transport Police/SEPT	▪ Police Officers provide an informed and sensitive approach to people in mental health crisis ▪ Sharing of mandatory training
1.18	Ambulance national specification – ensuring local specifications are define waiting times target for MH service users	From April 2015	East of England Ambulance Service	▪ Ensuring ambulance service meets contract requirements ▪ 30 minute response time for s136 call coding ▪ 8 minute response where restraint is being used
1.19	Undertake a review of the needs and current provision of children and young people services (including those with behavioural problems) within South West Essex inpatient care and paediatric wards with Commissioners and providers.	By 1st November 2015 – aligned with CAMHS re-procurement	CYMS /CAMHS Commissioners SEPT	▪ Scoping exercise leading to recommendations ▪ Review of, and suggestion of improved provision for children and young people with 'behavioural issues in crisis' ▪ Improved inpatient provision for Children and Young People
1.20	Health and Social care commissioners to establish the crisis/emergency care pathway for CYP with LDD, including children with LDD and neuro developmental disorders who present with challenging behaviour.	From May 2015	All Concordat stake holders	▪ Improve the understanding across health, education, social care, and police on the crisis/emergency pathway for CYP with LDD, and CYP with LLD and neuro developmental disorders who present with challenging behaviour.
1.21	Work with multi agency partners, building on existing joint work, to review and refresh multi-agency pathways and protocols for this client group, and identify areas for longer term service development, including potential for joint commissioning and/or service redesign.	From May 2015	CYMS /CAMHS Commissioners SEPT	▪ Improve the information available to CYP parents/carers on 'what to do' when behaviours start to escalate ▪ To help prevent CYP their families and carers reaching a crisis situation ▪ To improve multi agency working across all services ▪ Reduce inappropriate presentations to acute hospital A+E departments ▪ Reduce inappropriate admissions to acute sector paediatric wards
1.22	To undertake a needs analysis of potential service models for alternative to hospital admissions through pathway review (Mapping)	From July 2015	CCGs Thurrock BC Essex CC	▪ Reduction in hospital admissions ▪ Better experiences for people experiencing mental health crisis as evidenced through satisfaction surveys
1.23	Ensure service users with long –term conditions are screened for mental health problems and referred to appropriate mental health services (IAPT)	From April 2015	NELFT/SEPT	▪ To improve the working between mental health and physical health services. ▪ Bringing mental health closer to parity of esteem
1.24	Further evaluate the number of people using 111 who are having a mental health crisis.	From June 2015	111/CPR CCG	▪ Improved access to support for people experiencing mental health crisis

	Including the pilot of MH trained staff in 111			▪ Improved flow charts for 11 1 staff ▪ Sharing of 111 protocols ▪ Reduction in A&E admissions
1.25	Review current practise of Tele-care & Tele-health care. To establish opportunities to provide support to prevent crisis and give rapid response	September 2015	Thurrock BC / Essex CC/ CCGs/SEPT/ NELFT	▪ Earlier identification of impending crisis ▪ Supporting service users to remain in the community
1.26	South West Essex Crisis concordat action plan to be published on the national concordat website	March 2015	South Essex concordat action plan group chair	▪ National sharing of plans available for general public via national website ▪ To enable service users and carers to hold a stakeholder to account for implementation.
1.27	Confirm lead role of SRG mental health crisis sub group in oversight of development and implementation of action plan. Update TOR to reflect this.	April 2015	All Concordat stake holders	▪ Clear governance and accountability for implementation of action plan ▪ Terms of reference in place and agreed by all stakeholders.
1.28	Work towards delivery of NICE approved care packages as part of the PbR implementation and delivery of the SEPT mental health "Super CQUIN"	April 2017	SEPT/CCG's	▪ Care packages defined and agreed ▪ Service users in secondary care mental health services receive care packages in line with NICE guidance
1.29	Review the skill mix within the current RAID service to ensure it meets best practise	June 2015	SEPT/BTUH	▪ Improve clinical outcomes of service users ▪ Increase awareness of mental health across the Acute Hospital
1.30	Commitment from all to participate in any future rolling programme of multi-agency, multi-professional mental health crisis pathway training	From July 2015	All Concordat stake holders	▪ Increased awareness of mental health issues for police officers leading to a more personalised and sensitive responses ▪ Improved understanding between operational staff in partner agencies leading to more joined up responses and less 'hand off's ▪ Direction and consistency of all aspects of policing and mental health via appropriate group ▪ Sharing of mandatory training
1.31	Ensure SEPT workforce has the correct skill mix for delivering services in line with new PbR care packages	October 2015	SEPT/CPR CCG	▪ Workforce reviewed to ensure it has sufficient capacity and appropriate skill mix to meet the clinical needs of local case mix.

1.32	Review the current CRHT skill mix to ensure this meets the needs and reflects best practice.	October 2015	SEPT/CPR CCG	▪ Workforce reviewed to ensure it has sufficient capacity and appropriate skill mix to meet the clinical needs of local case mix.
1.33	Review outcome of Pilot Shared Care Protocol	From April 2015	SEPT	▪ Improved information sharing across the partner organisations ▪ Fewer A&E attendances ▪ Fewer emergency admissions ▪ Improved medication management ▪ Appropriate and prompt re-entry to services as required
1.34	Review/analysis of partner agencies mental health crisis related policies, procedures and protocols	July 2015	All Concordat stake holders	▪ Reflects best practice as evidences by analysis of national documentation including NICE guidance ▪ Evidence of a personalised approach ▪ Involvement of carers/friends and 'protected characteristic groups' ▪ Consistent with service specifications
2. ACCESS TO SUPPORT BEFORE CRISIS POINT				
2.1	Review information provision and pathway for patients who attend or access A&E following self-harm, who are not admitted	From April 2015	SEPT/BTUH	▪ Ensuring that patients are identified, and managed to prevent crisis and attendance at Emergency Department
2.2	Establish a South West Essex link with the British Transport Police to involve them in prevention projects to tackle mental health and suicidal behaviour challenges	From May 2015	SEPT/British Transport Police	▪ Prevention of people seeking to harm themselves on the railway
2.3	CAMHS self-harm reduction strategy to be developed	October 2015	CAMHS providers/ CCGs / ECC	▪ Reducing self-harm episodes in children and young people
2.4	Develop interface with Crisis Resolution Home Treatment Team and Independent Mental Health Advocacy	From May 2015	SEPT/CCGs	▪ Clarity of relevance of statutory advocacy to users of Crisis Resolution Home Treatment Team ▪ Service users empowered through access to appropriate advocacy in crisis
2.5	Analysis of service user experience	From July 2015	Healthwatch/ CCGs	▪ involvement of service users in assessment of current pathways and redesign of new ones
2.6	Promote use of personal health budgets to provide individualised care	From April 2015	CCGs/SEPT/ VSOs	▪ Improved use of services according to need ▪ Improve mental well-being and preventative measures

3. URGENT AND EMERGENCY CARE ACCESS TO CARE				
3.1	Local implementation of the Association of Ambulance Chief Executive national S136 guideline for transportation of people under Section 136 detention	From April 2015	East of England Ambulance service	▪ All Section 136 requests for ambulance transportation would be categorised as appropriate
3.2	Discuss and review of multi-agency 'Standards/pathway to be utilised for mental health assessment' around crisis focusing: • Training • Communications • Pathway	From April 2015	All Concordat stake holders	▪ A set of multi-agency standards around MH assessment to be defined by the CCC group ▪ Shared understanding between key stakeholders ▪ Users/carers know what they can expect from key agencies in a MH assessment ▪ A timely and efficient assessment process
3.3	Development of an improved approach between CCGs and NHS England commissioners in relation to the availability and access to CAMHS beds and the step up and step downs services required	From April 2015	NHS England, South West Essex CCGs	▪ Improved multiagency communications
3.4	Essex wide GP CAMHS crisis line to be developed for advice support and signposting.	February 2015	South West Essex CCGs	▪ Improve communication between GPs and CAMHS providers ▪ To ensure the most appropriate response is delivered to the service user ▪ Regular audit of the use and effectiveness of the line
3.5	Review and evaluate street triage model delivery to ascertain possible service gaps in current provision.	May 2015	Essex Police	▪ Improve out comes for service users in crisis ▪ Reduction in s136 detentions ▪ Reduction in usage of s12 doctors ▪ Improved mental health awareness in Police
3.6	Explore options for developing an advise and helpline for service users and carers	From July 2015	SEPT/ECC/TBC CCGs	▪ Reduce crisis episodes ▪ Support carers
3.7	Develop the MH Crisis Specific Information Exchange Agreement (SIEA) or equivalent addressing safeguarding concerns	From July 2015	All Concordat stake holders	▪ Information is appropriately shared in mental health crisis safeguarding situations ▪ Avoid duplication ▪ Ensure service users safety
3.8	Audit current safeguarding referrals where	From July 2015	South West	▪ Improved understanding of mental health safeguarding situations

	there is an underlying mental health problem (including carers)		Essex CCG's	
3.9	Review interface between daytime Approved Mental Health Professional and EDT (to include planned OOH Mental Health Act assessments)	July 2015	ECC	▪ Ensure that Mental Health Act assessments are undertake in a timely fashion in accordance with the legislation/Code of Practice ▪ To ensure workforce levels are at the required standards to meet level demand in services
3.10	Review housing and accommodation needs as part of crisis pathways for people with mental health long terms conditions	From May 2015	District Councils /VSOs	▪ Improved access to housing support for people with mental health problems
3.11	Data collection and Audit of experience of subjects of s135 ands136	From April 2015	Essex Police/SEPT	▪ Detainee experience of 136 Suite Opportunity to improve experience of S136 detainees
3.12	Independent Mental Health Advocacy service information material to front line staff	From May 2015	Basildon Mind	▪ Improved awareness and understanding of the IMHA role. ▪ Increase in referrals for clients to the IMHA service ensuring service user involvement in decisions affecting their lives.
3.13	To develop a campaign to raise awareness of services available to people in mental health crisis. To coincide with World Mental Health Day "Dignity in Mental Health"	10th October 2015	All Concordat stake holders	▪ Raise awareness of mental health issues ▪ Improve patient experience and quality outcomes ▪ Reduce stigma ▪ Improve diagnosis, timely access and early intervention ▪ Reduce crisis episodes
4. QUALITY OF TREATMENT AND CARE WHEN IN CRISIS				
4.1	Review existing patient pathways in place for frequent attenders with mental health problems at the	October 2015	BTUH/SEPT	▪ Work with partners to review frequent attenders ▪ Develop pathway plans for better management to prevent attendance ▪ Increase community support upon discharge to prevent crisis admissions. (IAPT)
4.2	Ensure all organisations are aware of the work of the British Transport Police surrounding suicide prevention at Railways	From June 2015	British Transport Police	▪ Dissemination of the BTP crisis number ▪ Earlier intervention of potential railway suicides Reduction in railway suicides
4.3	Collaboration between Police, primary care, mental health providers and social care to produce a local mental health information sharing system in order to identify people at	From July 2015	All Concordat stake holders	▪ Improved quality of assessments ▪ Prompt identification of people with mental health problems leading to more appropriate care

	risk of serious mental illness			
5. RECOVERY AND STAYING WELL/PREVENTING FUTURE CRISES				
5.1	Information for the Independent Mental Health Advocacy service and engagement with Service User Group	From May 2015	Basildon Mind	▪ Opportunities to engage with other service users and play an active role in the forum, contributing in consultations etc., raising their awareness of existing or alternative services increasing their choices and improving their knowledge ▪ Improved awareness and understanding of the IMHA role. ▪ Increase in referrals for clients to the IMHA service ensuring service user involvement in decisions affecting their lives
5.2	Provide coping with crisis and developing plans (Recovery Colleges)	From October 2015	South West Essex CCGs	▪ All Wellbeing Plus clients will be able to attend workshops to develop their own personal plans (or review existing ones) and share strategies and techniques with other clients
5.3	Undertake audit of A&E attendances for people with mental health problems, to support identification of any gaps in current service provision and pathways.	From April 015	BTUH	▪ Reduction in crisis admissions
5.4	Implementation of social prescribing scheme across BBCCG	From April 2015	ECC	▪ Improving support in primary care ▪ Improving community resilience
5.5	Promote and extend the use of Advance Care Plans, Crisis Plans Decisions and Advance Decisions for mental health patients including Children and Young People and people with dementia	From April 2015	SEPT	▪ All known service users will have a future crisis plan that lessens the likelihood of a repeat crisis and ensures the wishes of the service user are taken into consideration ▪ Evidence that these plans are routinely part of the CPA process
5.6	Audit current use of Crisis Care Plans in line with NICE quality standard 14 – Crisis planning	January 2015	SEPT/CPR CCG	▪ Establish current practice and standards related to crisis plans ▪ Establish what learning is required and promote a standardised approach to crisis plans ▪ Ensuring adherence to national standards
5.7	IAPT services continued development to support people with mild to moderate mental health problems	From April 2015	IAPT providers /South West Essex CCGs	▪ Improving recovery in service users with mild to moderate anxiety and depression, reducing risk of future criris
5.8	Explore use of Personal budgets and Personal	From April 2015	LAs/SW CCGs	▪ Improving the individualised care of people frequently presenting in

	health budgets to support people frequently in crisis			crisis to promote recovery, independence and better quality of life