NHS

Nottingham North and East

Clinical Commissioning Group

Putting good health *into practice*

Commissioning Strategy

2012/13–2014/15

August 2012

Document Purpose: This document is the commissioning strategy for 2012/13 – 2014/15 for NHS Nottingham North and East Clinical Commissioning Group
Title: NHS Nottingham North and East Clinical Commissioning Group Commissioning Strategy 2012/13 – 2014/15
Editor: Dr Tony Marsh/Samantha Walters
Publication Date: July 2012
Target Audience: Nottinghamshire Health and Wellbeing Board, NHS Commissioning Board, Patients and Public
Circulation List: Nottinghamshire PCT Cluster Committee, NHS Midlands and East, Nottinghamshire Health and Wellbeing Board, Nottinghamshire County and Borough Councils, Provider organisations, Voluntary sector organisations, Nottinghamshire CCGs, Nottingham North and East CCG Patient and Public Reference Group
Cross Ref: Nottinghamshire PCT Cluster Integrated Plan 2012/13 Nottinghamshire County Health and Wellbeing Strategy 2012/13
Superseded Docs: Nottingham North and East Clinical Commissioning Group Commissioning Plan 2012-13
Action Required: Note
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For Recipient's Use
Version control: Draft Version 1 March 2012 Draft Version 2 June 2012 Draft Version 3 July 2012 Draft Version 4 August 2012 Draft Version 5 August 2012 Final Version 1 August 2012

Contents

Tables of information

Figures

Foreword

Nottingham North and East Clinical Commissioning Group (CCG) is an ambitious, confident and dynamic new NHS organisation, focused on putting good health into practice. The CCG is responsible for planning and buying NHS services and ensuring the quality of local healthcare for a patient population of approximately 145,000. We cover a wide area stretching from Newthorpe in the west, across the top of Nottingham to Lowdham in the east, with our patient population mainly being based within the Gedling and Hucknall areas.

By 'putting good health into practice' we aim to improve the health of the community and reduce health inequalities, secure the provision of safe, high quality services, and achieve financial balance and value for money. This Commissioning Strategy 2012-15 sets out our approach, informed throughout by robust and on-going public and patient engagement, on how we will begin to deliver on our strategic vision.

The population of Nottingham North and East CCG is distributed across five local authority areas within Nottinghamshire County, namely Gedling, Ashfield, Broxtowe, Nottingham City, and Newark and Sherwood. The majority of patients registered with GP practices in the CCG area live within three districts: Gedling Borough, Ashfield District (mainly Hucknall), and Broxtowe Borough (parts of Eastwood). The remainder live in Nottingham City, Newark & Sherwood District and other parts of Nottinghamshire (see table below). Compared with other areas in England, our population has a higher percentage of both men and women aged 45 and older, and a lower percentage aged less than 30. Levels of deprivation within the CCG area vary significantly and although places such as Woodborough and Burton Joyce are among the least deprived in England, other areas including parts of Hucknall, Netherfield, Porchester and Killisick Estates experience higher levels of deprivation, identified as being in the 10% most deprived areas in England. This is reflected in variations in life expectancy across the population, with a difference of at least five years for both men and women.

In the first year of this strategy, our objectives are to continue to build organisational credibility and effectiveness. Only upon a sound functioning CCG, can we hope to deliver our vision. During 2012-13 we will develop our proper constitutional and governance arrangements, we will undertake to develop our leaders, and build clear and credible commissioning plans. With a strong clinical and multi-professional focus, and through meaningful engagement with patients, carers and local communities, we will continue to review and fine-tune our plans. If we are really to make a difference in tackling health inequalities and improving health and social care services, we must work effectively in collaboration with partners. Joint commissioning is a mechanism by which the County Council and its relevant CCGs can plan to invest public money to commission services that help to improve the health and wellbeing of all people across Nottinghamshire. We are fortunate in the county in having a strong history of successful multi-agency strategic partnerships, working together on common agendas, and this approach is a strong theme of our work going forwards.

Having extensively engaged with partners, providers, and patients and the public, and in line with national objectives, in the years to 2015 we aim to:

- Reduce health inequalities in the local population by targeting those people with the greatest health needs
- Drive up the quality of care in order to improve health outcomes and reduce unwarranted clinical variation
- Direct available resources to where they will deliver the greatest benefit to the local population
- Commission appropriate models of care for older and vulnerable people with complex needs, ensuring all patients are treated with dignity and respect
- Secure improved chances of a healthy life by targeting our prevention approach for children and young people
- Ensure that patients are able to make choices about the care they receive and are seen in the right place, at the right time, by the right person.

We will implement these aims through a commissioning framework based upon eight 'strategic building blocks' and six 'enabling building blocks'. Clinical engagement and leadership is central to our work and each of these identified strategy areas has a named champion, either a GP or another clinician from a CCG member practice.

With an opening commissioning budget of nearly £155m for 2012-13, and forecast severe budget restrictions in future years, we know that we must work efficiently and effectively in all that we do if we are to seek to achieve the vision. The pressures on public spending will remain for many years and only through closely following the QIPP (quality, innovation, productivity and prevention) agenda will we be able to make the progress we seek and that our population expects.

We thank you for reading this Commissioning Strategy 2012-15 and welcome your opinions on our plans. We hope you will wish to support us in our work and help shape the delivery of health and social care services for Nottingham North and East and the vision to improve the health of our population. In support of this over-arching strategy are four key documents, relating to communications and engagement, stakeholder engagement, organisational development, and equality and diversity, and we commend these to you as essential enabling strategies which will influence and guide our work.

Dr Tony Marsh, Chair

Samantha Walters, Chief Operating Officer

1 Introduction

1.1 Background

With the passing of the Health and Social Care Bill in 2012, the most extensive reorganisation of the structure of the NHS to date is now underway. The Health and Social Care Act will see the abolition of NHS Primary Care Trusts and Strategic Health Authorities transferring a large proportion of the budget for health services to Clinical Commissioning Groups (CCGs). These CCGs will be led by general practitioners using their knowledge and understanding of patients' needs. The key principles of the reforms are to put patients at the centre of the NHS, to change the emphasis of measurement to clinical outcomes and to empower health professionals, in particular GPs. Pivotal to the changes is the requirement to make quality and financial efficiency improvements in order to ensure that healthcare resources are used as effectively as possible.

1.2 What is NHS Nottingham North and East Clinical Commissioning Group (NNE CCG)?

NHS Nottingham North and East CCG is one of seven Clinical Commissioning Groups in Nottinghamshire, including Nottingham City and Bassetlaw. The CCG is made up of 21 GP practices covering a population of approximately 145,000, organised collectively to commission health services for the patient population living in Arnold, Burton Joyce, Calverton, Carlton, Colwick, Daybrook, Gedling, Giltbrook, Hucknall, Lowdham, Mapperley, Netherfield and Newthorpe. The geographic area covered by the CCG falls wholly within the Nottinghamshire County Council (upper tier local authority) boundary and is shown in Appendix 1, Figure 1.

The CCG is responsible for commissioning health services for patients registered with GP practices in the NNE area, and also for those patients who are unregistered but live in the geographical area covered by NNE CCG. Formal agreements are in place with neighbouring CCGs where GP practices are located close to the border of an adjacent CCG in order to ensure all patients have access to services irrespective of which GP practice they are registered with or where they live.

NNE CCG has delegated responsibility for an opening commissioning budget of £154.6m for 2012/13 to take forward the planning and purchasing of healthcare. Financial plans and budget allocations for 2013/14 are currently in development and will shape future commissioning intentions over the coming months. NNE CCG will continue to be required to find efficiency savings locally to support the government target of £20 billion of savings across the NHS by 2015. In 2012/13 this efficiency target is £5.245m and in 2013/14 it is likely to be of a similar magnitude resulting in an even greater need to prioritise spend and investment wisely.

1.3 Our Governing Body

NNE CCG's Board was initially established as a shadow board of NHS Nottingham City and Nottinghamshire County Cluster Primary Care Trust (PCT) Board in October 2011. In recognition of the importance of ensuring the CCG is clinically led and representative of member practices a review of the CCG's governance structure, in particularly the composition of Board membership, has recently been undertaken in order to ensure that it is fit for purpose and is aligned with 'best practice' advice.

The new structure was adopted in June 2012 with the Board being renamed as the Governing Body.

The Governing Body will ensure that:

- a culture is developed that ensures the voice of the member practices is heard and the interests of patients and the community remain at the heart of discussions and decisions
- the organisation acts in the best interests of the local population at all times

- the CCG commissions the highest quality services with a view to securing the best possible outcomes for their patients within their resource allocation and maintains a consistent focus on quality, integration and innovation
- there is effective performance monitoring and management of key provider organisations, including the quality of services
- decisions are taken with regard to securing the best use of public money
- the CCG, when exercising its functions, acts with a view to securing health services that are provided in a way which promotes the NHS constitution
- the CCG is responsive to the views of local people and promotes self-care and shared decision-making in all aspect of its business
- the CCG works constructively and collaboratively with other healthcare organisations (including CCGs) to share certain functions where appropriate with a view to maximising efficiency
- good governance remains central at all times.

In addition, in order to ensure there is a senior clinical forum, to strengthen clinical leadership, and to promote innovation, a Clinical Cabinet has been established as a Committee of the Governing Body with defined delegated responsibilities. The Clinical Cabinet is chaired by the Lead Clinician/Chair and membership includes GPs and other clinicians from CCG member practices. Clinical members from the Governing Body, the Accountable Officer and the Lay Member with responsibility for Patient and Public Involvement sit on the Clinical Cabinet in order to provide the direct linkage between the two forums.

The Governing Body meets every second month, alternating with the Clinical Cabinet.

The Clinical Cabinet acts as a Committee with delegated authority from the Governing Body providing the focus on the design and delivery of pathways and services.

Key responsibilities include:

- reviewing all clinical proposals in order to make recommendations to the Governing Body
- monitoring the CCG's performance against its agreed aims and priorities in year; reporting performance (particularly cases of underperformance) to the Governing Body and proposing aims and for subsequent years relative to the needs of the local population
- monitoring the CCG's performance against the national healthcare agenda; reporting performance (particularly underperformance) to the Governing Body and supporting Nottingham Health Community's commissioning intentions
- supporting the CCG in ensuring that quality is given the highest priority in all commissioned services with a view to securing the best possible outcomes within NNE CCG's resource allocation
- supporting the development of a new culture that ensures the voice of the member practices is heard and the interests of patients and the community remain at the heart of discussions and decisions
- supporting the CCG in delivering its commissioning plan
- supporting the CCG in developing and implementing intentions with a strong commitment to NNE priorities
- identifying and supporting innovation across the CCG
- engaging with and promoting NNE to partners and stakeholders.

The Clinical Cabinet meets every two months, alternating with meetings of the Governing Body. All members are expected to attend each meeting.

The governance structure diagram can be found in Appendix 2.

1.4 Our corporate objectives for 2012/13

NNE CCG is ambitious, and enthusiastic about the opportunity presented to CCGs to lead future commissioning of local health services. The health service reforms are designed to unleash the potential for clinical leadership. It is recognised that clinicians in general practice

are trusted local community leaders who have the ability to give a voice to the population of patients and communities they serve. In order to fulfil its statutory responsibilities the CCG has agreed corporate objectives which underpin the vision and core values of the organisation.

The CCG's corporate objectives for 2012/13 are set out below:

Proper constitutional and governance arrangements
Ensure that the necessary management and governance structures and processes are in place in order to achieve authorisation as a statutory body with effect from 1 April 2013
Achieve our financial duty to breakeven on income and expenditure, including delivery of required surplus targets and associated QIPP requirements
Continue to develop financial and activity information for the Governing Body and member practices, taking into account the developing requirements of the users
Ensure expenditure on administration is kept within the prescribed running cost allowance
Promote environmental and social sustainability corporately and as a commissioner
A strong clinical and multi-professional focus
Ensure clinical commissioning is supported by an appropriate, effective and efficient management structure
Ensure all GP practices in NNE are fully engaged in the activities of the CCG
Ensure NNE CCG clinicians are engaged in clinically led commissioning and contract negotiations
Ensure clinical leadership and engagement supports delivery of our statutory responsibility to safeguard the quality of all the services we commission, to monitor quality, and to support improvements in the quality of services
Ensure a strong clinical focus that ensures quality and innovation are key elements of all service improvements
Meaningful engagement with patients, carers and their communities
Continue to develop and implement the CCG's Communication and Engagement Strategy
Ensure patient and public involvement is at the heart of all key commissioning decisions
Enable patients to make choices with respect to aspects of their care, and to involve patients, their carer's and representatives, in decisions about their care
Collaborative commissioning
Continue to establish and cement strong collaborative commissioning arrangements with key partners and other local stakeholders, including other members of the local health economy and local authorities
Continue to develop and strengthen the relationship between NNE CCG and the Nottinghamshire County Health and Wellbeing Board
Clear and credible plans
Develop strategic objectives and commissioning priorities for 2013/14
Ensure all plans contribute to on-going improvements in health services for the population of NNE CCG, ensuring this is achieved within available resources
Leadership development
Ensure that all clinical and non-clinical staff working within NNE CCG have access to appropriate education and development opportunities, annual appraisals and personal development plans

Comply with the public sector equality duty ensuring that Governing Body members and staff receive training on the Single Equality Act 2010, and that all staff involved in developing and commissioning services are trained to complete Equality Impact Assessments
Be a good employer

1.5 Our strategy for primary care

NNE CCG's overarching primary care strategy is to continue to develop primary care through engagement with GP practices. The CCG has a dedicated Primary Care Operations team that is entirely practice-facing and members of the team are becoming embedded into the everyday functions of general practice.

The CCG is developing a 3 year Primary Care Strategy that sets out its plan in respect of how it aims to continue developing primary care over the next few years. Some of the key principles are:

- to ensure primary care provision across the CCG matches the needs of the population and is available for everyone
- to be responsive to the needs of patients and practices and adopt a 'you said, we did' culture
- to encourage innovative ways of working and sharing examples of good practice
- to ensure all staff in the CCG have a working knowledge of practices, including shadowing practices and working closely with clinicians in work streams
- to understand that success can only be achieved by working closely with neighbouring CCGs and also across the wider NNE CCG team.

The PCT has established a Primary Care Development Group which includes representatives of all Nottinghamshire CCGs as well as Contracting and Performance staff from the PCT. It meets to ensure that:

- the transition from shadow form to statutory organisation status is robust
- quality in primary care is improved
- monitoring systems are in place to ensure on-going performance.

NNE CCG's Primary Care Strategy is based on transparency and responsiveness to working with and for our patients, practices and other stakeholders. This is to ensure that NNE CCG is a truly 'bottom-up' focused membership organisation.

NNE CCG's Primary Care Strategy can be found on the CCG's website. Alternatively a hard copy of the strategy is available on request.

1.6 Our plan for organisational development

Organisational development is a planned and systematic approach to enabling sustained organisational performance through the involvement of its people. NNE CCG has fully embraced the philosophy and concept of Organisational Development (OD) and recognises that a strategic approach to development is vital during this period of significant and fundamental change.

NNE CCG's OD plan has been developed in order to:

- Support the delivery of this Commissioning Strategy
- Enable the Governing Body to mature and expand its skill and knowledge base during the authorisation process and beyond
- Achieve authorisation by 31 March 2013
- Ensure that the actions we take in the shorter term support delivery of our longer term objectives
- Ensure that the organisational enablers for delivery are in place and being progressed.

The Organisational Development Plan will be refreshed regularly in line with requirements.

NNE CCG's Organisational Development Plan can be found on the CCG's website. Alternatively a hard copy of the strategy is available on request.

1.7 Our progress to date

Nottingham North and East CCG received delegated authority from NHS Nottinghamshire County Board in July 2011 and aims to become a statutory body from April 2013. Over the last year NNE CCG has used experience gained from operating as NNE Practice Based Commissioning (PBC) Group since 2006, building on a culture of developing locally focussed commissioning models.

Successes include:

1.7.1 Lings Bar Community Hospital

NNE recognises the importance of integrated care in order to ensure co-ordinated and seamless care for patients, and the CCG therefore led a successful project to improve the quality of care for patients in a local community hospital. A utilisation review of a Community Hospital indicated that a number of patients could be more effectively managed. Almost 46% of patients admitted did not meet the criteria for an in-patient stay at some point in their stay. The majority of these patients could have been managed in a homecare/community care setting giving an opportunity to develop integrated model of care as an alternative. Modelling suggested that the existing level of care provided in the hospital could be redesigned through:

- A proportion of patients being cared for in a community setting
- A proportion of patients being managed in a hospital setting with faster discharge when medically fit.

NNE CCG therefore worked with key stakeholders to design a community model of integrated care, improve the interface with social care in order to reduce length of stay, and explore alternative uses for community hospital space.

As a result:

- The length of stay at the Community Hospital has reduced by 20% since the project began in November 2011
- The social work team, now based at the community hospital, has reduced the delayed transfers of care for the first time in 3 years from a monthly average of 300 days to less than 50 days per month
- 24 beds (1 ward) were removed in November 2011 with a commissioner recurrent saving of £1.2m
- In May 2012 a haemodialysis unit was opened in the empty ward following work across the health community to identify how best to utilise the empty space. This has avoided a new build spend of £7m which was planned before the space at the community hospital was identified
- An enhanced community support model has commenced in the CCGs. The community hospital discharge team, the community geriatrician and community matron identify patients who could be managed at home with extra support. To date 80 patients have been discharged sooner (at 13 days) and a package of nursing, therapy and personal care has supported the patient at home for an average of 11 days.

Patent feedback on the community model has been overwhelmingly positive:

> "I was very poorly and wasn't really in touch with what was happening. I preferred to be at home and so when I went home and had the Enhanced Service it was better for me. I had one-to-one care."

This project has demonstrated NNE CCG's tenacity to see an integrated care model through, and its ability to truly engage with partners across health and social care to work together towards a common goal to ensure that patients receive the right care, in the right place at the right time, thereby creating real change for patients and make best use of healthcare resources.

The project was recently presented at Primary Care 2012 and was also featured in the NHS Institute for Innovation and Improvement Bulletin on 25th May 2012.

1.7.2 Inclusive Leadership Programme

NNE CCG is committed to promoting equality, valuing diversity, and improving patient experiences by achieving excellence and combating unfair treatment. In recognition of this earlier in 2012 the CCG was recommended and approved as one of only three national pilot sites for the Inclusive Leadership Programme that will support NNE CCG's Governing Body to move from good intentions to active implementation of inclusive leadership. The programme is designed to develop a deep understanding of diversity and inclusion and to build capacity to lead, integrate diversity and inclusion into business objectives and make inclusive leadership decisions throughout the commissioning and evaluation process.

The CCG is required, as part of the commissioning cycle, to identify vulnerable populations, target marginalised groups and local populations, clearly identify health inequalities and advise on commissioning to meet their health needs. Taking part in this pilot will allow NNE CCG not only to meet its corporate and commissioning responsibilities through inclusive leadership but also allow meaningful engagement that will result in transformational change that will ultimately provide a more enhanced and appropriate services for all our patients. Representatives from the CCG have met with the programme lead to start looking at how to implement the programme to meet the specific needs of the CCG.

1.7.3 Specialist Nursing Community Care

As a PBC consortium NNE CCG focused on Chronic Obstructive Pulmonary Disease, Heart Failure, Diabetes and Stoma Nursing Services and therefore the CCG has a track record of successfully delivering specialist community nursing. For all of these conditions NNE CCG either invested in existing teams or commissioned a new service. The CCG recognised the importance of commissioning these services in order to provide patient's with dedicated and specialist care in the community as well as supporting practices in relation to capacity and effective case management. Education is important to NNE and as such, all commissioned services included an education programme for clinical staff, for example dedicated practice learning times for GPs and Talkin' Lunch, lunch time sessions for practice nurses. These services continue to be funded throughout 2012/13.

1.7.4 COPD/Pulmonary rehabilitation

Through service redesign and effective commissioning of services NNE CCG has delivered on its commitment to improve the management of COPD in the community. An increased number of COPD nurses have been employed and this has resulted in, amongst other successes, an increased provision for pulmonary rehabilitation for COPD patients in their localities. This has improved patient awareness and knowledge of their disease, and enabled more rapid intervention by medical services in tackling exacerbations of this illness. The CCG also recognised an inconsistency in the quality of delivery of COPD care across its practices and has invested resources in an innovative partnership with the education wing of GSK to assess COPD diagnosis and management. This has resulted in closer adherence to NICE guidelines by GPs managing this chronic respiratory disease. In addition this project aims to improve the quality of life of COPD sufferers, ensure a more appropriate use of expensive drugs, thereby reducing prescribing costs for practices, and reduce unnecessary patient admissions to secondary care.

In order to provide mentoring to our practice nurses and Community COPD Nursing Teams, NNE has employed and worked closely with a Respiratory Consultant from Nottingham University Hospitals NHS Trust on a monthly sessional basis.

1.7.5 Mental Health

One of the first services NNE CCG commissioned as a Practice Based Commissioning Consortium was additional mental health councillors in the community. The Consortium recognised the growing concerns over mental health issues and the need for additional support for patients due to limited capacity in the community. Due to its success, the services

were amalgamated into the Psychological Therapies service which is provided county wide and is a national requirement.

1.7.6 Community Clinics

Commissioned from a mixture of NHS providers, PWSIs (Professionals With Special Interest's) and the private sector, NNE CCG has implemented community clinics for pain services, dermatology, ophthalmology, soft tissue services and hand services. These services provide cost effective quality services in convenient community locations and with waiting times shorter than, or at least equal to, equivalent hospital services, thereby reducing the need for referrals into secondary care.

1.7.7 Crisis Intervention Community Support Service (CICSS)

Commissioned from the British Red Cross NNE CCG has provided the CICSS service which is a short term home visiting service for vulnerable individuals one to four times per day. GP practices refer directly into the service and patients are seen within one hour of referral. CICSS provides low level care to address individual needs over a four week period. Recognising the benefits of CICSS the CCG has expanded the service to carry out falls assessments, dedicated support for the Heart Failure Nursing Community Nursing service and more recently, a pilot of higher level personal care. The service has directly supported practices, patients and carers, thereby avoiding hospital admissions. CICSS has won an award from Practical Commissioning and was a finalist in the Health Services Journal Awards. This will continue to be funded throughout 2012/13.

1.7.8 Injury Minimisation Programme for Schools (IMPs)

IMPs is a successful initiative involving NNE CCG working with Nottingham University Hospitals NHS Trust (NUH) and local schools to provide educational practical visits to A&E for children. The visits include an element of teaching in respect of basic first aid skills and general informal chats with the children on appropriate use of A&E departments. This will continue to be funded throughout 2012/13.

1.7.9 Use of Technology

In 2009/10 NNE commissioned an electronic link to a private sector specialist company which enables NNE GP practices to seek speedy expert advice on ECG readings. Due to its success in interpreting ECG readings and avoiding patients having to go to the hospital, the service has continued since. A similar use of technology was implemented with the trial of an electronic link between NNE GP practices and NUH to allow for the transmission of digital HD clinical photos utilising the specialist digital cameras purchased by NNE for each practice which links into the practices' computer systems.

1.8 Other successes

NNE CCG is committed to using available resources as effectively and efficiently as possible in order to ensure patients continue to receive the quality services they require despite existing and on-going financial pressures. In 2011/12 NNE CCG achieved a reduction in spending of £1m (from £6 to £5m – approx. 17%) from the previous year on procedures of limited clinical value which includes hernias and varicose veins procedures. This was achieved by instigating clinical triage and assessment of referrals and publicity around what procedures were covered. This represented a step change in clinical behaviours in the consulting room through evidence-based reasoning and communications between the CCG and the practices at the point of referral.

NNE CCG also achieved a significant 10% appropriate reduction (compared to an average of 1% nationally) of GP to first outpatients referrals compared with the previous year. This was largely due to working with GP practices to support them to use prospective peer review of referrals as an educational opportunity and promote discussions around pathways and service development amongst GPs.

1.8.1 Medicines management

NNE CCG has implemented the Medicines Management Facilitators (MMF) scheme which sees GP practice staff take on a role within the surgery dealing with prescribing issues and working closely with the CCG Medicines Management Team.

In addition the CCG Medicines Management Team has developed supportive and effective relationships with GP practices, undertaking regular visits to all GP practices whilst providing intense, targeted support for individual practices where required.

The result of this is that the Medicines Management Team working in partnership with GP practices delivered savings of £824,740 from the GP practices prescribing budget against a target saving requirement of £758,420 in 2011/12. This has been achieved as a result of close working relationships between the medicines management team members and the GP practices that they work in, with clear direction from the prescribing committee and clinical leadership in this area. The medicines management team in NNE CCG have been regularly praised by GPs and practice managers for the close support that they give and for their responsiveness to issues within practices. A few examples of the feedback received are included below:

17th Feb 2012 from a Practice Manager:

> "It's coming up to appraisal time for most of us, and I thought that it was important to pass on our feedback on the services provided to us by ——. They are excellent. She works really well with our team, is supportive, very professional, informative and we really appreciate her being here"

12th April 2012 from a GP:

> "Not only do all the prescribers warrant a big 'well done', but so do the PCT prescribing advisers. ——, —— and —— and others in their team are always a delight to work with and give us great support including with email queries"

9th April 2012 from a GP:

> "Wonderful! Great support here at —— from —— and clearly from other team members in the other practices, well done"

30th March 2012 from a GP:

> "It's a great achievement and congrats to the whole team"

30th March 2012 from a GP:

> "May I add my thanks and gratitude to not only all of you prescribers, but also the whole Prescribing Support Team"

1.8.2 Scriptswitch

Scriptswitch is a software tool used by GP practices within NNE CCG that provides prescribers with recommendations/information at the point of prescribing. The tool was initially purchased on a three year contract but because of the significant benefits associated with using the tool the contract has been renewed for a further 12 months. The system is integrated with practice clinical systems and alerts prescribers to information and recommendations for alternative medications. As well as being cost effective, use of the tool has supported training of clinicians to prescribe appropriately and has also supported educational discussions between prescribing clinicians. In addition this is a valuable tool for practices particularly when employing new staff or sessional staff who may not be familiar with the local policy and formulary.

1.8.3 Data validation

NNE is committed to validating secondary care activity, and has spearheaded this over several years. This has led to new and improved methodologies being created, adapted and implemented to ensure that poor data quality and incorrect attribution is identified and then resolved. NNE CCG actively engages with the eHealthScope tool to ensure practices are involved in understanding and validating their own data.

Since 2009 data validation has been a key focus for NNE, resulting in the identification of the following wrongly attributed costs & activity to NNE CCG:

Year	Incorrect costs to NNE	Net Savings after all CCG's validation
2009-10	£640,048	£353,108
2010-11	£624,939	£171,935
2011-12	£518,327	£223,785
Total	**£1,783,314**	**£748,828**

Table 1: Savings due to data validation

1.9 Our vision and values

NNE CCG's vision is:

"Putting Good Health into Practice"

This vision will be delivered through:

1. Improving the health of the community and reducing health inequalities
2. Securing the provision of safe, high quality services
3. Achieving financial balance and value for money

The CCG's values have been clinically determined and will underpin all decision making and actions of the organisation. These values are presented using the acronym for **HEALTH:**

Putting Good Health into Practice

Honesty, openness and integrity are central to everything we do
Empowering and communicating with our patient community
Appropriate use of our resources to deliver best value
Leadership that is strong and visible
Together with our partners, strive to improve the health of our community
High quality is our standard

2 Understanding the Health Needs of Our Population

2.1 Our Population

2.1.1 Population and projections

The population of Nottingham North and East CCG is distributed across five local authority areas within Nottinghamshire County, namely Gedling, Ashfield, Broxtowe, Nottingham City, and Newark and Sherwood. The majority of patients registered with GP practices in the CCG area live within three districts: Gedling Borough, Ashfield District (mainly Hucknall), and Broxtowe Borough (parts of Eastwood). The remainder live in Nottingham City, Newark & Sherwood District and other parts of Nottinghamshire (see table below). The CCG is establishing good links with local councils and will continue to build on these as an important feature of our partnership arrangements.

Local Authority Area	% NNE CCG Popn.
Gedling Borough	62.4%
Ashfield District	22.3%
Broxtowe Borough	6.8%
Nottingham City	4.6%
Newark and Sherwood District	3.5%
Other areas	Approx. 0.4%

Table 2: Population of NNE CCG by Local Authority Area

Compared with other areas in England, the population of Nottingham North and East has a higher percentage of both men and women aged 45 and older, and a lower percentage aged less than 30 (see Appendix 1, Figure 2).

In 2010, Gedling had 24,700 residents aged between 0-19 years. This is projected to increase by 15% between 2010 and 2030. The proportion of children in Gedling statemented for Special Educational Needs is 0.9%, compared to a County figure of 1.1%. The number of children diagnosed with autistic spectrum disorder across Nottinghamshire has increased substantially (3 fold) over the last 10 years.

In 2010, Ashfield had the highest number of 0-19 year olds in Nottinghamshire County, at 28,100. Ashfield is projected to have a 14% increase in its 0-19 year old population by 2030. Children identified with special educational needs are the second highest in Ashfield (1.5% and 1.2% respectively). Across the NNE CCG area, the highest proportions of younger people live in Hucknall, Eastwood, Arnold, Carlton and Calverton.

There were 85,900 adults aged 18-64 living in NNE CCG in 2010. The adult population is expected to increase by 9.7% by 2025 (compared with 8.9% increase for Nottinghamshire's registered population average).

NNE CCG has the second highest percentage of older people over the age of 65yrs (16.9%) compared with all Nottinghamshire CCGs. An increase of 33% is expected in the older population by 2025, particularly in the 75-79 age group. This would see a rise from 26,000 to 34,500 people aged 65 or older across Nottingham North and East CCG, with a greater number of females than males (18,900 and 15,600 respectively). In addition, as the population ages, the number of older people living alone is expected to increase to around 40% across Nottinghamshire. Across NNE CCG area the highest proportions of older people live in Eastwood, Burton Joyce and Newstead.

In Gedling, 1 in 7 pensioners live in poverty. A similar ratio of the 50-64 year old population is claiming at least one benefit. Awareness about benefits that are available to claim in this age group is reasonable, with a good proportion of those that are eligible claiming winter fuel payments.

Across Ashfield district, 1 in 5 pensioners live in poverty. Of particular relevance to NNE CCG is the high numbers of pensioners living in poverty in the Hucknall area. A similar ratio of the 50-64 year old population is claiming at least one benefit. Awareness about benefits that are available to claim in this age group is reasonable, however the older people in Ashfield are least likely to claim winter fuel payments compared with older people living in all districts of Nottinghamshire. This suggests that there is inequity and lack of awareness with regard to this benefit payment.

2.2 The Health of Our Population

2.2.1 Health and deprivation

Health is influenced by many factors outside the direct control of the NHS. These are often described as the 'wider determinants of health', and include education, environment, employment, crime and housing. Levels of deprivation across a number of factors, such as

life expectancy, poverty and educational achievement, are a useful way of identifying and measuring differences between areas within the CCG, across Nottinghamshire, and throughout England. These differences, termed *health inequalities,* are where health differences are a result of where people are born, grow, live, work, and age. Those born into disadvantaged groups are likely to live more of their lives in ill health and die at a younger age than average.

Nottingham North and East CCG has reviewed the Nottinghamshire Joint Strategic Needs Assessment (JSNA) which has been updated in recent months, and worked closely with Public Health colleagues to determine its profile; this has shaped the CCG's aims and priorities and is the source of information included in the following sections in respect of key health issues and key health priorities. Levels of deprivation within the CCG vary significantly. Although areas such as Woodborough and Burton Joyce are among the least deprived in England, other areas, including parts of Hucknall, Netherfield, Porchester and Killisick Estates, experience higher levels of deprivation, and are identified as being in the 10% of most deprived areas in England (Appendix 1, Figures 3 and 4).

In Gedling, deprivation is lower than the national average; however, 3420 children live in poverty. Life expectancy for men living in Gedling is higher than the England average. Life expectancy is 79.5 years for men, and 83 years for women. Both are higher than the England average – in men, significantly so. Life expectancy is 7.2 years lower for men in the most deprived areas of Gedling than in the least deprived areas.

In Ashfield, deprivation is higher than the national average and 5,300 children live in poverty. Areas of Ashfield where NNE CCG registered populations live, such as Hucknall, include some of the most deprived 20% of areas nationally. Life expectancy for both men and women is significantly lower than the England average. Life expectancy is 8.7 years lower for men and 10.6 years lower for women in the most deprived areas of Ashfield compared with the least deprived.

Population and health inequalities information supports the CCG in identifying the health needs of the population, and therefore impacts on the services commissioned for the area. For example, higher than average numbers of older people within the area suggest that there will be higher than average levels of long term and life threatening conditions.

Across Nottinghamshire, the trend in death rates over time is reducing. However, the gap between those experiencing the best health and those who have the worst health is not narrowing as quickly as it should (Appendix 1, Figure 5).

2.2.2 Key health issues

Long term conditions:

The prevalence of long term conditions among adults is similar to the national average. In Nottingham North and East CCG the most common long term conditions are hypertension (38,439 individuals), common mental health disorders (17,460), asthma (10,560), chronic kidney disease (11,201), diabetes (8587), chronic back pain (7,062) and coronary heart disease (7,063) and cancer (5,207).

An estimated 1,407 women are living with Breast cancer in NNE CCG; this is the most common cancer in women. For men, the most common cancer is prostate cancer, with an estimated 692 living with this disease in the CCG. Gedling district has a significantly higher incidence of malignant melanoma than the England average. However, the numbers are small with approximately 22 new cases a year.

The unmet need (measured as those whose illness is undiagnosed) is also particularly high for some of the long term conditions noted above. Across Nottingham North and East CCG, there is a relatively high proportion of unmet need for dementia, hypertension, COPD, chronic kidney disease and diabetes.

There are currently expected to be 1822 people living with dementia in NNE CCG. In 2010/2011, 53% of people were undiagnosed in NNE CCG. This was comparable with the average diagnosis rate across Nottinghamshire. The number of people newly diagnosed with dementia across Nottinghamshire is expected to almost double between 2010 and 2030.

This is a significant challenge for health and social care delivery, with direct costs to the NHS predicted to treble by 2030.

Hospital admissions:

Across Nottinghamshire, the rate of planned hospital admissions has increased over the last four years, whereas emergency admissions have remained relatively stable. Older people are 3 times more likely to have an emergency hospital admission than any other age group. Falls are a significant health issue for older people both nationally and locally. In 2010, Nottingham North and East had a low planned admission rate compared to other CCGs in the County (ranked four out of six, high to low) but an average emergency admission rate (ranked three out of six).

Carers:

Nottinghamshire has a high proportion of unpaid carers across the County compared to England. Gedling has an estimated 12,460 residents who provide unpaid care; this is the second-highest number for all the districts in Nottinghamshire. Ashfield has the highest number of residents providing unpaid care (12,631).

Mental health:

In 2008, NNE CCG had an estimated 17,460 adults with a common mental disorder; 14.7% of the adult population compared with 13.6% across Nottinghamshire County. In 2007-2009, Gedling district had the second highest suicide rate in Nottinghamshire. This was almost 50% higher than the Nottinghamshire rate, but is not statistically significant. Areas of Arnold are in the highest 20% nationally for rates hospital stay for self-harm across the NNE CCG area.

Specialist Children and Adolescent Mental Health Services (CAMHS) in Gedling are delivered through a locality based team, which has only 1% of the County caseload. Emotional disorders and problems make up 80% of presentations, and 20% are eating disorders. Gedling has the second lowest specialist CAMHS admission rate in Nottinghamshire (44.8 per 100,000).

Ashfield scores poorly in relation to six indicators associated with increased risk of a child developing mental health problems. As of 2009, children in Ashfield were more at risk of poor mental health than the East Midlands as a whole. There are also significantly higher levels of deprivation, drug use and mental illness compared to the regional average.

Specialist CAMHS in Ashfield district are delivered through a locality based team, with the highest County caseload. They also have the highest number of children waiting to access the service, and the highest number of staff. There are a relatively high number of children on the caseload with additional needs (including those with a learning disability, young offenders, or children looked after). Almost 40% of cases present with hyperkinetic disorders. There are low levels of eating disorders, substance misuse and self-harm.

Alcohol and drug misuse:

The rate of alcohol-related hospital admissions is increasing in all areas across Nottinghamshire. The admission rate for patients registered with a GP in Nottingham North and East CCG is consistently below the County rate. For NNE CCG's population it is relevant to note that small area (MSOA) JSNA indicators show that there are no areas within NNE CCG with high rates of hospital stays for alcohol related harm when compared with the national average.

Smoking:

Smoking is the primary cause of preventable illness and premature death in England, and the single biggest cause of inequalities in death rates. Smoking is responsible for around 1300 deaths across the County every year. Smoking prevalence in the adult population is lower in Gedling (19.3%) and Broxtowe (17.1%) but higher across Ashfield (25.9%) than England (20.8%) or the East Midlands (21.1%) (Appendix 1, Figure 6).

Obesity:

The percentage of obese adults in Gedling district is expected to be slightly lower than the England average, but not significantly so. Gedling district has a significantly lower percentage of the adult population who are physically active. Children in Gedling have significantly lower levels of obesity than the England average.

Adult obesity is expected to be significantly higher than the national average in Ashfield, with areas of Hucknall in the top 20% nationally. Ashfield district also has the highest prevalence of obese year 6 children in the County, however none of the areas of Ashfield district which are included in the NNE CCG area are in the top 20% nationally. Reception year children in areas of Hucknall and Bestwood are in the top 20% nationally for obesity. Ashfield district also has the lowest level of participation in sport and physical exercise in the County (in the 5-16 year old age group) (Appendix 1, Figure 7).

Immunisation and vaccinations:

Nottingham North and East CCG has achieved the 95% recommended coverage for primary immunisations. The CCG is below the recommended 90% coverage for preschool immunisations (MMR) but is above the national average of 78%. Nottingham North and East achieved the national target of uptake for flu vaccinations for people aged 65 and older in 2011/12 (75.3% compared to the target of 75%).

Sexually transmitted infections (STIs)

Overall, Gedling district has a significantly lower rate of all newly diagnosed acute sexually transmitted infections compared to England. The rate for Ashfield district is not significantly different from the national average.

When considering specific STIs, Gedling and Ashfield districts are in the top 20% nationally for new diagnoses of Herpes and Gonorrhoea. Gedling district also has the highest prevalence of diagnosed HIV across the County at 0.8 per 1,000 aged 15-59 years (Notts County 0.6 per 1,000).

The prevalence of chlamydia among 16 to 24 year olds in Gedling district is comparable the East Midlands rate and is lower than the Nottinghamshire County prevalence. In Ashfield district, diagnosis of chlamydia is higher than the County average and in the top 20% nationally.

Domestic Violence:

The highest incidence of domestic violence cases was in Ashfield and Mansfield. Young women – especially teenage mothers – are particularly at risk.

Teenage pregnancy:

The teenage conception rate for Gedling district is comparable with the County average, however teenage conception rates for Ashfield are higher than the County average. Below district level, pockets of Ashfield relevant to NNE CCG in Hucknall have rates in the top 20% across Nottinghamshire. Within Gedling district, in areas within Carlton and Arnold, teenage conception rates are in the top 20% in the County.

Dental health:

Gedling has the highest average number of decayed, missing or filled teeth (DMFT) per child aged 0 to 5 years in the County; this is a significant difference. Ashfield and Mansfield have a relatively low average of DMFT in 0-5 year olds compared to the rest of the County. Water is fluoridated in Ashfield and Mansfield.

Access to services:

NNE CCG's population has relatively good access to health services although some rural areas around Newstead and Lowdham experience poorer access to health services.

Causes of death

The main causes of death for all ages in the CCG are Cardiovascular Disease, Cancer and Respiratory Illness (Appendix 1, Figure 8). Death rates under the age of 75 are mainly linked to cancer (lung and prostate in men, breast and lung in women).

In order to tackle the root causes of ill health and health inequalities across the area, Nottingham North and East CCG is committed to working in partnership with both Nottinghamshire County Council and the relevant District Councils, the police, schools, voluntary sector, and other local organisations and groups as appropriate. Joint approaches to tackling issues will aim to have a positive impact on the long-term health of the population.

2.3 Key health priorities for Nottingham North and East CCG

2.3.1 High priority areas

- Assess the level of health and social care required for future provision of services across Nottingham North and East, in particular for those aged 65 and above
- High rates of teenage conceptions in small populations across the NNE CCG area
- Mental health: highest rates of common mental health disorders in NNE CCG, high suicide rates (though not significantly different for national average), rates in highest 20% nationally for hospital stays for self-harm for small areas within the NNE CCG area, Ashfield district shows higher risk of children developing mental health problems
- Average number of decayed, missing or filled teeth per young child in Gedling is the highest in Nottinghamshire
- Carers: Gedling and Ashfield have the highest number of carers in the County
- Improved identification of people with long-term conditions, especially dementia.

2.3.2 Issues for further consideration:

- Sexually transmitted diseases: Gedling and Ashfield districts are in the top 20% nationally for gonorrhoea and herpes infections. Gedling district has the highest diagnosed HIV prevalence in Nottinghamshire Districts
- Meeting the current and future needs of the increasing numbers of 0-19 year olds in Gedling and Ashfield districts
- Smoking and obesity (adult and child) in the Hucknall area
- Variation in excess winter deaths between Gedling (lowest in the County) and Ashfield (highest in the County).

2.3.3 Positive outcomes:

- Over the last 10 years all-cause mortality rates have fallen. Early death rates from cancer and heart disease and stroke have fallen
- Gedling has low levels of obesity in adults and children compared to the rest of the County and England
- Educational attainment is high in Gedling
- Gedling has the lowest level of excess winter deaths in the County.

2.4 What our patients are telling us

The views and comments of patients and the public are very important to Nottingham North and East CCG. As such the CCG regularly encourages both patients and the public to feed back any gaps in service provision, including their perceptions of local health needs. This information is collected at community events, patient groups and opportunistic feedback and is used to inform on-going service improvement and commissioning plans.

A number of key themes have emerged to date, with our patients telling us that there is a need for:

- The development of Mental Health Care Services and creation of awareness campaigns to reduce stigma associated with Mental Health

- Early intervention of positive health messages to children through education, and encouragement of health screening amongst adults
- The provision of information about local healthcare services to patients allowing individuals to make an informed choice, promoting self-help and voluntary services to provide additional help and support to the public
- Older people and their carers to be a priority
- Additional help and support for carers with the suggestion that there could be local champions linked to GP practices so that carers have a named point of contact
- Awareness raising of local problems relating to drugs and alcohol, and to ensure that services are available to young people
- More support for people who are obese including healthy eating campaigns
- More education around teenage pregnancy and for services to be available to support those individuals when needed
- Better foot care services, especially for the elderly who require toe nail cutting
- Better joined up care when patients are discharged from hospital, especially for those people living on their own.

3 Our Aims and Priorities for 2012/13 to 2014/15

Early in the life of the CCG, the Board held a facilitated development session to explore the health needs of Nottingham North and East. This discussion was formative in structuring how the activities of the CCG have been organised. The discussion was focussed around the requirements of both the Operating Framework for the NHS in England 2012/13 and also the NHS Outcomes Framework 2012. Three of the five domains identified in the Outcomes Framework were key in determining the CCGs aims and priorities for 2012/13 to 2014/5. These are:

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

In addition each of these will be underpinned by the remaining two Outcomes Framework domains focussed on safe, quality services for all patients, namely:

- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

Priority setting was further supported by local information derived from the existing JSNA supplemented by further analysis from public health colleagues. The JSNA will continue to be pivotal in determining key priority areas to be addressed by the CCG and this Commissioning Plan will be updated in line with on-going development and updating of the JSNA, with the support and guidance of public health.

3.1 Nottinghamshire Health and Wellbeing Board Strategy

The passing of the Health and Social Care Bill in 2012 places a duty on Nottinghamshire County Council to establish a Health and Wellbeing Board and develop a supporting strategy to meet the health and wellbeing needs of local people from April 2013. The shadow Nottinghamshire Health and Wellbeing Board was set up in May 2011 and NNE CCG's Clinical Lead/Chairman is an active member of the Board.

The first Health and Wellbeing Strategy for Nottinghamshire brings together identified priorities that are common to the core Health and Wellbeing Board partner organisations. As such the priorities identified in this CCG Commissioning Strategy reflect those included in the Nottinghamshire Health and Wellbeing Strategy. The priorities have also been reviewed against the JSNA to confirm that they are representative of existing local needs, therefore ensuring alignment of these key documents.

NNE CCG is also a key member of the Joint Strategic Needs Assessment Outcomes Group, which is a defined sub-group of the Health and Wellbeing Board, thereby ensuring NNE

CCG's engagement in the on-going development and implementation of the Health and Wellbeing Strategy. NNE CCG will ensure that this Commissioning Strategy is reviewed and updated regularly to reflect any future changes to the Health and Wellbeing Strategy in order to maintain consistency and alignment.

3.2 Our Aims

NNE CCG's aims take into consideration the population profile and groups with the greatest need, whilst also ensuring that focus on the wider population is maintained. They also reflect where clinicians felt change could be more directly affected and where the majority of resources are deployed.

For 2012/13 to 2014/15 NNE CCG's key aims are to:

- Reduce health inequalities in the local population by targeting those people with the greatest health needs
- Drive up the quality of care in order to improve health outcomes and reduce unwarranted clinical variation
- Direct available resources to where they will deliver the greatest benefit to the local population
- Commission appropriate models of care for older and vulnerable people with complex needs, ensuring all patients are treated with dignity and respect
- Secure improved chances of a healthy life by targeting our prevention approach for children and young people
- Ensure that patients are able to make choices about the care they receive and are seen in the right place at the right time by the right person.

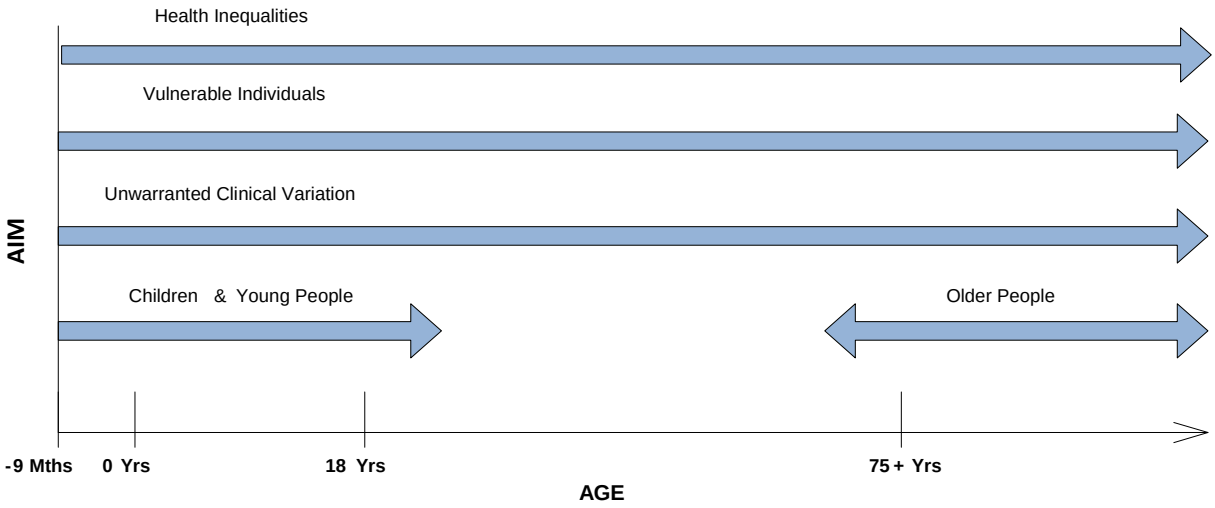


Figure 1: Aims relative to the population demographic

3.3 Unwarranted clinical variation

NNE CCG is committed to addressing unwarranted clinical variation between GP practices, but even though benchmarking of practice performance across key activity domains such as urgent care, planned care, prescribing, and immunisations has been undertaken, reducing unwarranted clinical variation remains an on-going challenge.

Our work in reducing unwarranted variation focuses on all patient groups including:

- Mothers and newborns
- People with need for support with mental health
- People with learning disabilities
- People who need emergency and urgent care
- People who need routine operations
- People with long term conditions
- People at the end of life

- People with continuing healthcare needs.

As such the CCG will continue to target this area of work supporting practices to further reduce unwarranted variation by adherence to agreed protocols and care pathways. During 2012/13-2013/14 practices will continue to be supported in the implementation locally of the Right Care programme, outlining clinical thresholds for a range of key procedures. Work has commenced with the NHS 'Right Care' team to establish how unwarranted variations in care between constituent GP practices can be reduced. This will be supported by using the 'Atlas of Variation' and drilling down to CCG level data to map spend on healthcare against patient outcomes to aid local decision making, with the aim of ensuring that best value can be achieved within the available resources.

Practice level activity targets will be established to address unwarranted clinical variation and also to support delivery of NNE CCG's QIPP target.

3.4 Commissioning Framework

Following consideration of JSNA information (including disease prevalence, age groups, care pathways and existing programmes of work), NNE CCG defined eight broad clinical groupings and six enabling strategy areas to use as the framework for the CCG's commissioning approach. The clinical groupings have been termed 'strategic building blocks' and the enabling strategies as 'enabling building blocks'; each has an identified clinical Champion who is either a GP or another clinician from a CCG member practice. The strategic building blocks provide clinical focus and leadership, whilst the enabling building blocks underpin our commissioning processes to achieve high quality responsive services.

Strategic Building Blocks
Long Term Conditions (including Cancer and End of Life Care)
Planned Care
Unplanned, Urgent & Emergency Care
Mental Health & Learning Disabilities
Health & Wellbeing for All (including Tobacco & Obesity)
Children, Young People & Maternity
Effective Medicines Management
Older People, Community Care & Re-ablement
Enabling Building Blocks
Primary Care & Practices
Patient & Public Engagement /Partnership Working
Equality & Diversity
Information Management
Education, Workforce & Research
Safeguarding & Clinical Governance

Table 3: Strategic and Enabling Building Blocks

3.5 Our Strategic Priorities for 2012/13

NNE CCG identified strategic priorities by considering how to deliver its aims, relative to each strategic building block. The targeted methodology also applied health needs and how to maximise health outcomes within the resources available (see Figure 2).

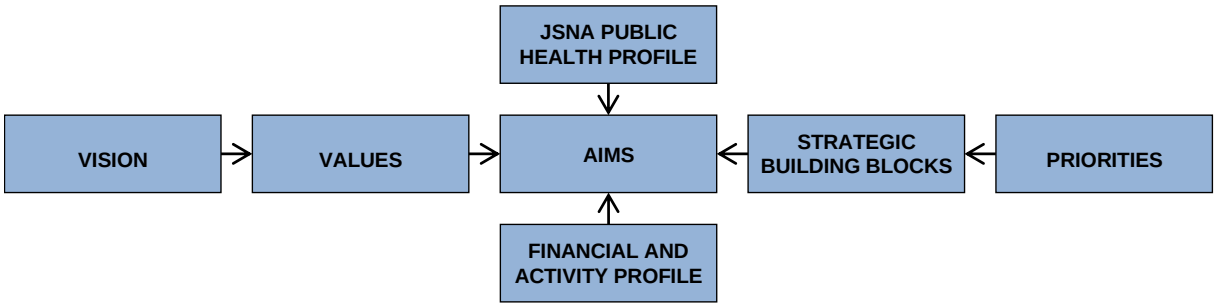


Figure 2: Commissioning Framework Methodology

The CCG's strategic priorities, relevant to its aims, are described in individual plans in the following section of this document, with each including the following elements:

- Why is change needed?
- Aims and objectives
- What are we doing about it?
- What key performance indicators will we use to monitor progress?
- Implications, risks and mitigating factors.

Strategic management and coordination of the building blocks is undertaken by the CCG's Service Improvement Group which is accountable to the Governing Body. This group is also responsible for identifying opportunities for service improvement and providing support to the Clinical Cabinet in respect of determining future commissioning priorities. In addition the group is responsible for developing, monitoring, reviewing and updating of the CCG's QIPP plan, including setting QIPP targets for each clinical building block, and ensuring building block priorities and plans reflect QIPP principles.

It is recognized that these plans represent only a 'snap-shot' in time and will continue to need to be reviewed and updated regularly in line with emerging national and local policy and priorities, progress against targets, and effectiveness.

Building Block	**Long Term Conditions (including cancer & end of life)**
Champion	**Dr James Hopkinson**
Financial Year	**2012-13**

Why is change needed?

There is the opportunity for CCGs to work together to enhance EOL services. Unplanned EOL care can often result in unnecessary and expensive trips to A&E with crisis admissions to hospital. Failure to co-ordinate care can is distressing for individuals and can have a detrimental effect on the bereaved. NHS Nottinghamshire County surveys found that patients and patient groups identified choice of preferred place of death as a priority.

Aim

To commission appropriate models of care for older and vulnerable people with complex needs to ensure the quality of care to improve health outcomes and reduce unwarranted clinical variation.

Objectives

- To improve the experience of end of life care by patient and carers through improved co-ordination of services for patients and carers
- To ensure greater choice in place of death, in particular an increase in the proportion of deaths that occur at home
- To decrease the number of emergency admissions within last year of life

What are we doing about it?

HOW	WHEN						IN YEAR	
	Q1	Q2	Q3	Q4	13/14		INVEST	NET SAVINGS
Pilot a Cardio-Respiratory Palliative Care Nurse							£70,000	
Continue to train practices on the end of life pathway and the importance of timely identification on palliative care register								
Continue to work with CCGs and partners of the Nottinghamshire EOL strategic plan to meet pathway gaps (locality registered and coordinated centre, rapid response, care support)								
To commission a Palliative Care Coordination Electronic System								
To support the public health compassionate communities approach for palliative care (facilitating the conversation about end of life)								

What Key Performance Indicators will we use to monitor the progress?

- Number of patients registered on palliative care register as a proportion of all deaths
- Proportion of patients who die in their preferred place
- Proportion of patients on an End of Life register who don't have cancer

Relevant NHS Outcome Framework indicators

- 4.6 Improving the experience of care for people at the end of their lives

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Lack of engagement by Practices	Template in development available for SystmOne to record information required
Patient information not updated on the system meaning that services use out of date patient information	
That there is a risk to patient confidentiality	Development of new system to record patient data. Learning from system in the North of the County

Communications and Engagement Implications

- The compassionate communities' model will support the engagement with carers and families to raise the issue of death and dying.

Building Block	**Long Term Conditions - COPD**
Champion	**Dr James Hopkinson/Dr David Hannah**
Financial Year	**2012-13**

Why is change needed?

The prevention, early identification and recognition of COPD symptoms, with good quality early diagnosis, high quality care following diagnosis and access to end of life care services supports a 25%- 30% reduction in unplanned admissions following full implementation of the pathway.

Aim

To drive up the quality of care in order to improve health outcomes and reduce unwarranted clinical variation

Objectives

- **To improve diagnosis of COPD**
- **To contribute a reduction in the number of patient s and /or carers with depression and/or anxiety disorder**
- **To improve the self- management and independence of patients with COPD**
- **To reduce disabling breathlessness for individual patients and improve quality of life**
- **To improve the quality of life for carers**
- **To improve safety for patients receiving oxygen therapy in the home**

What are we doing about it?

HOW	WHEN						IN YEAR	
	Q1	Q2	Q3	Q4	13/14		INVEST	NET SAVINGS
Review of Community Specialist COPD services including pulmonary rehabilitation								
Encourage COPD patients to stop smoking								
Develop a COPD Clinical Nurse Lead role for the CCG							£5,000	
Training • Provide provision for a designated spirometry nurse in all practices • Provide training and education on the accuracy of COPD diagnosis for GP practices								
Maintain the impetus of the POINTS audit programme across all practices								
Increase the number of COPD patients who have a self – management plan								
Implement a comprehensive oxygen assessment and review service							£48,000	
Increase the use of Telehealth in managing long-term conditions								

What Key Performance Indicators will we use to monitor the progress?

- **Number of patient referred to the community COPD services**
- **Number of hospital COPD admissions**
- **Proportion of COPD population recorded**
- **Number of exacerbations recorded**
- **FEV1 % recorded**
- **Oxygen prescribing usage**
- **Number of staff attending and completing training**

Relevant NHS Outcome Framework indicators

- **2. Health-related quality of life for people with long term conditions**
- **2.1 Proportion of people feeling supported to manage their condition at home**

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Admissions continue to rise for patients with COPD	Work with identified practices where admissions are highest. Share good practice between practices
Smoking prevalence rises	Ensure stop smoking services are accessible for the COPD population
Oxygen prescriptions rise	Development of an oxygen register and review system for HOOFs

Communications and Engagement Implications

- **A patient opinion survey will be undertaken to gain patient views on the COPD services. This will be used to inform the development of future COPD care.**

Building Block	**Long Term Conditions - Diabetes**
Champion	**Dr Paramjit Panesar/Dr James Hopkinson**
Financial Year	**2012-13**

Why is change needed?

One third of annual deaths of people with Diabetes are classed as preventable. Improved chronic and planned management of diabetes could reduce mortality rates. Diabetes is a major improvable risk factor for coronary disease and myocardial infarction. There is a rising prevalence of undiagnosed diabetes. The direct costs of type 2 Diabetes are estimated to be around 7–12% of total NHS expenditure. Education is central to support management of the disease including necessary lifestyle changes and side effects.

Aim

Drive up the quality of care in order to improve health outcomes and reduce unwarranted clinical variation

Objectives

- To improve quality of life for patients with diabetes and their carers (including confidence through education)
- To reduce the incidence of other medical conditions that are directly attributable to poor self-management in individual patient
- To improve patient outcomes in the treatment area of cardio-metabolic disease
- To increase life expectancy of patients with diabetes
- To enable patients to make positive behaviour choices
- To increase the number of patients managed in the community

What are we doing about it?

HOW	WHEN						IN YEAR	
	Q1	Q2	Q3	Q4	13/14		INVEST	NET SAVINGS
Reduce First to Follow Up consultations 171 Type 2 diabetes patients to be discharged from secondary care with a clear outline of referral guidelines for new patients going into secondary care.								£308,000
Reduce First to Follow Up consultations. Scope the discharge of type 1 from secondary care with a clear outline of referral guidelines for new patients going into secondary care								
Through a reassessment of diabetes pathways and treatment targets to ensure that NNE follows the latest NICE guidance and quality standards								
Review the role of Diabetes Specialist Nurse								
Provide training and development to up skilling practise relating to prevention and care of patients with diabetes. • Support from specialist diabetes nurse • Provision of specialist training courses • PLT sessions								
Targeting self-care resources appropriately to local populations, including working with patients and carers on knowledge levels and confidence								
Implement the Evidence into Practice programme for patients with type 2 diabetes							£72,000	£79,000
To scope the use of tele-health in managing long-term conditions:								

What Key Performance Indicators will we use to monitor the progress?

- **Number of first to follow up consultations**
- **Proportion of patients managed in the community**
- **Number of practices undertaking the Evidence into Practice programme**
- **Number of practitioners attending training and/or achieving qualifications**

Relevant NHS Outcome Framework indicators

- **Reducing mortality from the major causes of death (1.1)**
- **Reducing time spent in hospitably people with long-term conditions**

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Type 2 patients cannot be managed in the community	Work with Practices to identify the support needed to enable patients to be managed in primary care
Practitioners do not come forward to access the training and development	Consider the provision of backfill to release time to train
Financial savings identified are not fully realised	Project lead to identify progress from quarter1
Practices are not engaged	Clinical champions to champion work

Communications and Engagement Implications

- **Liaison will take place with Type 1 and 2 patients identified for primary care management from secondary care.**

Building Block	**Planned Care**
Champion	**Dr Paramjit Panesar/Dr James Hopkinson**
Financial Year	**2012-13**

Why is change needed?

- View that patient treatment delivered and place of delivery is not optimum in terms of patient outcomes and experience
- Financial constraints

Aim

- Improved Patient experience, treatment & outcomes (right place first time)
- Financial savings achieved by not paying for unnecessary secondary care interventions
- Reduce unwarranted variation

Objectives

- Reduce referrals for first outpatient attendances in Secondary Care
- Reduce follow up outpatient attendances in secondary care
- Reduce procedures undertaken in secondary & primary care especially those of Limited Clinical Value
- Reduce Direct Access referrals to secondary care for Pathology & Radiology
- Increase service provision in the community by Opticians

What are we doing about it?

HOW	WHEN						IN YEAR	
	Q1	Q2	Q3	Q4	13/14		INVEST	NET SAVINGS
Reduce referrals and spend against Procedures of Limited Clinical Value & Cosmetic procedures including:- • Review of Pain Management Pathway	■	■	■	■	■			£162,000
Reduce First to Follow Up consultations	■	■	■	■	■			£308,000
Practice review of service utilisation with a focus on reducing variation, using alternatives to referral, peer review of practice, use of advice & guidance, expending CAS usage	■	■	■	■	■			£405,000
Community Ophthalmology services • Implement ophthalmology CAS • Development of the Triage and Treatment Service that will enhance Community provision across NNE and reduce referrals into secondary care • Referral Refinement scheme to include more local community providers			■	■	■			£37,000
Implement orthopaedic ICATS system					■			£39,000
Practice review of direct access pathology & imaging utilisation via ICE and introducing referral protocols		■	■	■	■			£90,000
Review clinical setting and seek to have patients treated in most appropriate setting within secondary care	■	■	■	■	■			£287,000
Review orthopaedic rehab pathway and price at NUHT					■			£0
Early Social Services assessments – Hip & Knee patients								£0

What Key Performance Indicators will we use to monitor the progress?

- **Metrics of:**
  - **Referral rates**
  - **Referrals**
  - **Expenditure – absolute**
  - **Expenditure – rates**

  For the following – Outpatient First Attendances/ Follow Up Attendances/ Procedures/ Pathology & Radiology
- **Increased attendance at community opticians and increase of providers across NNE.**

Relevant NHS Outcome Framework indicators

- **Improving outcomes from planned procedures (3.1)**
- **Improving recovery from injury and trauma**

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Lack of resources / personnel to lead each project	Planned Care Building Block team & access to TF funding
Lack of clinical GP engagement to lead each project	As above plus Champion identified
Financial target not realistic	Project lead to evaluate during Q1
Lack of engagement by practices	Clinical champion/lead identified for each project
Referrals are not reduced	Board Performance Management process / information

Communications and Engagement Implications

- **Patient and public engagement on pathway development and changes**

Building Block	**Unplanned Care**
Champion	**Dr Tony Marsh**
Financial Year	**2012-13**

Why is change needed?

40% of referrals by the Emergency Services to the Emergency Department are not admitted to hospitals. 30% of patients seen by ambulance crews are not conveyed to hospital. 10% of ED attendances are from patients aged 0-4 years.

Aim

To educate the general public on appropriate use of services to reduce both the number of high volume service users and 1-4 years attending ED.

To reduce unplanned admissions to ED and improve non-conveyance rates.

Objectives

- To reduce unplanned admissions to ED
- To roll out the Doctor First and alternative scheme across the NNE in order to reduce conveyance to ED by EMAS crews
- To increase the number of EMAS patients who receive 'hear and treat' through the development of a clinical hub and introduction of DoS
- To reduce the number of high volume service users who require attendance at ED through the development of multi-agency care

What are we doing about it?

HOW	WHEN						IN YEAR	
	Q1	Q2	Q3	Q4	13/14		INVEST	NET SAVINGS
Community Pathways - • Community Wards • Injury Minimisation programme	■	■	■	■	■			
• Assessment prior to discharge								
Primary Care – • Reduce practice variation • Report and monitor frequent attenders into ED to practices and associated community teams • Monitor emergency admissions and review appropriateness with practices through peer review • Share good practice • Information provided to clinicians to consider alternative services	■	■	■	■	■			
• Education with clinicians			■	■	■			
Community Wide- • Management of patient expectations, Publicise Right Care, Right Place, First Time	■	■	■	■	■			

• In partnership with EMAS
  • Number of patients who receive 'hear and treat' (20%) or 'refer and treat' (30%)
  • Reduce number of high volume service users attending ED
  • Increase non-conveyance rate
			■	■	■			

• In partnership with children's services identity the appropriate need of support for children and their families				■	■			
• Development of services – OOH, 111 and Primary care at the front door of ED					■			

What Key Performance Indicators will we use to monitor the progress?

Metrics of:

- **Attendance rates at ED**
- **Admissions rates**
- **Expenditure – absolute**
- **Hear and treat**
- **Refer and treat**
- **Non- conveyance rates improvement**
- **Practice data (access, opening, services available etc)**

Relevant NHS Outcome Framework indicators

Relevant NHS Outcome Framework indicators:

- **Improving patient experience of accident and emergency services**
- **Improving access to Primary Care Services**
- **Preventing lower respiratory tract infections (LRTI) in children from becoming serious**

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Lack of resources / personnel to lead each project	Unplanned Building Block team & access to TF funding
Lack of clinical GP engagement to lead each project	As above plus Champion identified
Financial target not realistic	Project lead to evaluate during Q2
Lack of engagement by practices	Clinical champion/lead identified for each project
Attendances are not reduced	Board Performance Management process / information
Patients continue not to use alternative community services	Awareness through campaigns, media, PPGs, Partners (LA), Educations etc

Communications and Engagement Implications

- **Roll out the *Choose Well* campaign across NNE in collaboration with partner organisations**

Building Block	**Mental Health and Learning Disabilities**
Champion	**Dr Paul Oliver**
Financial Year	**2012-13**

Why is change needed?

- Ageing population will increase the numbers of people with dementia significantly
- Variable access to adult and children's mental health services
- There is unwarranted clinical variation in this clinical area
- Care for older and vulnerable people with complex needs in particular around dementia can be difficult to access

Aim

- Drive up the quality of care in order to improve health outcomes and reduce unwarranted clinical variation
- Commission appropriate models of care for older and vulnerable people with complex needs, ensuring all patients are treated with dignity and respect
- Secure improved chances of a healthy life by targeting our prevention programmes for children and young people

Objectives

- To improve physical health through the management of depression
- To enhance quality of life for patients and carers
- To improve support for carers
- To support people with mental health problems and learning difficulties to remain independent
- To improve diagnosis rates of people with dementia
- To improve knowledge and skills in primary care
- To develop proactive care and reduce crises
- Ensure service provision is appropriate and meets the diverse needs of NNE residents

What are we doing about it?

HOW	WHEN						IN YEAR	
	Q1	Q2	Q3	Q4	13/14		INVEST	NET SAVINGS
ADULT • Implement Mental Health Intermediate Care Services and ensure integration with mainstream primary and community health and social care			■	■	■		£350,00	
• Implement the new Memory Assessment Service including training and support to primary care and awareness raising to increase diagnosis			■	■	■		£60,000	
• Offer an alternative approach to treating common mental health problems by via the Books on Prescription Scheme	■	■	■	■	■			
• Utilise dementia CQUIN to improve dementia training in acute and community providers	■	■	■	■	■			
• Delivery of an NNE carers strategy			■	■	■			
• Delivery of AQP for IAPT services and GP training to support appropriate referrals			■	■	■			
• Improve clinical decision making for patients with mental health problems and learning disabilities through the Six Hats Thinking Training		■	■	■			£10,500	
• Review current community services and tools available to practices, distinguishing between appropriate support for social problems and a diagnosis of depression		■	■	■				
• Strategies for mental health of offenders and military veterans			■	■				
• Develop awareness campaigns to help early diagnosis of dementia		■	■	■				
• Investigate the opportunity to develop a local mental health intermediate care team		■	■	■				
• Support training sessions to build confidence with healthcare providers when dealing with patients who have learning difficulties		■	■	■				

What are we doing about it? (continued)

HOW	WHEN						IN YEAR	
	Q1	Q2	Q3	Q4	13/14		INVEST	NET SAVINGS
CHILDREN • **Work with partners to support the Nottinghamshire County CAMHS Strategy and influence the development of CAMHS through attendance at the Nottinghamshire CAMHS joint commissioning group**								
• **To support development of transitional plans for young people moving from CAMHS to adult mental health services**								
• **Improve self-esteem of children and young people through redevelopment of the Positive Moves programme**								
• **Support TaMHS early intervention to improve emotional health and wellbeing in school settings**								
• **Review service provision for young people with neurological issues**								
• **Target the 'out of area' use of beds for eating disorders and look at our home provision for these services.**								

What Key Performance Indicators will we use to monitor the progress?

- **The proportion of people under adult mental illness specialties on the Care Programme Approach (CPA) who were followed up within seven days of discharge from psychiatric inpatient care**

Relevant NHS Outcome Framework indicators

- **1.5 Reduce premature death in people with serious mental illness**
- **1.7 Reduce premature deaths in people with learning disabilities**
- **2.5 enhance quality of life for people with mental illness**
- **2.4 enhance quality of life for carers**
- **4.7 Improve experience of healthcare for people with mental illness**

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Mental health admissions continue to rise	Regular monitoring of admissions
Services are not integrated with mainstream provision	Linking MHIC implementation into the integrated health and social care pilot
GP practices have insufficient skills and time to support these patient groups	Primary care training and support built into implementation programmes
Open referrals for IAPT through AQP poses significant financial risk	Initial launch will be GP referral only/. Monitoring of referrals and GP training to support referral management
Tight timescales for IAPT AQP implementation will not be achieved	
Lack of engagement by practices	Clinical champion/lead identified for each project

Communications and Engagement Implications

- **Consult with public and patients to provide reviews on the service we provide**
- **Engage with practices to ensure awareness of service provision and referral pathway**
- **Engage with service providers and partner agencies to review services to ensure they meet the needs of the NNE population**
- **Enhance communication between health care providers and patients with learning difficulties**

Building Block	**Health & Wellbeing**
Champion	**Dr Sylvester Nyatsuro**
Financial Year	**2012-13**

Why is change needed?

Smoking is the leading cause of preventable illnesses and deaths, Nottinghamshire smoking prevalence rate is 22%, this is higher than the national average; Ashfield has a smoking prevalence of 32% almost equalling England's worst rate of 33.5%. 17.3% smoke during pregnancy and prevalence is increasing amongst children and young people.

Obesity is linked to increased risk of heart disease, diabetes, some cancers and reduces life expectancy by an average of 9 years. One in four adults is estimated to be obese and rates continue to rise in children. In Nottingham North and East more than 24.8% of children are not within a healthy weight range with deprived areas having the highest levels.

Aim

Drive up quality of care in order to improve health outcomes and reduce unwarranted variations in services

Objectives

- To support an integrated community approach to reduce premature deaths and disabilities linked to obesity
- To reduce the number of people who smoke and are exposed to second hand smoke
- To reduce the number of people who smoke during pregnancy
- To increase life expectancy and quality of life
- To promote positive behaviour change
- Ensure all resources address the diverse needs of NNE residents

What are we doing about it?

HOW	WHEN					IN YEAR	
	Q1	Q2	Q3	Q4	13/14	INVEST	NET SAVINGS
Develop a Health Partnership across Local Authorities and Public Health to have a coordinated cohesive approach to address shared health priorities within NNE							
Smoking • Work with all partners to support and promote stop smoking services with a full range of locations and target audiences							
• Develop a resource pack to support services to reduce the number people who smokers during pregnancy							
• Link actions around smoking cessation to specific disease group , in particular COPD, diabetes and Cardio- Vascular Disease							
• Work with partners, patient groups and the Schools Sports Partnership to develop appropriate messages and resources to prevent young people becoming smokers – align messages and actions to General Practice							
• Explore possibility of smoking cessation training for secondary school and leisure centre employees							
Obesity • Work with partners to reviewing and expand on existing pathways and learning materials available							
• Directly targeting unhealthy diets and physical inactivity in adults and children							
• Work with patient groups and partners to review and where appropriate expand physical activity provision across NNE							
• Support and promote Local Authority Physical Activity action plans							

What Key Performance Indicators will we use to monitor the progress?

- **Smoking status at time of delivery**
- **Smoking prevalence rate adult (over 18's)**
- **Smoking prevalence (15's)**
- **Smoking quitters at 4 weeks**
- **Number of smoking cessation training sessions delivered**
- **Mortality from cancer and CVD**
- **Prevalence of obesity at aged 4-5 and 10-11**
- **Estimated prevalence of adult obesity**
- **Proportion of patients who are active at 12 months from the Positive Moves Exercise referral scheme and Active Ashfield**
- **Proportion of families accessing nutrition programmes**

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Lack of resources / personnel to lead each project	Building Block team & access to TF funding
Lack of clinical GP engagement to lead each project	As above plus Champion identified
Financial target not realistic	Project lead to evaluate during Q1
Lack of engagement by practices	Clinical champion/lead identified for each project

Communications and Engagement Implications

- **It is recognised that different localities across NNE have various health needs and priorities. Therefore, in collaboration with partner organisations the District Health Partnership will develop a shared communication strategy to support the delivery of this building block, ensuring that patients and partners are aware of service provision, pathways and activities in each locality. The strategy will be discussed and reviewed at the District groups quarterly meetings**

Building Block	**Children & Young People**
Champion	**Dr David Hannah**
Financial Year	**2012-13**

Why is change needed?

Investment in children's and young people's health improves long term outcomes, is cost effective, reduces pressure on health services and improves quality of life.

Aim

Reducing unwarranted variation in services, drive up quality care and improve health outcomes by targeting prevention programmes for children and young people.

Objectives

- To reduce childhood diseases by improving the uptake of immunisations and vaccinations in children aged 1-5
- To improve health and wellbeing
- To improve the support and co-ordination/integration of community care that families receive
- To reduce health, social and educational problems in later life
- To improve support for families
- To increase health benefits for mother and baby through the uptake and continuation of breastfeeding

What are we doing about it?

HOW	WHEN					IN YEAR	
	Q1	Q2	Q3	Q4	13/14	INVEST	NET SAVINGS
Immunisations and Vaccinations • Provide additional resource non-recurrently to increase capacity to the public • health immunisations and vaccinations team to engage with GP Practices to promote the uptake of immunisations and vaccinations • This additional capacity will enable a second Practice visit to Practices where uptake is rag rated as red • The aim is to move red rag rated Practices to Amber and Amber rag rated practices to Green by April 2013 (as evidenced by quarter 4 reporting in May 2013			■	■		£5,000	
Improved co-ordination with community teams • Meet with local health visitors by locality to improve integration within the early years system including engagement with Children's Centre's and day care provision • Meet with local midwifery teams by locality to improve integration between the locality team and the GP practice		■	■				
Breastfeeding • To develop a breastfeeding peer support programme and social marketing plan			■	■			

Service Specification development and implementation
• Contribute to the development and implementation of service specifications:
  • General Community Paediatric Service Specification
• Deliver the healthy child programme
  • Healthy Child Programme - 0-5 HV core offer
  • Healthy Child Programme - 0-19 SN core offer
		■	■	■			

Specialist Children's Services • Scope the integration of Specialist Children's Nursing Services		■	■	■	■	£70,000	
• To work in partnership with local partners to implement the troubled families agenda			■	■	■		
• To implement the Family Nurse Partnership initiative				■	■	£100,000	

What Key Performance Indicators will we use to monitor the progress?

- **Percentage of immunisations complete for routine vaccinations at 2 years**
- **Percentage of infants who are totally or partially breastfeeding at 6-8 weeks**
- **Rate of accident and emergency attendance per 1000 population aged under 5 years**
- **Teenage pregnancy rate**
- **Percentage of children living in poverty (Local Authority measure)**

Relevant NHS Outcome Framework indicators

- **Reducing deaths in babies and young children**
- **Improving women and their families' experience of maternity services**

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
No increase in uptake for imms and vacs	Work with identified practises to encourage uptake and share good practice
Teenage pregnancy continues to rise	Sexual health, education information and advice and or teenagers are included in the FNP and troubled families workstreams
Community services fail to engage effectively with GP practices	On-going development of relationships between local practitioners to continue
Breast feeding rates don't increase	Revisit action plan regularly of FNP

Communications and Engagement Implications

- **Engagement of children and families will be a key part of the implementation and success of projects specifically trouble families and FNP**

Building Block	**Medicines Management**
Champion	**Adrian Kennedy**
Financial Year	**2012-13**

Why is change needed?

- Unintended errors in the prescription, administration and reconciliation of high risk medicines account for a significant proportion of harm caused to patients
- Medicines-related harm results in otherwise avoidable admissions to hospital
- Failed concordance wastes resources, including medicines
- Access to medicines is sometimes compromised, particularly at the extremes of age

Aim

- Drive up the quality of care in order to improve health outcomes and reduce unwarranted clinical variation
- Commission appropriate models of care for older and vulnerable people with complex needs, ensuring all patients are treated with dignity and respect
- Secure improved chances of a healthy life by targeting our prevention programmes for children and young people

Objectives

- Reduce medicines-related harm
- Reduce avoidable admissions to hospital
- Improve medicines reconciliation/transfer of care
- Reduce wastage
- Standardise therapeutic drug monitoring
- Reduce inequalities resulting from poor or impaired access to medicines for children and young people as well as older people.

What are we doing about it?

HOW	WHEN						IN YEAR	
	Q1	Q2	Q3	Q4	13/14		INVEST	NET SAVINGS
• Establish medicines management protocols for high risk medicines	■	■	■	■				
• Recommend review of all repeat NSAID prescriptions (ref; PINCER)			■	■	■			
• Review all patients with dementia for use of antipsychotics		■	■	■				
• Ensure adherence to local best practice guidelines	■	■	■	■	■			
• Support delivery of medicines review by primary care professionals i.e. in residential care	■	■	■	■	■			
• Support the introduction of medicines management facilitators, MMF, in practices	■	■	■	■	■			
• Promote policies to reduce drug wastage	■	■	■	■	■			
• Ensure Pharmacy First is available across NNE, particularly during out of hours	■	■	■	■				
• Implement the Community Stoma Nurse Service across NNE	■	■						
• Work with neighbouring CCGs and 'Hub' to ensure local decision-making, w.r.t. medicines, is fit for purpose	■	■	■	■	■			

What Key Performance Indicators will we use to monitor the progress?

- Audit the coding of medicines related harm/admissions in all sectors
- Audit the use of 'Top 5' high risk medicines and related harm
- Monitor the utility of targeted MURs in key areas
- Evidence of collaboration between 10 care clinicians e.g. in 'New medicines Service' NMS
- Monitor impact of stoma nurse service
- Prescribing cost growth and cost/ASTROPU

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Lack of resources / personnel to lead each project	Medicine Management Building Block team & access to TF funding/FURs
Lack of clinician engagement to lead each project	As above plus Champion identified
	In-practice support from team plus Practice MMFs
	Monitoring and feedback to stakeholders – formally and informally

Communications and Engagement Implications

- **Specify the highest risk therapies and provide guidance on risk management**
- **Continue to engage with GP practices and other stakeholders**

Building Block	**Older People**
Champion	**Sheila Price**
Financial Year	**2012-13**

Why is change needed?

Investing, redesigning of services for an aging population will promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living.

Aim

Commission appropriate models of care for older and vulnerable people with complex needs, ensuring all patients are treated with dignity and respect

Objectives

- **To understand how older people use existing services in NNE**
- **To combine patient care by working in partnership**
- **To support older people to remain in their own homes**
- **To evaluate alternative models of community care**
- **To improve access to appropriate Health Services for patients in care homes**
- **To improve the health of the frail and elderly population**

What are we doing about it?

HOW	WHEN					IN YEAR	
	Q1	Q2	Q3	Q4	13/14	INVEST	NET SAVINGS
Community Setting • **Implement the Integrated Health and Social Care model in partnership with Nottingham County Council, Nottingham University Hospitals NHS Trust and the Voluntary sector**						**£569,757**	**£270,509-£1,746,624**
• **Commission a Crisis Intervention Community Support Service**						**£155,000**	
• **Implement the Enhanced Community Support Service (as an alternative to Lings Bar Hospital)**						**£50,000**	
• **Roll out the community geriatrician programme**							
• **Scope for a fracture liaison service aimed at identifying patients aged 50 years and over who present with a fragility fracture and who may have osteoporosis, and require treatment**						**£100,000**	
One Care Home One Practice Pilot Programme • **Implement the Nottingham North and East Primary Care Service specification to improve the quality of healthcare in care homes and avoidance of unnecessary hospital admission** • **Programme roll out**						**£15,978** **£255,000**	 **£26,000**
Frail Elderly • **Work in collaboration with Productive Nott's Frail Elderly project.** • **Frail and elderly people** • **Integrated care transfer** • **Integrated unplanned care** • **Accessing information** • **Assisted technology**							

What Key Performance Indicators will we use to monitor the progress?

Community Setting

- **Evaluation for the Enhanced Community Support programme will be supported by collaboration of Leadership in Applied Health Research (CLAHRC) in Nottinghamshire**
- **Reduction in the number of unplanned admissions with in the over 65**
- **Increased number of patients remaining at home**
- **Total number of visits received by patient**
- **Improved patient experience with access to the right services at the right time**
- **Reduction of outpatient referrals into secondary care**
- **One Care Home One Practice Pilot Programme**
- **Reduced emergency activity from care homes**
- **Qualitative performance**

All patients have a positive experience of Care by ensuring that NICE quality guidelines for Patient Experience are incorporated into all Action plans

Relevant NHS Outcome Framework indicators

- **2.1 Ensuring people feel supported to manage their condition**
- **Improving recovery from fragility fractures**
- **Helping older people to recover their independence after illness or injury (3.6 & 3.6.ii)**

Implications, Risks and Mitigating Actions

Risks	Mitigating Actions
Financial benefits not easily identified	Clear evaluation and data sets will be agreed
Financial benefits are not as high as planned	Scenarios developed as part of financial modelling to show best and worst cases
Apportionment of savings between provider and commissioner are disputed	Joint principles will be agreed between provider and commissioner
Admissions continue to rise	Admissions to be monitored on a monthly basis. Pilots will be flexible to changing demands
Service providers may not deliver proposed services	Pilot programmes will test the model

Communications and Engagement Implications

- **Advocacy has been established to support patient GP choice in the Care Homes project**
- **A communication and engagement group has been established to support the integrated health and social care model**

4 Our Financial Plans

4.1 Our Financial Strategy and Assumptions

This Commissioning Strategy is underpinned by a financial plan that aims to maximise the rate of return for money invested whilst ensuring financial viability and resilience as an individual organisation.

Due to NNE CCG's close working relationship with NHS Nottinghamshire Cluster PCT and the sustained good financial performance seen across the PCT and the 5 successor CCGs, there will be no legacy debt at the end of 2012/13 when the PCT is abolished.

However the national economy continues to experience significant financial pressures which are having long term implications for funding across the public sector services. This presents a difficult planning environment for NNE CCG to operate in. In addition the 2012/13 budgets have been set by the PCT's Professional Executive Committee based on historical spend with a 20% movement to the estimated "target share" of the CCGs' total share of the PCT budget, as we await confirmation as to the resource allocation for CCGs. For NNE CCG this is a target share of 21.66% (crude population 21.55%) and this uncertainty remains the biggest risk to the CCG's financial plan.

In line with the PCT's Financial Plan, other assumptions in the CCG's financial plan are as follows:

- **Allocation Growth** – the CCG is assuming 0% real growth for the 2 years 2013/14 and 2014/15
- **Surplus** – the CCG is planning to deliver 0.3% of it Recurrent Revenue Limit (RRL) in 2013/14 and 2014/15
- **Transformational Funds** – the CCG is planning to make available 2% of the RRL available from recurrent resources but to be allocated on a non-recurrent basis to support the significant changes which will be undertaken within the health community to deliver the health service transformation required
- **Contingency Reserve** – the CCG has included 0.5% of its RRL as a recurrent contingency reserve within the financial plan for each financial year to mitigate against risk
- **Uplift assumptions** – the following base case inflation planning assumptions are included which are consistent with the current operating framework, national tariff arrangements and local health economy agreements.

Uplift Assumptions	2013/14	2014/15
Service Level Agreements (SLAs) Net of CIP	(1.80%)	(1.80%)
CQUIN	0.00%	0.00%
Prescribing (Gross before QIPP)	5.00%	5.00%
PCT HQ Budgets (Gross before QIPP)	2.20%	2.20%
Pay Award Inflation	0.00%	0.00%

Table 4: Uplift assumptions

The assumption around zero growth is based upon the NHS Nottinghamshire County PCT's Financial Plan. In 2012/13 PCTs did receive minimum growth to meet Operating Framework commitments, which could be the position for 2013/14, but the expectation would be that if low level growth was received, it would come with additional commitments in the 2013/14 Operating Framework.

For NNE CCG, the recurrent financial budget for 2012/13 and the baseline financial plans for the two years 2013/14 to 2014/15 is as follows:

NNE CCG £ms	2012/13 Recurrent Budget	2013/14 Plan	2014/15 Plan
Enhanced Services	1.2	1.2	1.2
Healthcare Contracts	125.0	128.8	130.6
Corporate & Administration	5.4	5.8	5.9
Prescribing	22.9	24.0	25.2
Other Reserves inc. Transformation	10.3	10.2	10.2
Contingency Reserve	0.8	0.8	0.8
Planned Surplus	0.5	0.5	0.5
QIPP Challenge 2013/14	0.0	-3.3	-3.3
QIPP Challenge 2014/15	0.0	0.0	-3.1
Total	**166.1**	**168.0**	**168.0**

Table 5: Recurrent budget 2012/13 (net of the QIPP target); Baseline financial plans 2013/14, 2014/15

4.2 Strategy under different Financial Scenarios

The baseline financial plans for the two years 2013/14 to 2014/15 are based on planning assumptions which are consistent with the current operating framework, national tariff arrangements and local health economy agreements, and in line with the Nottinghamshire County PCT's Financial Plans assumptions.

The CCG has worked through two further financial planning scenarios in terms of possible worst case and best case financial environments. This includes changes to the assumptions around PBR and Prescribing uplifts, allocation growth and QIPP targets, and could see the QIPP challenge in 13/14 range between £2.9m (1.7%) and £5.5m (3.3%) and in 14/15 range between £2.6m (1.6%) and £5.3m (3.2%).

The best case scenario would allow the CCG to invest more in health improvement areas, which would increase the pace of implementation and enable our vision to be delivered more quickly.

The worst case scenario would require a review of all investments, including invest to save schemes, and would ultimately require disinvestment/activity reductions in further areas.

We will continue to develop the financial scenarios to enable us to manage any changes from the announcement of CCG allocations and the publication of the 2013/14 Operating Framework. This will also enable us to use our processes to maximise health gain for any given available resource, and to understand the challenge of our QIPP plans. The diagram below shows how we will manage any changes to our base case financial plans:

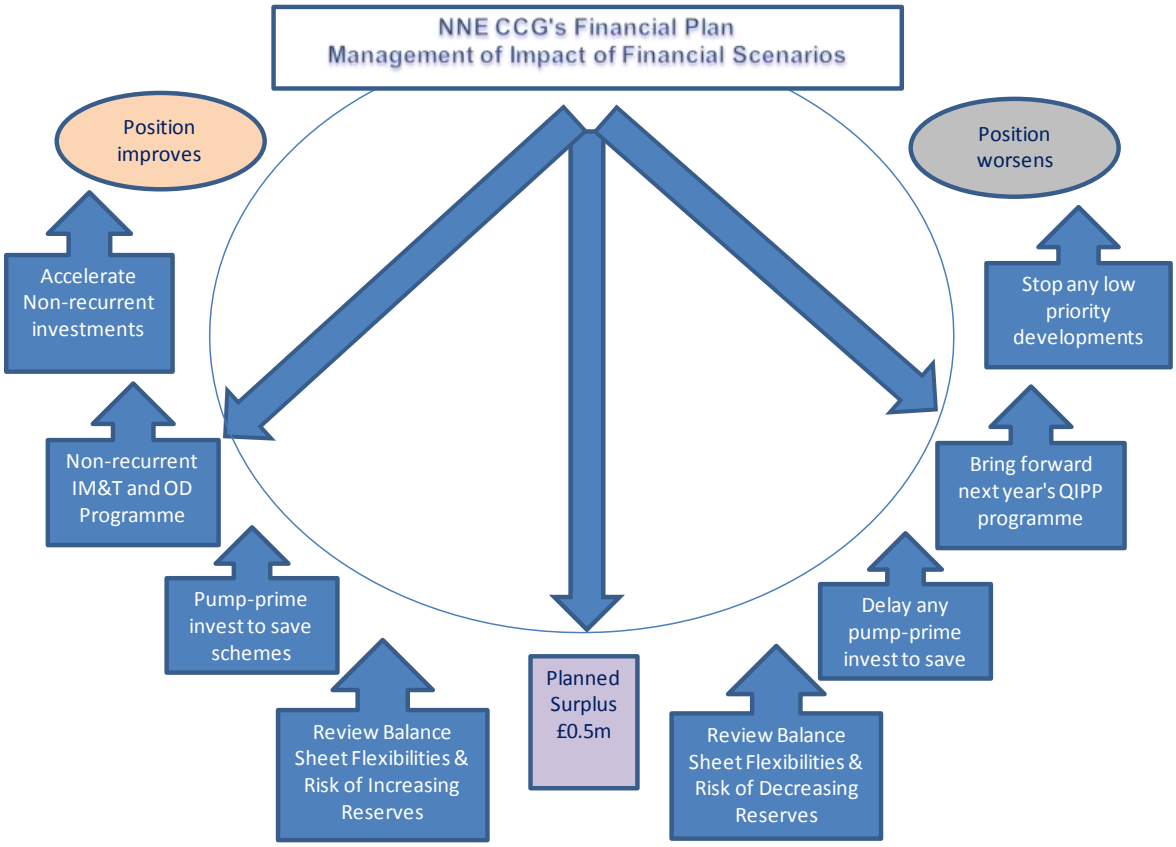


Figure 3: NNE CCG's Financial Plan: Management of Impact of Financial Scenarios

4.3 Quality, Innovation, Productivity and Prevention (QIPP) Financial Targets

Due to the predicted 0% future growth, it is anticipated that there will be insufficient resources available to meet the planning requirements as stated above to allow the CCG to focus on prevention and quality and continue to meet increasing demands. Delivery of significant and recurrent financial savings is therefore essential for the on-going financial balance of the CCG and for delivery of the organisation's strategic objectives and commissioning plans. In order to deliver the balanced financial position for 2012/13 a QIPP target of £5.3m has been netted off the CCG budgets. In line with best practice plans in excess of this amount have been identified and section 6.3 details these.

The CCG is already working closely with other CCGs to jointly manage QIPP across the County. There are shared and explicit risk management mechanisms, with clear accountability and reporting processes between the current collaborative commissioning and contracting teams and CCGs.

The CCG has planned to make available a 2% Transformational Fund to support the system changes that are faced in the coming years. In addition the CCG will continue to benchmark its services against other comparable CCGs to ensure it maximises opportunities for savings and delivers value for money.

Each QIPP scheme to be implemented will identify any impact on Quality and Equality and innovation will be key to delivery. NNE CCG's QIPP plan will ensure resources are committed as effectively as possible, and that services are delivered efficiently as possible. Both of these will be achieved whilst maintaining and improving the quality of services provided to the CCG's patient population.

Nb – please also refer to section 6.3 Productivity.

4.4 Financial Risk Management

The CCG recognises that the implementation of robust risk management procedures will support its strategic plan. Risk management forms an integral part of the overall management process and is the responsibility of all staff.

The CCG has identified a number of risks that may impact on our ability to deliver its financial strategy. These risks, the potential impacts and mitigating actions have been identified as part of the CCG's Business Assurance Framework, will be managed as part of the CCGs Integrated Risk Management Framework, and identified in the CCG's Risk Register. Scenario planning has been carried out within the financial plans to understand the base case and best/worst case financial risks.

The key areas of financial risk for the CCG are:

1) Achieving financial balance with an underlying recurrent surplus based on a number of risks around:
    - uncertainty of CCG allocations
    - requirements of the 2013/14 Operating Framework (or its successor)
    - on-going recurrent cost pressures e.g. activity levels higher than planned, increased expenditure in high cost/low volume cases, pressure arising from devolved budgets – "in the baseline issues"
    - delivery of QIPP not to required recurrent levels
    - cost Pressures arising from County Council spending plans
    - agreement of a risk pooling agreement.
2) Achievement of the running cost target - The NHS Commissioning Board Authority published the indicative running cost allowances for the 212 proposed CCGs for 2013-14 on 23rd May 2012. For NNE CCG this is an indicative running cost allowance of £3.59m.

Financial risks will be monitored and managed through a variety of means including:

- High level review of management accounts, budgets, medium term plans, forecasts, DH returns and annual accounts
- Adherence to the finance standing orders, prime financial policies and scheme of delegation and reservation
- Robust Service Level Agreements with the providers of financial services
- Systems of internal control to ensure transactions are properly recorded and assets safeguarded
- Independent review by Internal and External Audit
- Rigorous approach to QIPP Work streams
- Regular updates of the Financial Plan to reflect the previous year's recurrent underlying position
- Detailed review by the Governing Body on the financial position and forecasts including running costs.

To mitigate against financial risk the PCT has provided for a contingency reserve of £0.8m in each year. In addition there are agreed risk pooling arrangements in place during the financial year 2012/13 – these include the allocation of Continuing Care costs on a weighted capitation basis, allocation of Critical Care variances to plan on a weighted capitation basis and individual patient costs in excess of £100k shared across CCGs on a weighted capitation basis.

5 Commissioning Intentions 2013/14 to 2014/15

Work to identify NNE CCG's commissioning intentions for 2013/14 and 2014/15 has commenced and will continue to be developed during 2012 through a process of communication and engagement with member GP practices, the CCG Governing Body, other Nottinghamshire CCGs, Nottinghamshire County and Borough Councils, provider organisations and patients/public. Engagement with GP's and other member practice

clinicians and staff has started via meetings of the Practice Forum. A series of public consultation events currently underway is providing an opportunity for the CCG to gather the views of local people and patients in respect of their perception of health needs across the area. Commissioning intentions for 2013/14 are also to be discussed at the CCG's Clinical Cabinet meeting in September 2012. Priorities for 2013/14 and 2014/15 will reflect local health needs identified in the recently refreshed Joint Strategic Needs Assessment, priorities identified in the Health and Wellbeing Strategy as this continues to develop, and other national/regional/local target areas.

5.1 Nottinghamshire priorities

The pressure to deliver significant and recurrent financial savings will require all Nottinghamshire CCGs to continue to work together through agreed collaborative commissioning arrangements to transform services through increased clinical leadership and engagement, and greater innovation. The common **underlying priorities in respect of commissioning intentions for 2013/14 to 2014/15 will remain improvements in quality and the delivery of recurrent financial savings associated with QIPP programmes.** The process to confirm commissioning intentions for 2013/14 across Nottinghamshire was commenced at a meeting of the cross-county Professional Executive Committee in July 2012 and will continue over coming months.

6 Quality, Innovation, Productivity and Prevention

The current economic climate means that now, more than ever, the NHS needs to ensure the most effective use of resources whilst making efficiency savings. The Quality, Innovation, Productivity and Prevention (QIPP) programme is a national Department of Health strategy involving all NHS staff, patients, clinicians and the voluntary sector. It aims to improve the quality and delivery of NHS care while reducing costs to make £20 billion efficiency savings by 2014/15. 2012/13 is a significant year for the NHS as the service faces multi-faceted challenges of financial constraints, QIPP delivery, organisational transformation and a strong requirement to maintain or improve service performance levels.

NNE CCG has responded to its financial challenges by undertaking a formal QIPP (Quality, Innovation, Productivity and Prevention) approach to financial planning, to ensure that resources are committed as effectively as possible to deliver the right services in the right place, whilst maintaining and, wherever possible, improving the quality of the patient experience.

Our strategic building block priorities are subject to on-going review to ensure a focus on quality, innovation, productivity and prevention.

6.1 Quality

6.1.1 Quality Framework

Commissioning is a tool for ensuring high quality, cost–effective care which relies on adequate and meaningful data. Quality is a key thread that underpins the work undertaken by commissioning groups. Nottingham North and East Clinical Commissioning Group is working in partnership with other agencies and CCGs to improve health and change lives. The mission is to improve the health and wellbeing of people in Nottinghamshire with a specific aim to improve quality by delivering improved safety, effectiveness of services and improved patient experience. In essence this means monitoring the quality of all our provider organisations both in primary and secondary care.

The overarching principle is doing the right thing first time and every time in both commissioning and provider endeavours. We are maximising our use of regional and national enablers, such as quality indicators, NHS Evidence and NHS Choices in our quest for quality. We have a knowledge management framework to enable us to use what we know to best effect.

The three quality domains are:

- Patient Safety (the safety of treatment and care provided to patients)
- Patient experience (the experience patients have of the treatment and the care they receive)
- Clinical Effectiveness (measured by both clinical outcomes and patient-related outcomes).

Quality is only achieved when all three domains are met. Delivering on one or two is not enough. To achieve a good quality service the values and behaviours of those working in the NHS need to remain focussed on patients first. An organisation that is truly putting patients first will be one that embraces and nurtures a culture of open and honest cooperation.

To achieve this:

- Staff need to feel able to raise concerns about the quality of care at an early stage
- Clinical teams need to understand the quality of service they are providing to patients through a system of measurement and benchmarking
- Commissioners support providers to deliver high quality care
- Healthcare systems need to work collectively to work in partnership in order to monitor, share intelligence and to support improvement where potential or actual failures in the quality of care being provided to patients are identified
- Patients are actively listened to and proactively engaging with patients and the public to understand concerns.

Providers are supported to deliver high quality care in a number of ways:

- Providers and commissioners meet together at quality scrutiny panels to discuss quality issues
- Commissioners undertake regular quality visits to provider organisations to gain a clearer insight into the services they commission, and to gain a greater understanding of the quality of services through discussion with both patients and staff
- Quality metrics are reported to CCG Governing Bodies for additional scrutiny and action. In addition the CCGs are developing quality metrics in order to improve quality further.

6.1.2 Patient Safety

The last decade has seen a number of key publications that have informed and shaped the patient safety agenda. Patient safety includes:

- Safeguarding Children and vulnerable Adults

NHS commissioning organisations in Nottingham City and Nottinghamshire County will prioritise the safety and welfare of children and vulnerable adults across all commissioned and contracted services. The Children act's 1989 & 2004 outline statutory roles and responsibilities and duties relating to safeguarding and promoting the welfare of children for NHS organisations and partner agencies. These duties are summarised in "Working Together to Safeguard Children" Department of Health (DoH) 2010.

"The role of NHS Commissioners" DoH 2011 outlines commissioners role in preventing and responding to neglect, harm and abuse to adults in the most vulnerable situations, including the commissioning services for women and children who experience violence or abuse.

- Infection Prevention and Control (IPC)

All healthcare organisations are expected to minimise the risk of healthcare acquired infection to patients by complying with the 'Health and Social Care Act (2008): Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance'.

The Code provides the core essential elements that a healthcare organisation must meet in order to be registered with the Care Quality Commission.

- Clinical Effectiveness

Clinical effectiveness is about delivering the best possible care for patients through timely and appropriate treatments but also ensuring the right outcome for patients – "right person, right place, right time". Clinical effectiveness is made up of a range of quality improvement activities and initiatives including: evidence, guidelines and standards to identify and implement best practice, quality improvement tools, (such as clinical audit, evaluation, rapid cycle improvement) to review and improve treatments and services based on:

- the views of patients, service users and staff
- evidence from incidents, near-misses, clinical risks and risk analysis
- outcomes from treatments or services
- measurement of performance to assess whether the team/department/organisation is achieving the desired goals
- identifying areas of care that need further research
- information systems to assess current practice and provide evidence of improvement
- assessment of evidence as to whether services/treatments are cost effective
- development and use of systems and structures that promote learning and learning across the organisation.

6.1.3 Nottinghamshire Multi-Agency Safeguarding Hub (MASH)

The MASH will act as the first point of contact for Social Care for safeguarding concerns about children and vulnerable adults. It will include representatives from Children's Social Care, Adult Social Care, Police and Health working together at a central location. Virtual links will exist to other services and agencies such as the Probation Trust and housing.

The MASH will receive safeguarding concerns from professionals as well as members of the public and family members. It is anticipated that a significant number of contacts will be addressed at an early stage by a new team of Referral & Advice Officers who will be the first point of contact for the MASH. Working under the close supervision of qualified Adult and Children's social work professionals, Referral & Advice Officers will swiftly advise and signpost referrers to the most appropriate service, thereby filtering contacts and reducing the number of contacts being escalated to social work professionals inappropriately.

As a result, better decisions will be made about what action to take and support will be targeted on the most urgent cases. Better co-ordination between agencies will be initiated leading to an improved service for children, adults and families.

The MASH will also provide an advice line for professionals who have concerns about a child or adult. This will help clarify any causes of concern and offer advice on application of social care thresholds, or signpost to early intervention or other services as and when this is appropriate.

6.1.4 Safeguarding Governance and Reporting arrangements

The governance arrangements for safeguarding adults and children are shared across all the Nottinghamshire County CCGs. The safeguarding committee is a sub-committee of the CCG Governing Body. Minutes and reports from the safeguarding committee are reported to the NNE CCG Governing Body and the local safeguarding adults and children's boards. The Executive Lead attends both the adults and children's local safeguarding boards.

6.1.5 Safeguarding Training and Development

Nottingham North and East CCG is committed to ensuring all its staff, including the Governing Body, are supported to safeguard vulnerable adults and children through training and development. A suite of training materials are available to support staff. Governing Body members receive an annual presentation as part of the Board Development programme.

6.1.6 Patient Experience

Patient experience information enables NNE CCG to understand what it does well and identify areas for improvement. Triangulation of data from complaints, compliments, stories and patient satisfaction surveys helps the CCG understand how the services it commissions can be improved. Further intelligence is obtained from the Patient Reference Group and

feedback of patient stories from practice staff. Patient stories are now a key agenda item at meetings of the Governing Body which helps the Governing Body to understand the emotional, social and psychological impact of healthcare on patients, their carers and relatives. In addition local organisations such as LINks and the local authorities provide further intelligence.

Key publications such as: Listening and Learning: the Ombudsman's review of complaint handling by the NHS in England 2009-10, Care and compassion?, Report of the Health Service Ombudsman on ten investigations into NHS care of older people, A Service for Everyone, 2010/11, and key drivers such as the 'Patient Revolution' also provide valuable patient experience information that NNE CCG will use to inform its approach to improving the patient experience.

6.1.7 Governance for Quality

Although individuals and clinical teams are at the frontline and responsible for delivering quality care, it is the responsibility of the Governing Body to create a culture within the organisation that enables clinicians to work at their best, and to have in place arrangements for measuring and monitoring quality and for escalating issues. Governing Bodies learn from mistakes and promote an environment where staff and patients are encouraged to identify areas for improvement.

NNE CCG has developed its capability to proactively scan provider quality data and have added rigour to this process. Business intelligence, survey results, patient feedback, complaints, incidents and PALS contacts are combined to provide the CCG an overall picture of provider hotspots.

Key areas where quality is already driving commissioning within NNE CCG include:

- Quality standards are built into service specifications and contract quality schedules
- Quality is an integral aspect of the current review of clinical referral thresholds for secondary care
- Commissioning for Quality and Innovation (CQUIN) scheme and contract quality schedules. These are closely aligned with the CCG's strategic initiatives
- Providers are held to account for quality through regular quality scrutiny panels
- An innovative primary care quality accreditation scheme (ADVANCE) has been launched to ensure quality amongst primary care contractors
- A 'practitioner with special interest' accreditation scheme is in place to ensure consistent standards of competence regardless of care setting
- A programme from the NHS Institute for Innovation and Improvement has been commissioned to support our GP practices to improve the quality and safety of the services they provide.

6.2 Innovation

With financial resources becoming increasingly scarce, NNE CCG will continue to seek out opportunities to improve health care and service provision through collaborative working with partner organisations in order to ensure that innovation remains a core component of on-going service development. NNE CCG views integrated care as a key component in respect of improving patient care and care pathways and therefore, during 2012/13-2013/14 will continue to work closely with local provider organisations and other key stakeholders to implement plans to transform community health and social care services locally.

In particular NNE CCG is leading the implementation of an Integrated Health and Social Care Project, working closely with County Health Partnerships, Nottinghamshire County Council, NUH NHS Trust and other key partners to transform community nursing and rehabilitation services across the NNE CCG area. This project will be piloted throughout 2012/13 with plans for full roll-out in 2013/14 if successful.

6.3 Productivity

6.3.1 QIPP requirement 2012/13

In 2011/12 in order to balance its financial position NHS Nottinghamshire County (the PCT) had an overall QIPP efficiency target of £46.4m. Each of the five CCGs that had delegated responsibility from the PCT was tasked with delivering a proportion of this target. For 2011/12 the QIPP efficiency saving delivered by NNE CCG was £5.978m.

The PCT's opening QIPP target for 2012/13 is £31.4m and NNE's share of this is £5.245m. In line with best practice NNE CCG is working up schemes for 150% of this target and has currently identified £6.8m which can be summarised as follows:

NNE - OPENING QIPP 2012/13

Service Area	£ks	% Share
CHP - Community Provider	£ 571	8.4%
Continuing Care	£ 780	11.5%
Estates	£ 12	0.2%
Management & Admin.	£ 38	0.6%
NHCT - Mental Health	£ 552	8.1%
NUHT Acute Trust	£ 4,413	65.0%
Prescribing	£ 214	3.2%
SFHT Acute Trust	£ 211	3.1%
Total	**£ 6,791**	**100.0%**

Table 6: Opening QIPP target 2012/13

The requirement to achieve efficiency savings of this level means that the CCG must ensure that quality and best value services are commissioned for its patients and that QIPP principles are pivotal to all investment decisions.

In order to achieve this, delivery of QIPP is monitored and measured by the CCG's Service Improvement Group, membership of which includes GPs, a senior finance officer, and other representatives of the CCG's Governing Body. The group is responsible for developing and updating the CCG's QIPP plan in order to ensure delivery against target, and setting QIPP targets linked to each strategic building block. This group also ensures that QIPP principles are integral to all plans for on-going service development. In addition the group coordinates plans for the use of any non-recurrent funding that becomes available to the CCG to support service transformation, improvement and redesign. The Service Improvement Group is a sub-group of the Clinical Cabinet which is accountable to the Governing Body.

Achievement against the QIPP target is reported on a monthly basis to the Governing Body via the Finance Report.

6.3.2 QIPP 2013/14 and 2014/15

As identified in section 4.1 above, there are additional QIPP targets of £3.3m and £3.1m to be delivered in financial years 2013/14 and 2014/15 respectively in order to deliver a balanced CCG financial plan. The process to identify where these QIPP targets will be delivered from will commence during quarter 3 of 2012/13 and will take into account the full year impacts of current QIPP schemes plus the opportunity identified for new QIPP. This process will involve input from clinicians and other stakeholders as well as benchmarking referral and admission rates across other organisations and expected rates. The CCG Building Block priorities will also inform the QIPP planning process.

6.3.3 Productive Notts

Productive Notts is an alliance, formed in 2009, of the NHS commissioner and provider organisations across Nottinghamshire in partnership with Nottinghamshire County and Nottingham City Councils. The aim of Productive Notts is to facilitate the collective delivery of efficiency gains and implementation of innovative service delivery methods and integrated pathways across the Nottinghamshire health and social care community in response to the financial challenge faced by all organisations. We will continue our commitment as an active leader within Productive Nottinghamshire.

6.4 Prevention

Nottingham North and East CCG recognises the crucial role of prevention through health promotion to support both short and longer term improvements in the health of its population and therefore has established a Building Block priority area specifically focussed on Health and Wellbeing. Key priority areas for 2012/13 are smoking and obesity.

In addition NNE CCG has ambitious plans to address unwarranted clinical variation between GP practices through benchmarking of practice performance across key activity domains such as urgent care, planned care, prescribing, and immunisations. During 2012/13-2013/14 practices will continue to be supported in the implementation locally of the Right Care programme, outlining clinical thresholds for a range of key procedures. Work has commenced with the NHS 'Right Care' team to establish how unwarranted variations in care between constituent GP practices can be reduced.

7 Collaborative Commissioning with our Partners

7.1 Clinical Commissioning Groups

7.1.1 Provider contract co-ordination

Nottingham North and East, Principia Rushcliffe, Nottingham West, Newark and Sherwood, Mansfield and Ashfield and Nottingham City CCGs have established collaborative commissioning arrangements with a shared infrastructure to ensure the economies of scale fundamental to the new NHS environment. This shared infrastructure covers contract management, finance, information, performance monitoring, quality and patient safety. The arrangement maximises management and clinical capacity within an affordable running cost allowance.

Each CCG has taken a leadership role for the large NHS provider contracts. Nottingham North and East is the coordinating commissioner across Nottinghamshire for County Health Partnership and other non-acute contracts. NNE CCG also works closely with Nottingham West, Principia Rushcliffe and Nottingham City CCGs to commission the services of Nottingham University Hospitals NHS Trust.

Working collaboratively like this allows the CCG to flex its commissioning control appropriately. For example, the CCG directly commissions services to meet specific local needs but also identifies opportunities for commissioning along with other local CCGs when it is advantageous to do so. It is felt that this approach combines much needed local sensitivity with greater purchasing power and resilience, and significantly reduces risk.

7.1.2 Commissioning Support Services

NNE CCG has worked with other Nottinghamshire CCGs and Nottingham City and Nottinghamshire County Cluster PCT to determine how a range of functions that support commissioning might best be delivered in the future. The CCG, along with other local CCGs has decided that a number of these functions would be best delivered in a commissioning support organisation. Factors that have influenced which services might be provided by a commissioning support organisation include scale and the need for proximity to the clinical decision makers. A range of services have been agreed as those that are appropriate to be provided through a commissioning support organisation

At present these services include:

- Human Resources
- Communications
- Procurement - Supplies
- Procurement - Clinical
- Medicines Management
- Organisational Development
- Technical Finance
- Continuing Care
- Information Governance

The CCG has signed a Memorandum of Understanding with Greater East Midlands Commissioning Support Services (GEM), which has passed Checkpoint 2 as part of the process for becoming an authorised Commissioning Support Organisation, and will continue working with GEM during 2012 to develop and agree a service level agreement that meets the requirements of the CCG.

NNE will also work with other Nottinghamshire CCGs to develop plans to ensure that the CCG has the capacity and capability required to effectively manage the contract with GEM as an 'intelligent customer'. Work has commenced on the detailed financial analysis that needs to be undertaken to ensure that the model being proposed is affordable and demonstrates value for money. NNE CCG plans to take up the Business Development Unit's offer of technical support to analyse and undertake benchmarking of the service level agreement with the commissioning support organisation, and in addition the CCG will complete the 'ready reckoner' for commissioning support to ensure value for money.

7.2 Joint Commissioning

To tackle health inequalities and deliver meaningful improvements to health and social care services, public service organisations cannot stand alone. Joint commissioning is a mechanism by which the County Council and its relevant CCGs can plan to invest public money to commission services that help to improve the health and wellbeing of all people across Nottinghamshire. It is focussed on action in specific areas of care such as mental health, carer support, older people, physical disability, children's services, learning disability and autistic spectrum disorder. Nottingham North and East, Principia Rushcliffe, Nottingham West, Newark and Sherwood and Mansfield and Ashfield CCGs have each assumed lead responsibility for the commissioning of health services for the specific joint commissioning service areas.

Nottingham North and East CCG therefore has lead health responsibility for the multi-agency strategic partnership for Children and Young People and the Accountable Officer is a member of the Children's Trust Board. Nottingham North and East CCG is also the lead organisation for Children with Disabilities and/or Special Educational Needs.

7.3 Provider landscape

The main Nottinghamshire provider landscape is as follows: one acute aspiring Foundation Trust - Nottingham University Hospitals NHS Trust; one Foundation Trust - Sherwood Forest Hospitals NHS Foundation Trust; one mental health trust which has achieved the Foundation Trust Equivalent status and is currently applying for full Foundation Trust status - Nottinghamshire Healthcare NHS Trust (also provides community services via its community provider arm, Community Health Partnerships); a social enterprise providing community services - Nottingham CityCare Partnership, Nottingham NHS Treatment Centre a Wave 1 ISTC operated by Circle (re-procurement of treatment centre services is currently underway and NNE CCG has clinical representation and engagement in the procurement process), NEMS which provides out of hours primary care cover, and East Midlands Ambulance Service (EMAS) which provides ambulance services. Patients within NNE CCG will receive services from all of these provider organisations as appropriate. In addition patients receive a range of primary medical services from GP practices across the patch.

7.4 NHS Commissioning Board

The NHS Commissioning Board will be part of a comprehensive commissioning system for healthcare services. The Board will have a dual role in that it will both deliver its own commissioning functions and ensure that the whole of the architecture is cohesive, coordinated and efficient. CCGs and the Board will have to work together closely at local level. The Board will support CCGs and hold them to account whilst ensuring they have the freedom to deliver improvements in outcomes for their local populations in a clinically led and bottom up way.

The NHS Commissioning Board will have 27 local offices or Local Area Teams (LAT) based within their geographical area. Specifically, all LATs will take on direct commissioning responsibilities for primary care GP services, dental services, pharmacy and certain aspects of optical services. The Government's vision is for decisions about services to be made as locally as possible, involving the people who use them as much as possible. To this end, the NHS Commissioning Board will work in partnership with CCGs and other local networks; and will ensure that there is a locally responsive approach, supported by joint health and wellbeing strategies, joint strategic needs assessments and pharmaceutical needs assessment. In addition, although NNE CCG will commission the majority of NHS services for its population it will also have a statutory responsibility to support the NHS Commissioning Board to improve the quality of primary medical care. NNE CCG is committed to working with the NHS Commissioning Board both throughout the authorisation period and beyond.

8 Stakeholder engagement

8.1 Constituent GP practices

In order to fully reflect the needs of local populations the GP practices have formed three locality groups, which enable clinical and non-clinical practice staff to meet regularly to discuss issues at a local level. An inter-practice agreement is in place, to which all practices have signed up. Each practice has an identified clinical and management lead as part of this. In addition there is an established clinically driven Practice Forum, which meets monthly and has been running successfully for six years. The Practice Forum is the vehicle for ensuring the ideas/views of constituent GP practices inform the Governing body as well as enabling Governing Body decisions to be shared with individual GP practices. Information is also passed to the Practice Forum from Locality Group meetings. Practice Learning Time events are bi-monthly and attended by clinicians and non-clinicians from across the CCG.

8.2 Partnership Working

Operating in a challenging economic environment, Nottingham North and East CCG recognises that working in partnership will be a crucial success factor if health inequalities are to be addressed and services improved. This will involve effective engagement and partnership working with borough/district councils, local people, voluntary organisations and other key partners, for example working with the British Royal Legion to improve the management of veterans' health. The CCG has a range of arrangements including:

- The Local Authority Partnership sub-group of the Governing Body, membership of which includes each of the four main District/Borough Councils, County Council, LINk and CCG Governing Body members. This group determines areas for collaboration and ensures alignment/consistency of messages
- Integrated working opportunities through co-location with Gedling Borough Council;
- Clinical Lead is a member of the Health and Wellbeing Board
- Accountable Officer is a member of the Gedling Leaders' Forum and the Ashfield Health Forum
- Active members of the Hucknall and Gedling Partnership Forums
- Representation on the Local Involvement Network (LINk) Executive Board.

Through collaborative working the CCG is committed to actively supporting priorities identified by its partners, for example substance misuse and domestic violence. The

Governing Body composition ensures that complex issues can be considered with the benefit of a wide range of experience and perspectives.

The CCG recognises that predecessor organisations, partners in health, the local authority, social care, and the voluntary sector all have a great body of knowledge and expertise to contribute to the achievement of NNE CCG's ambitions. Indeed, there are many existing policies and priorities which form the evidence base and context for this plan. The central importance of patient and public involvement and partnership working were identified early in the formation of the CCG. The CCG's plans and priorities will continue to evolve through engagement with patients, public, partners and stakeholders.

8.3 Patient and Public Involvement

Nottingham North and East CCG is fiercely committed to patient, carers and public involvement to focus on delivering the services and outcomes that are the most relevant to local people. The CCG has plans to implement the NHS 'Right Care Programme' aimed at maximising the value that the patient derives from their own care and treatment. No patient faced with a significant decision about their healthcare should decide in the face of *avoidable ignorance*. In particular, we are committed to:

- providing patients with genuine options over their care
- giving patients the tools they need to help them decide the right way forward
- ensuring decisions are taken with patients, carers and clinicians - sharing the decisions made about their care.

Patient and public views are sought using various means including; workshops, meetings, the CCG website and newsletters. The 'Take a Healthy Interest' database which has been compiled by NHS Nottinghamshire County is also utilised. The CCG will build on its existing mechanisms of patient and public involvement and in partnership with stakeholders will develop new and innovative methods to ensure that the patient and public voice shapes CCG plans for the future. Using social media and digital technologies as an integral part of the CCG's approach it will pro-actively initiate two-way conversations. It is the CCG's intention to create a social media presence that contributes to both new and existing conversations which are relevant to our patients, public and stakeholders.

8.4 Communication and Engagement Strategy

NNE CCG's Communication and Engagement Strategy is to ensure that all communications activity with identified stakeholders reflects the principles of Nottingham North and East CCG and supports the CCG's overall vision and values. It has been developed in partnership with its Patient and Public Reference Group and with help from the CVS. The CCG also continues to work closely with Nottinghamshire County LINk until HealthWatch is established.

The CCG believes that meaningful stakeholder engagement will be integral to its success, and will continue to build on current engagement activities by raising awareness with key groups and identifying appropriate new stakeholders – persons or groups with a direct interest, involvement or investment in the CCG's activities. The use of digital technologies and social media has been included in addition to more traditional methodologies, recognising the need to use a variety of means to create and maintain meaningful two-way dialogue with all stakeholders. Stakeholder analysis has been used to inform the development of a Stakeholder Engagement Plan which is appended to the Communication and Engagement Strategy.

NNE CCG's Communication and Engagement Strategy can be found on the CCG's website. Alternatively a hard copy of the strategy is available on request.

8.5 HealthWatch

HealthWatch will be the new consumer champion for both health and social care. It will exist in two distinct forms – local HealthWatch at local level and HealthWatch England at national level. Local HealthWatch will be established in April 2013 and will replace LINks. The aim of local HealthWatch will be to give citizens and communities a stronger voice to influence and

challenge how health and social care services are provided within their locality. Local HealthWatch will have a seat on the Nottinghamshire Health and Wellbeing Board ensuring that the views and experiences of patients, carers and other service users are taken into account when local needs assessments and strategies are prepared, such as the Joint Strategic Needs Assessment (JSNA). This will ensure that local Healthwatch has a role in promoting public health, health improvements and in tackling health inequalities. NNE CCG is committed to working with the local HealthWatch in order to ensure that the views and concerns of patients and the general public are incorporated in all commissioning decisions and service design, and to help the CCG understand where patients believe services are doing well and where they can be improved.

8.6 Patient Participation Groups

All 21 practices within Nottingham North and East CCG have a Patient Participation Group with some successfully running virtually. The CCG has actively used these forums to consult on service changes, primary care development and Nottingham North and East CCG's commissioning focus.

8.7 Patient and Public Reference Group

NNE CCG has a well-established Patient and Public Reference Group (PPRG) which has been meeting for three years. This group meets bi-monthly in order to be aligned with meetings of the Governing Body, and is instrumental in supporting the CCG with patient and public involvement, engagement and consultation. The group has been further strengthened by integrating membership across GP practices' Patient Participation Groups (PPG). Members also include representatives from the CCG Governing Body, the Local Involvement Network (LINk), the Community Voluntary Sector (CVS) and the Local Authority. The CCG is committed to the development of the role of the PPRG to influence commissioning intentions and actively inform commissioning plans for service change. A training programme tailored to meet individual member needs is being developed in association with Gedling CVS.

8.8 The Patient Revolution

The main objective of the 'Patient Revolution' is to ensure that the patient and public voice is heard and acted upon, by placing patients at the centre of care, capturing patient experience and making use of the best mechanisms available. It is one of five ambitions of the NHS Midlands and East Cluster and has three core elements:

- Greater shared decision making and involvement between patients and professionals
- Greater community participation
- Improved customer experience of patients and carers.

The aim is for patients to have greater choice and control in enable to help them make decisions regarding their treatment; to be able to access services in ways that are convenient to them; and to have the information that enables them to do that. NNE CCG is committed to supporting patients to make appropriate decisions and will use patient feedback to drive improvements in patient safety and services, and to hold providers to account for the quality, choice and convenience of care. Evidence sources will include the 'Friends and Family Test', from April 2013 and monitoring of the NHS Staff Survey which identifies whether NHS staff are happy for their friends and family to be treated at their place of work.

Patient choice and patient involvement are key elements of the NHS reforms:

"No decision about me, without me"

8.9 Carers

NNE CCG is developing a Carer's Strategy based on national guidance and initiatives, as well as leading the agenda locally with clear clinical leadership. The CCG is working closely with County Health Partnership's Carer's Co-ordinator to determine a clear process for identifying and supporting carers but also to train practice staff in working with carers and patients. There will be a launch of the new Carer's Strategy during 2012/13 following

consultation with practices and patients to ensure the proposed strategy will meet the needs of our carers and the people that they care for.

8.10 Seldom Heard Groups

It is NNE CCG's aim to seek and take into account the views of **all** patients, their carers and others when designing, planning, delivering and improving health care services. However it is realised that the views of some are more difficult to determine and require the CCG to seek them out. NNE CCG's activities include working with local groups of people with protected characteristics, as defined in the Equality Act 2010, to ensure that their needs are met and progress is being made in respect of reducing inequalities. The CCG values difference and promotes equality to ensure that all individuals, whether patients or staff receive a high quality of care.

8.11 Governing Body Representatives

The importance of the patient voice is reflected by the inclusion of both a patient representative and a Lay Member with responsibility for Patient and Public Involvement on the Nottingham North and East CCG Governing Body.

8.12 Securing Additional Capacity

NNE CCG has recently renegotiated its contract with Gedling Community and Voluntary Services (CVS) to secure additional resource to support our patient and public engagement activities.

Early discussions have taken place with some of our partners (Local Authority, Nottingham University Hospitals NHS Trust and Nottinghamshire Healthcare NHS Trust) about how we can collectively work with the local community on patient and public engagement.

9 Statutory and Policy Context

There are a number of other national and local drivers which will also influence the direction and ambition of NNE CCG's local strategic priorities. These include:

9.1 NHS Operating Framework

The NHS Operating Framework 2012/13 sets out the planning, performance and financial requirements for NHS organisations and is the basis on which we will be held to account. This is particularly important as 2012/13 is a year of transition from Primary Care Trusts to Clinical Commissioning Groups and understanding where responsibilities lie will be critical to maintaining and improving services for our patients.

9.2 NHS Outcomes Framework

The Outcomes Framework sets out the high-level national outcomes that the NHS should be aiming to improve across five domains: preventing people from dying prematurely, enhancing quality of life for people with long-term conditions, helping people to recover from episodes of ill health or following injury, ensuring that people have a positive experience of care, treating and caring for people in a safe environment and protecting them from avoidable harm. Overall there are a total of 60 indicators against which outcomes will be measured nationally.

9.3 The Equality Act 2010

The Equality Act 2010 brings together for the first time all the legal requirements placed on private, public and voluntary organisations in respect of equality. The Act protects people from discrimination and covers nine protected characteristics which cannot be used as a reason to be treated unfairly. Every person has one or more of the protected characteristics, and therefore the act protects everyone against unfair treatment.

The Public Sector Equality Duty (section 149 of the Equality Act 2010) applies to public bodies and others carrying out public functions and as such NNE CCG must, in the exercise of its functions, have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not
- foster good relations between people who share a protected characteristic and those who do not.

The Equality Duty is supported by specific duties, which require public bodies to:

- publish information to show their compliance with the Equality Duty, at least annually
- set and publish equality objectives, at least every four years.

The Public Sector Duty encourages engagement with the diverse communities affected by its activities to ensure that all policies and services are appropriate and accessible to all, and meet the different needs of the communities and people served. Nottingham North and East CCG is committed to understanding how equality can drive improvements and strengthen the accountability of services to patients and the public, and to enable the CCG to meet its duties it will use the Equality Delivery System (EDS). This tool has been developed to support NHS commissioners and providers to deliver better outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse. Nottingham North and East aims to use the EDS to make positive differences to healthy living and working lives.

9.4 CCG Inequality Duty (Health & Social Care Act)

In the exercise of its functions, the CCG will have a duty to have regard to the need to:

- reduce inequalities between patients with respect to their ability to access health services
- reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

The CCG will also have a duty to integrate services, with a view to:

- securing the provision of health services ensuring they are integrated with the provision of other health services, health-related services or social care services where it considers that this would meet reduction in inequalities as stated above.

9.5 Regional Commissioning Framework

This SHA cluster framework outlines a shared understanding of expectations and a consistent set of conditions explaining how the SHA and CCGs will operate together to maintain or improve service performance levels.

9.6 Any Qualified Provider

Any Qualified Provider (AQP) was introduced by the DH as part of its strategy to increase patient choice and personalisation. The overall aim is that by giving greater patient choice and control, the result will be better care and improved access, outcomes and experience for all. It was agreed across all CCGs in Nottinghamshire County that there would be a ‘county wide’ approach for the first wave of AQP. The three priority services for inclusion in the first wave are Podiatry, IAPT and direct access non-obstetric ultrasound, with implementation expected by September 2012.

NNE CCG is committed to considering the appropriateness of using the AQP approach in future years when reviewing commissioning arrangements for existing services or when planning to procure new services.

9.7 National Tariff for Mental Health

A new payment mechanism for mental health services is being proposed. This presents a financial risk for both commissioners and providers requiring careful management.

9.8 Re-ablement Funding Framework

During 2011/12 NHS Nottinghamshire County and Nottinghamshire County Council managed a joint re-ablement plan. Nottingham North and East contributed directly to the plan and will continue its support in 2012/13.

9.9 NHS Constitution

Nottingham North and East CCG is fully committed to the rights and pledges to patients and staff within the NHS Constitution and is also committed to promoting and raising awareness of the Constitution with the public.

9.10 Authorisation

From April 2013, healthcare commissioning will be the responsibility of the NHS Commissioning Board and CCGs. In order to assume that statutory responsibility Nottingham North and East will be assessed through an authorisation process.

9.11 Innovation Health and Wealth

The Health and Wealth Report identifies high impact changes which providers will need to have delivered in order to pre-qualify for the 2013-14 CQUIN schemes. Commissioning for Quality and Innovation (CQUIN) is a framework that enables commissioners of care to financially reward providers where they can demonstrate they are delivering high quality care to agreed standards. Commissioners are required to satisfy themselves that all eligible organisations are delivering the high impact innovations set out in the document in order to pre-qualify for CQUIN payments. This will take effect from 2013/14.

10 Glossary/Abbreviations

Antipsychotics

Antipsychotic drugs are a group of medicines used to manage symptoms such as agitation, anxiety, mania and aggression in people with conditions such as schizophrenia or dementia. Evidence shows that the use of these drugs for elderly patients with dementia increase their risk of suffering cerebro-vascular events including stroke and this outweighs the likely benefits in the treatment of behavioural symptoms of dementia. Guidance suggests they should not be prescribed and GPs are reviewing those patients who have been prescribed antipsychotics to decide whether it is still appropriate.

Authorisation

Authorisation is a process that will determine Clinical Commissioning Groups (CCGs) readiness to be established as a statutory organisation. CCGs will be judged on a number of areas, e.g. governance arrangements, clinical and professional focus and leadership.

Clinical Commissioning Group

Clinical Commissioning Group is the term given to a form of commissioning that is clinically led by a group of GPs and other staff working together within a defined area, e.g. geographical. They are currently operating in shadow form and, subject to authorisation, will become statutory organisations from 2012/13 (subject to passage of legislation).

Commissioning

Commissioning relates to the purchasing and contracting of health care services. It involves identifying health needs, service planning and design and purchasing services from appropriate providers and subsequently managing the contracts put in place.

End of Life

The Department of Health have developed an End of Life strategy to ensure that the care people receive at the end of life is compassionate, appropriate and gives people choices in where they die and how they are cared for. The pathway includes health and social care services.

Health and Social Care Bill 2011

Proposals for a Health Bill were included in the Queen's Speech for the first Parliamentary session of the coalition Government. The Health and Social Care Bill will bring forward the legislative changes required for the implementation of the proposals in the White Paper: Equity and Excellence, Liberating the NHS which includes the establishment of Clinical Commissioning Groups.

Health and Wellbeing Board

Local authorities will have a responsibility to establish a Health and Wellbeing Board that will lead on improving the strategic co-ordination of commissioning across NHS, social care and related children's and public health services. Clinical Commissioning Groups will be represented on the Health and Wellbeing Board.

Health Needs Assessment

Health needs assessment is a method for reviewing the health issues facing a population, leading to agreed priorities and allocation of resources that will improve health and reduce inequalities.

Health Outcomes

Health Outcomes are a change in the health status of an individual, group or population which is attributable to a planned Nottingham North and East intervention or series of interventions, regardless of whether such an intervention was intended to change health status. Outcomes may be for individuals, groups or whole populations. Interventions may include government policies and consequent programmes, laws and regulations, or health services and programmes, including health promotion programs.

IAPT (Improving Access to Psychological Therapies)

Improving Access to Psychological Therapies (IAPT) is a Department of Health project. Psychological therapies have been shown to be an effective intervention for people with common mental health problems such as depression and anxiety disorders, including posttraumatic stress disorder and obsessive-compulsive disorder. Within Nottinghamshire the service is called "Let's Talk Wellbeing" and individuals can self-refer or be referred through their GP.

JSNA – Joint Strategic Needs Assessment

The purpose of JSNA is to pull together in a single, ongoing process all the information which is available on the needs of our local population ('hard' data i.e. statistics; and 'soft data' i.e. the views of local people), and to analyse them in detail to identify: a) the major issues to be addressed re health and well-being, and b) the actions that we as local agencies will take to address those issues.

Locality Group

Nottingham North and East practices have formed into three groups relative to geographic location. These groups meet regularly (quarterly or monthly) and attendance varies depending on the agenda. The groups consider local population needs, local issues, clinical pathways, processes and procedures in practices. They are chaired by a Practice Manager who directly feeds back to a wider meeting of practice representatives.

Long Term Conditions

A condition that can not be cured but can be managed through medication and/or therapy. There is no definitive list of long term conditions – diabetes, asthma and coronary heart disease can all be included.

Medicines Management

Medicines management supports better and more cost-effective prescribing in primary care, as well as helping patients to manage medications better. Good medicines management can help to reduce the likelihood of medication errors and hence patient harm.

NHS Operating Framework

The NHS Operating Framework is a document issued by the Department of Health annually in December giving the planning and priorities for the year ahead. This enables NHS organisations to plan for the financial year starting in April.

NICE (National Institute for Health and Clinical Excellence)

The National Institute for Health and Clinical Excellence (NICE) was set up in 1999 to reduce variation in the availability and quality of NHS treatments and care - the so called 'postcode lottery'.

NICE evidence-based guidance and other products help resolve uncertainty about which medicines, treatments, procedures and devices represent the best quality care and which offer the best value for money for the NHS. NICE also produce public health guidance recommending best ways to encourage healthy living, promote wellbeing and prevent disease. NICE public health guidance is for local authorities, the NHS and all those with a remit for improving people's health in the public, private, community and voluntary sectors. (NICE site)

Non-Executive Director (NED)

Non-executive directors bring expertise and experience, and often particular, knowledge as a member of the local community, to the work of the Board. Their focus is at a strategic level and is impartial, providing an independent view that is removed from the day-to-day running of the organisation.

OOH (out of hours service)

Commissioned service to provide primary care medical attention during times when GP practices are closed.

Pathway

A pathway defines a patient's journey through care for a specific health condition. The pathway identifies what care and treatment is required along the pathway and the expected outcomes of that care and treatment.

Patient and Public Reference Group

Patient Reference Groups, or Patient Participation Groups as they are sometimes known, bring together a group of registered patients of a GP practice with the aim of involving them in decisions about the range and quality of services provided, and, over time, commissioned by their practice through the Clinical Commissioning Group.

Planned Care

Planned care is pre-arranged, non-emergency care that includes out-patient appointments and planned operations. It is usually provided by consultants in a hospital setting.

Primary Care

Primary care is the care provided by people you normally see when you first have a health problem. It includes services provided by GP practices, dental practices, community pharmacies and high street optometrists.

Primary Care Trust (PCT)

Primary Care Trusts are currently responsible for the planning and paying for health care services in its area. The responsibility for this is due to transfer to Clinical Commissioning Groups by April 2013 when Primary Care Trusts will cease to exist.

Re-ablement

Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living.

Registered population

Registered population refers to those people registered with a GP practice.

Resident population

Resident population refers to residing in a geographic area.

Secondary care

Secondary care is defined as a service provided by medical specialists who generally do not have first contact with patients. Secondary care is usually delivered in hospitals or clinics and patients have usually been referred to secondary care by their primary care provider (usually their GP).

Self-Management

Patients and carers are actively involved in their health care and to provide a variety of creative and individualized strategies to deal with their health problem in their daily life and ultimately to live as normally as possible despite their symptoms. Self-management support can viewed in two ways – as a portfolio of techniques and tools to help patients choose healthy behaviours and a fundamental transformation of the patient-caregiver relationship into a collaborative partnership.

Strategic Health Authority (SHA)

Strategic Health Authorities form the intermediate tier of the NHS between the Department of Health and the NHS commissioning and provider trusts in the region.

Take a Healthy Interest

Take a Healthy Interest is an NHS Nottinghamshire County forum through which individuals are consulted on and can have a say in the services planned and paid for by the PCT.

Unplanned Care, urgent and emergency care

Unplanned care refers to a patient who is admitted to hospital but not in a planned way from a waiting list, for example the patient would be admitted as an emergency.

Appendices

Appendix 1. Population and health maps and charts

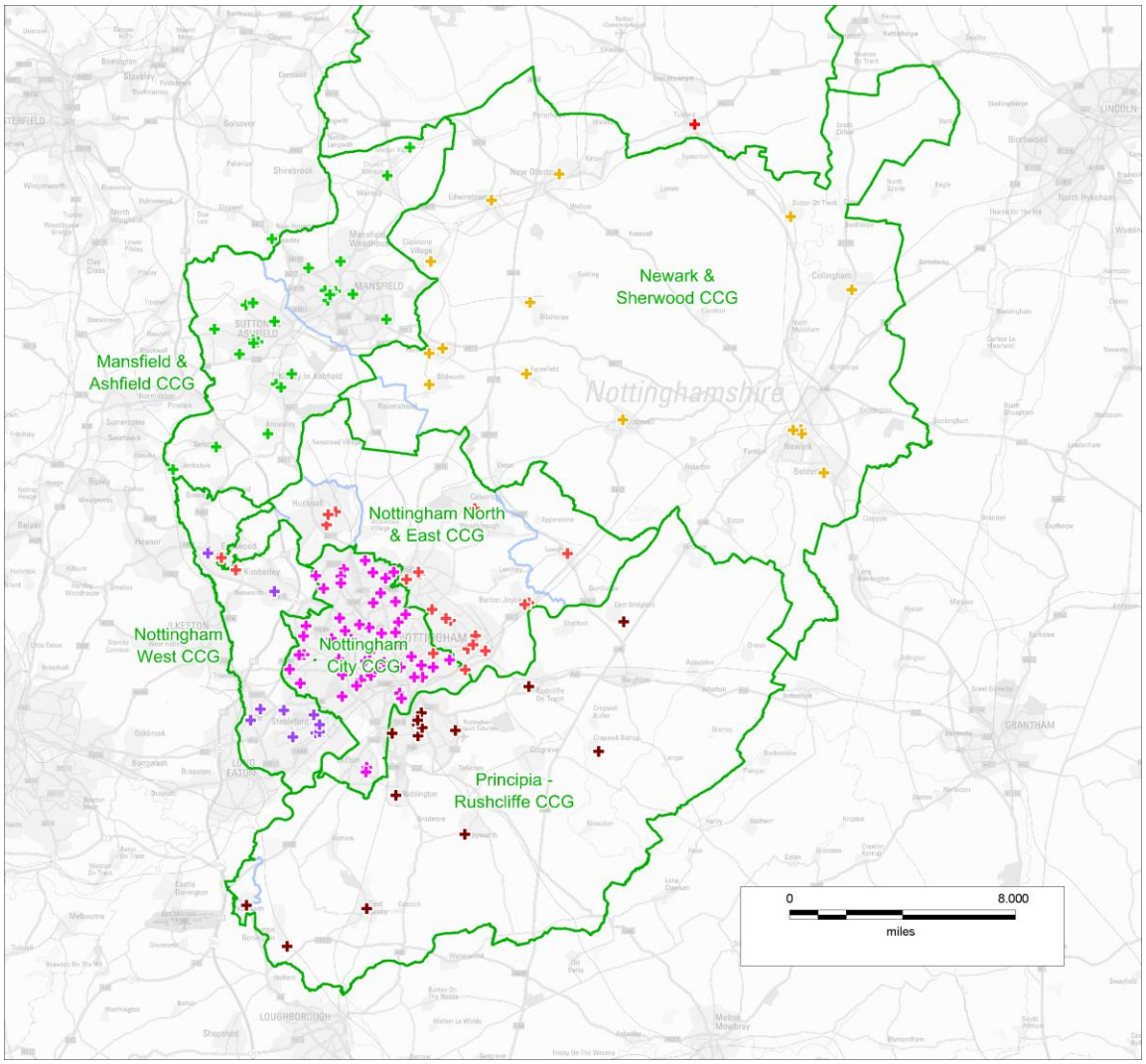


Figure 4: CCGs within the geographical area covered by Nottinghamshire County Council (excluding Bassetlaw)

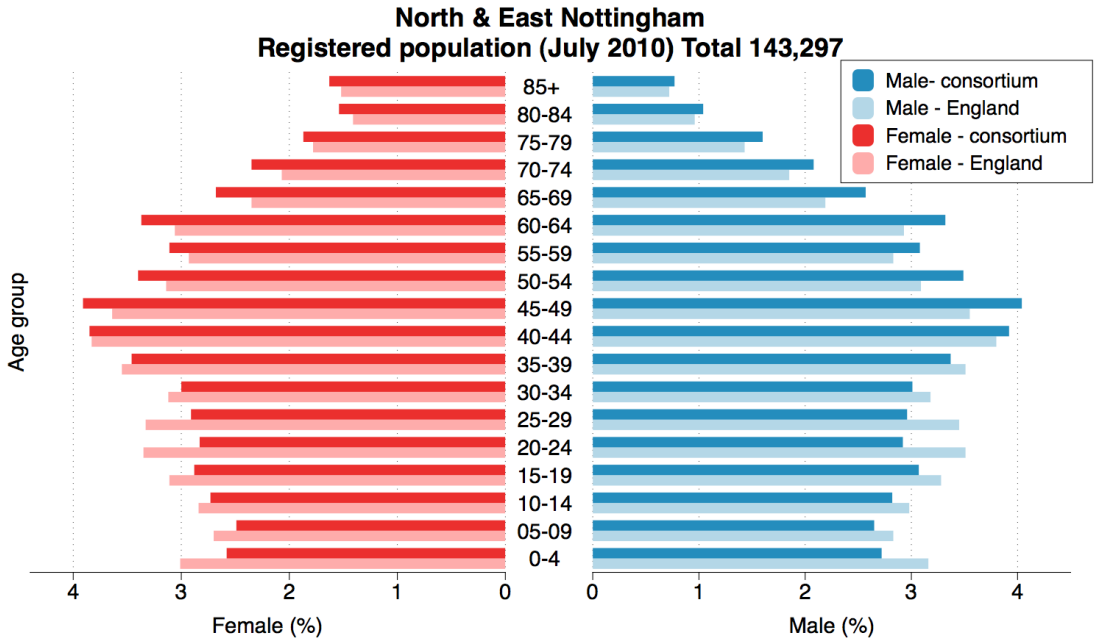


Figure 5: Population age distribution

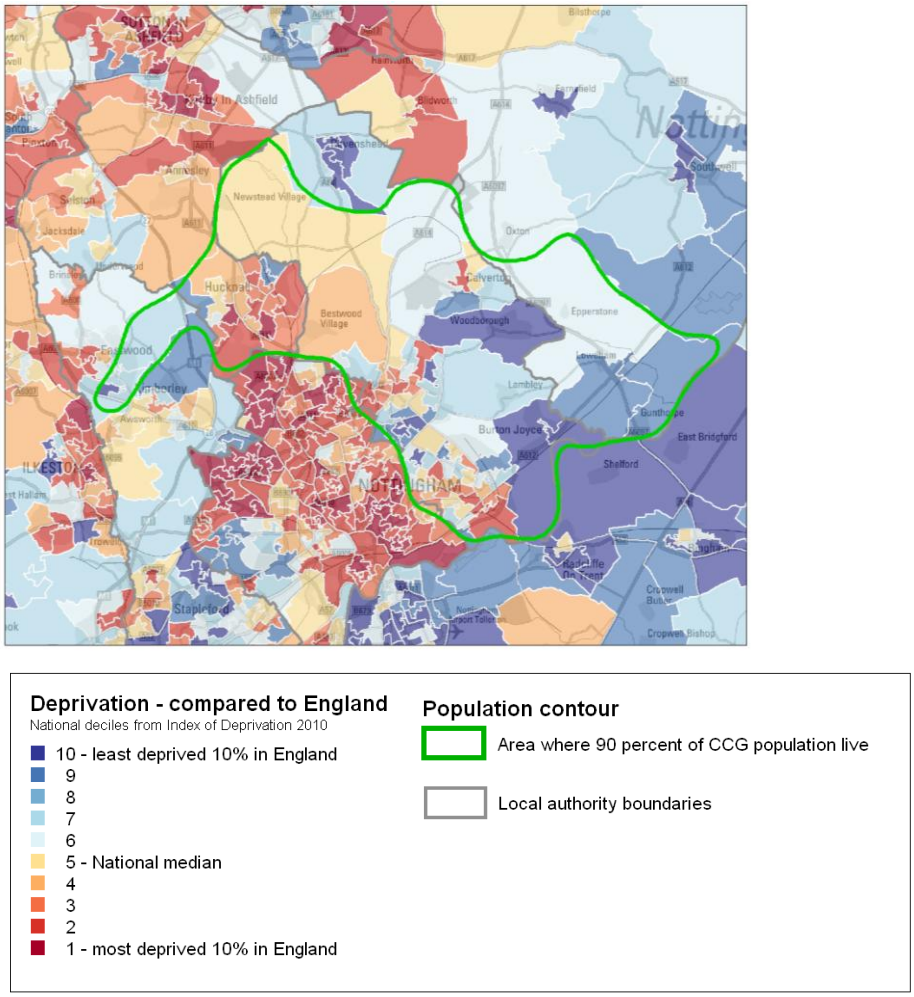


Figure 6: Population Deprivation

Parts of Hucknall, Porchester estate and Netherfield have more deprived populations. Ravenshead, Woodborough and Burton Joyce are among the least deprived in England.

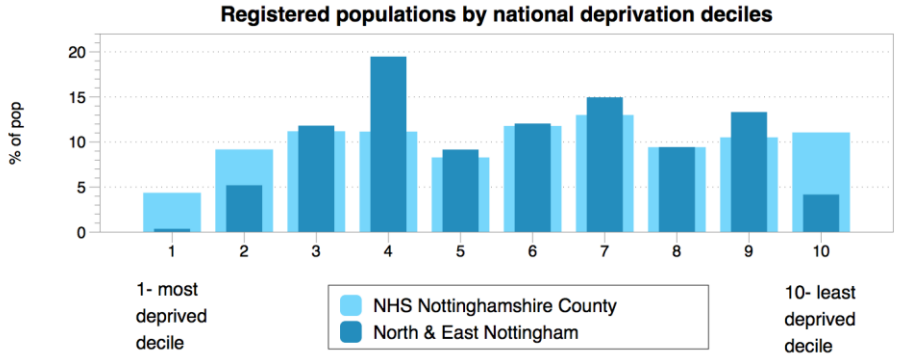


Figure 7: Deprivation levels compared with Nottinghamshire County overall

Nottingham North and East CCG has a spread of levels of deprivation, and has fewer people in the most and least deprived groups compared with the County overall.

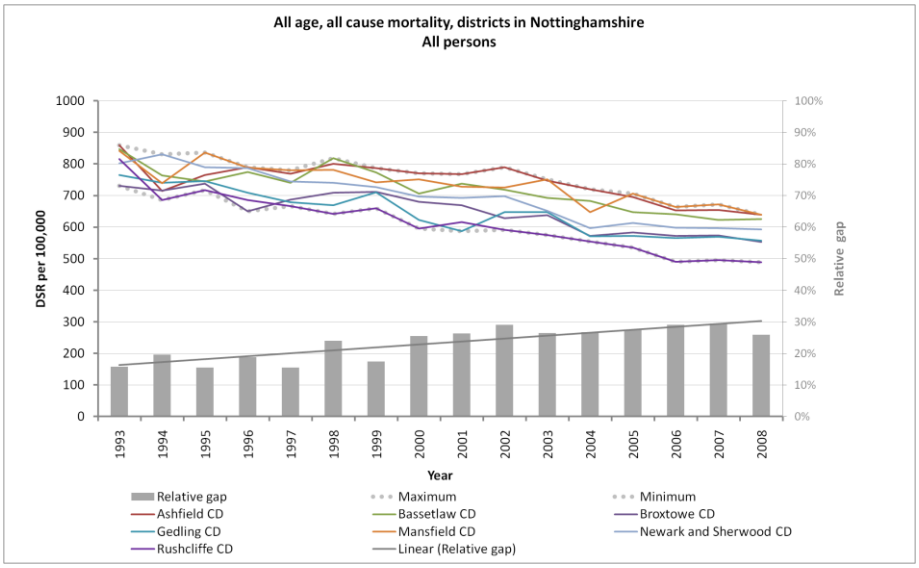
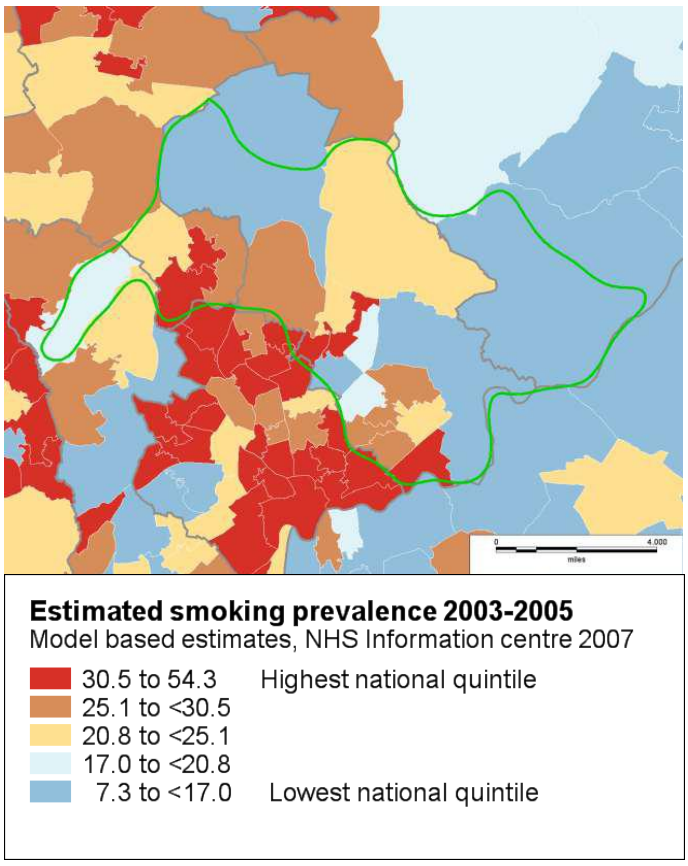


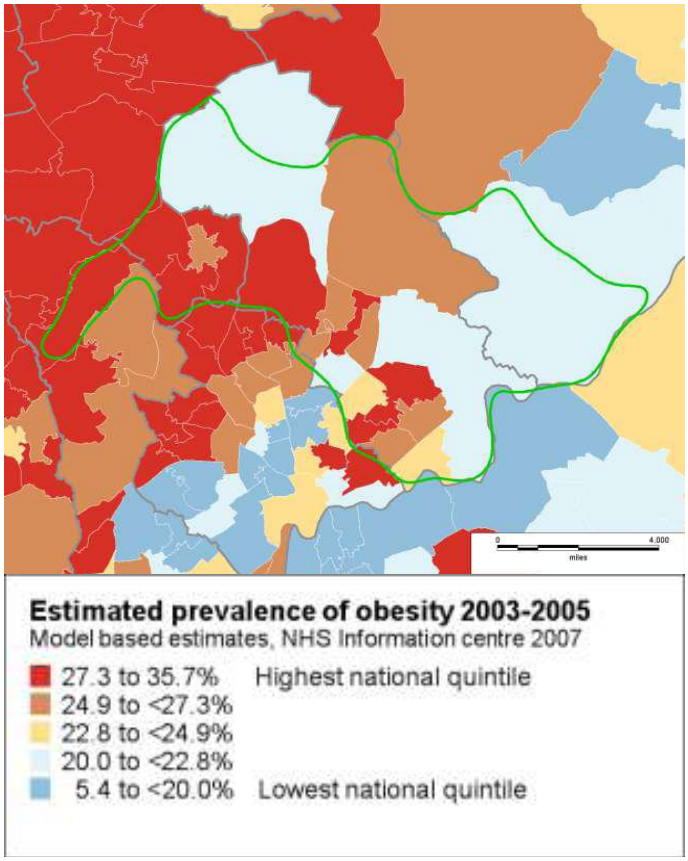
Figure 8: Mortality trend by District

The all age, all cause mortality trend is down but the relative gap is growing wider.



Smoking significantly contributes to top 3 main causes of death and explains 50% of the difference in life expectancy across the County
Smoking prevalence Follows the pattern of deprivation…

Figure 9: Smoking prevalence in Nottinghamshire



…as does obesity prevalence
Large areas of the CCG are expected to have above average adult obesity

Figure 10: Obesity prevalence in Nottinghamshire

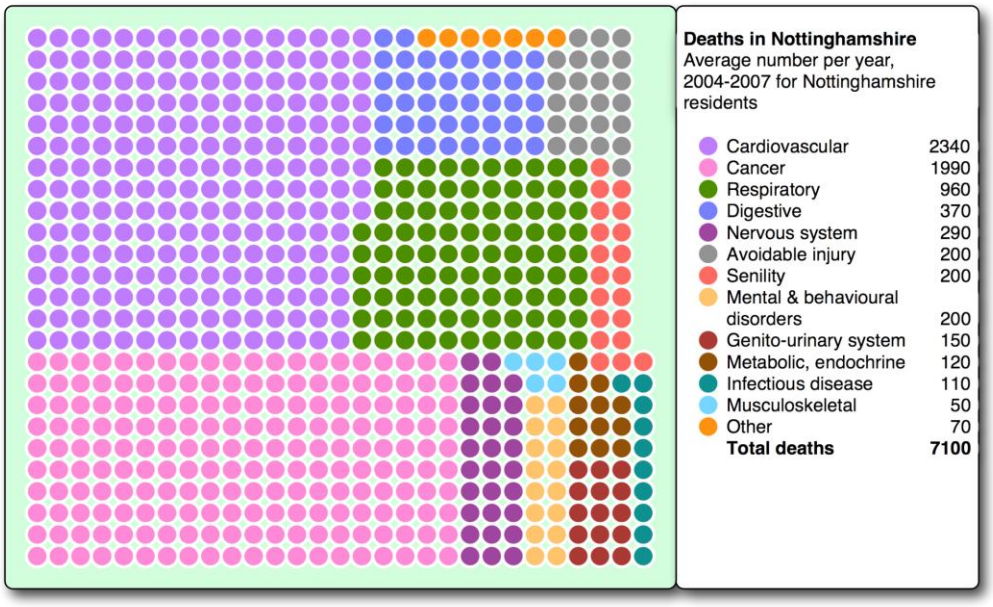
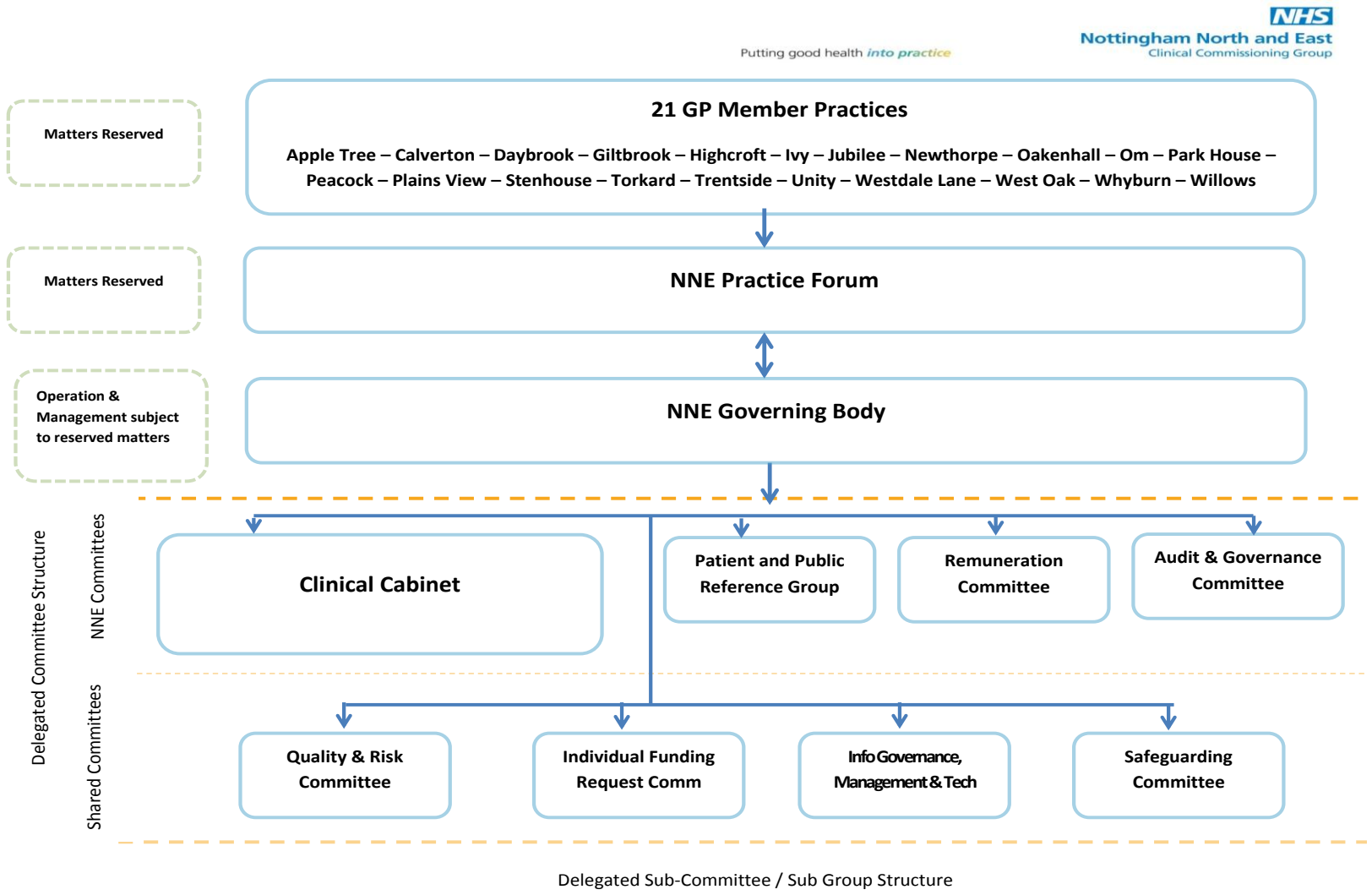


Figure 11: Main causes of death across Nottinghamshire

Each dot represents 10 deaths.

Appendix 2. Revised Governance Structure June 2012



Delegated Sub-Committee / Sub Group Structure

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