GB 14/009

CCG Strategic Outline Commissioning Intentions

2014/2017

A Statement of Intent

NHS Nottingham West Clinical Commissioning Group
NHS Nottingham North and East Clinical Commissioning Group
NHS Nottingham City Clinical Commissioning Group
NHS Newark and Sherwood Clinical Commissioning Group
NHS Mansfield and Ashfield Clinical Commissioning Group
NHS Rushcliffe Clinical Commissioning Group

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VERSION RECORD	

Version	Date	Status	Author	Comment
1	August 2012	Approved	Oliver Newbould	2013/2016 Strategic Outline Commissioning Intentions published.
2	October 2013	Draft	Clare Hopewell	Annual Update
3	November 2013	Draft	Clare Hopewell	Feedback from Oliver Newbould/Vicky Bailey

1. Statement of Strategic Intent to be Developed and Refined

1.1. The purpose of this document is to describe the shared outline commissioning intent for the 6 CCGs currently operating within Nottinghamshire and to outline the mission, values and aims of the CCGs for improving quality. They are designed to be read and understood in the context of our individual CCG plans which focus on the specific health needs of the populations served. The document has been created through dialogue between the CCGs as part of the Collaborative Commissioning Congress and through wider stakeholder engagement both as part of "Call to Action"[1] and a specific provider/commissioner Congress event.

1.2. The title "Strategic Outline Commissioning Intentions" recognises that the document describes the CCGs' commissioning intent for the coming three years, but also that further significant detail will be added as the document develops and national planning guidance is issued. The commissioning intentions described are foremost based on the views of local clinical leaders.

1.3. The timing of this document is intended to provide early signposting to providers as to the themes which are likely to emerge within the 2014/15 contracting cycle and to support integrated planning for the next three years across the whole of the Health and Social Care community.

1.4. The document is broken down into six broad sections:

- A description of the strategic intent of Commissioners
- The Commissioners' principles and approach to delivery
- An overview of the future state of the health economy
- How we intend to commission for quality
- Commissioners' financial assumptions
- Sector specific commissioning intentions.

1.5. The CCGs have well established and clear arrangements to capture the views of a wide range of healthcare professionals including public health, social care and provider services. The Collaborative Commissioning Congress Strategic All-Day Event in September 2013 focused on setting the context in which commissioners were operating and on the agreement of the key transformational priorities for the Nottinghamshire Health Community to inform the Commissioning Intentions and Contract Negotiations.

1.6. The agreed strategic priorities were agreed as:-

- Main focus The Frail Older People System

[1] http://www.england.nhs.uk/2013/07/11/call-to-action/

- Continue Urgent Care Reform
- Alignment of CQUIN (Commissioning for Quality and Information) across providers

1.7. Specifically, the commissioning intentions will be:

- Presented to the Nottinghamshire County and Nottingham City Health and Well Being Boards in draft form in December 2013.
- The subject of patient and public engagement events organised by individual CCGs as part as "Call to Action", the feedback from these being shared at the Collaborative Commissioning Congress in November 2013.
- Shared with providers in draft form in November 2013.
- Used to inform the Health and Social Care community's response to the Integrated Transformation Fund (ITF) and individual CCG Call to Action Plans to be published in March 2014.

1.8. As a result of this process, and following the publication of national planning guidance in the late Autumn/early Winter, the final commissioning intentions, to be issued in January 2014, will form the starting point for the 2014/15 contract negotiations.

2. ***Strategic Commissioning Intent based on the Outcomes Framework and Joint Strategic Needs Assessment (JSNA)***

2.1. The NHS Outcomes Framework 2013/14[2] is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. They focus on:

- Preventing people dying prematurely
- Improving 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

2.2. The Government has built the definition of quality described in the Outcomes Framework into the Health and Social Care Act 2012. The definition frames the proposed new duties on the Secretary of State for Health, the NHS England and our CCGs to act with a view to securing continuous improvement in the quality of services provided to patients.

2.3. Seven principles were established in the NHS Constitution, the NHS belongs to all[3] in March 2013:-

2.3.1. The NHS provides a comprehensive service, available to all.
2.3.2. Access to NHS services is based on clinical need, not an individual's ability to pay.
2.3.3. The NHS aspires to the highest standards of excellence and professionalism.

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213055/121109-NHS-Outcomes-Framework-2013-14.pdf
[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf

2.3.4. The NHS aspires to put patients at the heart of everything it does.
2.3.5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.
2.3.6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
2.3.7. The NHS is accountable to the public, communities and patients that it serves.

These guide the NHS in all it does. This brings in a number of challenges to commissioners not least the one of workforce in terms of recruitment and quality.

2.4. The **continuous improvement in the quality of services** within these domains will remain the key focus of local CCGs. In this context, the term "Quality" is perhaps better described as **Quality, Innovation, Prevention and Productivity** (QIPP) which is the integrated theme of our commissioning intentions. A focus on QIPP is the means by which CCGs will significantly improve services whilst operating in a challenging economic environment. In order to achieve the necessary change, CCGs have agreed a common approach based on five Principles:

2.4.1. **GP Leadership will be at the Heart of Commissioning Innovation**

During the 2012/13 contracting round, many local GPs became actively involved in contract negotiations with providers, and with a wide range of service redesign initiatives. This trend continued in 2013/14 and will continue in 2014/15 with providers being increasingly required to engage with a range of CCG clinicians in the redesign and performance management of local services.

2.4.2. **Commissioning of Services will become Outcome Focussed**

CCGs wish to employ procurement flexibilities to commission services on the basis of outcome, rather than input. This approach will involve all sectors of the local NHS but will primarily focus on services based in the community.

For 2014/15, it is the intentions of CCGs to shadow run a Risk and Reward Integrated Outcome Based Contract for the Frail Older People System which will be supported by non-recurrent monies used to support community care and CQUIN linked to Key Performance Indicators (KPIs). During 2014/15 the Collaborative Commissioning Congress will review, revise and sign-off this model to be implemented live from April 2015.

2.4.3. **Our CCGs will be Proactive rather than Reactive to the need for change**

CCGs wish to develop longer term commissioning strategies that are able to recognise and address the transition issues associated with strategic change and innovation. Reactive investment of non-recurrent support should become a thing of the past and non-recurrent support will be made within a clear strategic context. Investment relating to the JSNA will be clearly demonstrated.

2.4.4. **Our CCGs will continue to focus on the needs of their local populations**

Whilst this document describes a strategic and collaborative approach to commissioning intentions, CCGs will continue to commission services that meet the needs of their own populations. Existing and new service providers will need to be able to adapt generic service offers to meet the local needs of the patient populations served by our CCGs.

Services will only be commissioned from providers at a level that is sustainable and affordable by all CCGs.

2.4.5. **Commissioning Intentions centre on the JSNA**

Addressing and improving the health of the populations serviced by CCGs in Nottinghamshire is their central objective, and this document recognises the key priorities described in Nottinghamshire County's (currently draft and being consulted on) and Nottingham City's (approved June 2013) Health & Well Being Strategies[4] [5]. These are described in Appendix 1 of this document.

The Nottinghamshire County JSNA[6] and Nottingham City JSNA[7] have been produced in line with the Health and Well-being Boards' responsibilities which in turn have been used to agree the priorities to develop these strategies.

In particular, the commissioning intentions are designed to actively promote health, address long-term conditions and reduce health inequality. The specific demographics related to the health needs of each individual CCG are referenced in the JSNA and in detail as part of their plans.

3. ***Strategic Commissioning – So what will be different?***

3.1. The following section describes the local health services to be commissioned over the next three years. The "future state" is described in the context of the NHS Outcomes Framework:

3.1.1. **Preventing people dying prematurely**

Local CCGs will work proactively with the Local Authority and other key stakeholders to address risk factors associated with lifestyle choices (diet, smoking, exercise, alcohol consumption and sexual health). Opportunities to support patients to make healthy lifestyle choices will be taken by all health professionals at all points of care delivery by continuing to promote 'every contact counts.

People with serious mental health problems and learning difficulties are more likely to die prematurely, and through better quality of care these deaths could potentially be avoided. CCGs will work with the Local Authority to improve the care of people suffering from Dementia and will take steps to reduce the gap in life expectancy of people with Learning Difficulties.

3.1.2. **Improving quality of life for people with Long-Term Conditions**

CCGs will place considerable emphasis on the effective management of long-term conditions in the community setting through improved support and advice to patients, their families and carers, and GPs. This will be delivered through improved access to specialist clinical advice and support the community, increased input from community nursing teams, greater use of the voluntary sector and other community services, and

[4] http://www.nottinghamshire.gov.uk/caring/yourhealth/developing-health-services/health-and-wellbeing-board/strategy/
[5] http://www.nottinghamcity.gov.uk/onenottingham/CHttpHandler.ashx?id=44557&p=0
[6] http://www.nottinghamshire.gov.uk/thecouncil/plans/strategydevelopment/joint-strategic-needs-assessment/
[7] http://www.nottinghaminsight.org.uk/insight/jsna/jsna-home.aspx

innovative use of assistive technology (both telehealth & telecare). We will improve self-care and patient responsibility, and reduce dependency on health and social care.

Commissioners will continue to work with local cancer networks to ensure the provision of excellent and accessible cancer treatment delivered in a way that maintains clinical skills.

The impact of these interventions will see a dramatic reduction in the number and severity of relapses experienced by patients, resulting in fewer hospital admissions and fewer beds required for the treatment of patients with common chronic illnesses.

3.1.3 **Helping people to recover from episodes of ill health or following injury**

CCGs and hospital providers will continue to focus on and eradicate avoidable readmissions. These efforts will be supported by a re-audit of hospital readmissions early in each new financial year.

Working in partnership with Social Care and hospital providers, CCGs will develop a new range of services designed to safely and effectively rehabilitate patients in a community setting as soon as is possible after an acute hospital admission. These will include the extension and development of comprehensive geriatric assessment as appropriate.

CCGs will work with hospital and mental health providers to ensure that people admitted to hospital with a pre-existing mental health condition do not experience longer hospital stays than people without those conditions.

These services will increase the need for responsive and comprehensive community, in-reach and outreach services whilst reducing the need for acute hospital beds by reducing the average length of stay for hospital admissions.

3.1.4 **Ensuring that people have a positive experience of care**

Patients and their families and carers within Nottinghamshire and Nottingham City will experience a seamless transition between health and social care services where a transition is required. This will be achieved by far closer integration between practitioners into pathways of care and will support the CCGs' intentions to improve delivery of rehabilitation, long-term conditions, NHS Continuing Care and end of life care. The Ambulance Service will support the integration of care, and will play an increasing role in ensuring patients receive high standards of care without emergency admission to hospital.

CCGs will continue to improve access to clinical services. This will include excellent access to primary care, low waiting times for acute care and locally accessible services for diagnostics and specialist opinion.

Treatment of mental health issues will become more focussed on early intervention and effective treatment and rehabilitation in a community setting, reducing the need for inpatient treatment and rehabilitation. Where more specialised treatment is necessary, this will be provided more locally and more cost effectively than at present with far fewer out of area referrals.

In all sectors, patients will be encouraged to make positive choices about their healthcare and CCGs will increase the number of service providers available where this will have a

positive impact on service quality (including further development of the Any Qualified Provider (AQP) initiative). People receiving NHS Continuing care and some patients with Long-Term Conditions will be able to manage their own healthcare budgets where they wish to do so.

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

Working with care homes, providers of community services and hospital providers, CCGs will develop services to support a significantly greater proportion of people to die at home, when this is their choice at end of life. This will reduce unplanned hospital admissions but will require additional capacity and better integration in community based services.

CCGs will continue to drive up standards of care in all providers, and will use CQUIN flexibilities to incentivise best practice. This will further support the CCGs' intentions to commission services on the basis of outcomes rather than input. There will be continued emphasis on reducing Health Care Acquired Infections, Pressure Sores and Never Events.

3.1 In summary therefore, within three years local health services will see **significantly greater focus on early intervention and treatment in a community setting**, reducing the need for unplanned episodes of care in the acute sector. Where admission to acute care is required, **standards will be universally high** and lengths of stay will be considerably shorter than at present. This will be achieved through a renewed focus on **intensive rehabilitation in a local community setting**. The overall impact on acute bed use will be of the scale suggested by recent utilisation reviews in acute and community wards, where potentially 25% of existing inpatients could be treated in an alternative community setting.

3.2 Hospital, community and social care services will be far **better co-ordinated**, and patients will experience a **seamless transition between care providers**. This process will be supported through deployment of the ITF at a local level. Where possible, patients and their families and carers will be encouraged and supported to make **positive choices about their health** and health services. This will include implementation of the National Information Strategy.

3.3 The net impact of these changes will be a **significant reduction in the volume of general and mental health services commissioned in an acute setting**, but a consequent **growth in community based services**. This transition will be brought about by a range of measures which will include the development of existing community services, transformation of acute sector points of delivery and the introduction of new service providers.

3.4 The future vision of local health and social care services is entirely consistent with and supports the on-going work of the **Strategy & Implementation Group for Notts South (SIGNS)** in the South of the County and the **Mid Nottinghamshire Integrated Care Transformational Programme** in the North of the County and the strategic plans for **Urgent Care Reform**. This vision is strongly supportive of **Promoting Integration across Partners** as described by the Nottingham City and Nottinghamshire Health and Wellbeing Strategies. Sir David Nicholson's letter 10th October 2013[8] also supports this vision and states that the Integrated Transformational

[8] http://www.england.nhs.uk/wp-content/uploads/2013/10/david-letter-comm.pdf

Fund will be a "game changer" creating a substantial ring-fenced budget for investment in out-of-hospital care.

4 How we Intend to Commission for Quality

4.1 Commissioning is a tool for ensuring high quality, cost–effective care. Quality is a key thread through the work undertaken by our CCGs. The development of a shared quality framework across our CCGs makes explicit our commitment to quality. The mission is to improve quality by delivering improved safety, effectiveness of services and improved patient experience.

4.2 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 that define Quality are:

- **Patient Safety** - that the NHS do no harm to patients, ensuring the environment is safe and clean, reducing avoidable harm.
- **Patient Experience** - how personal the care is – the compassion, dignity and respect with which patients are treated.
- **Clinical Effectiveness** - understanding success rates from different treatments for different conditions including clinical measures, complication rates and measures of clinical improvement.

4.3 To achieve this:

- Clinical teams and commissioners need to understand the quality of service they are providing to patients through a system of measurement and benchmarking;
- Our CCGs will continue to 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 we are proactively engaging with patients and the public to understand their concerns.

4.4 To support partnership working, commissioners during 2014/15 intend to align a number of CQUINs across providers where CQUIN can only be accessed in collaboration and can not be awarded individually. The key areas being developed are the management of falls, data sharing and transfers of care.

4.5 Providers will continue to be 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.

4.6 The last decade has seen a number of key publications that have informed and shaped the patient safety agenda (should we make reference to Francis, Keogh, and Berwick? – Cheryl's query?). Patient safety includes:

4.7 **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" NHS Commissioning Board 2013.

4.8 **CCGs take responsibility for safeguarding children and vulnerable adults**
Clinical Commissioning Groups: -

a) Will identify a strategic Governing Body lead for safeguarding children and young people and vulnerable adults, to promote their needs across service planning and delivery.
b) Will comply with S10 and S11 of the Children Act 2004 and any subsequent statutory guidance relating to vulnerable groups.
c) Will co-operate with the Local Authority in the operation of the Local Safeguarding Children Board and the Safeguarding Adults Board
d) Will promote the commissioning of services which prioritise the safety and welfare of children and vulnerable adults through local partnership arrangements and discharge their functions having regard to the need to safeguard and promote the welfare of vulnerable individuals.
e) Will promote the planning and provision of a range of safeguarding training to enable staff to recognise and report safeguarding issues.

4.9 **Nottinghamshire Multi-Agency Safeguarding Hub (MASH):** All our County CCGs have committed to support the Nottinghamshire Multi-Agency Safeguarding Hub. 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.

4.10 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.

4.11 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.

4.12 **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' (known as the Hygiene Code). The Code provides the core essential elements that a healthcare organisation must meet in order to be registered with the Care Quality Commission. Commissioners continually monitor provider compliance against the 'Hygiene Code'.

4.13 **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. These will be used to systematically 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 across the organisation;

4.14 **Patient Experience:** Patient experience information enables our CCGs to understand what it does well and identify areas for improvement. Triangulation of data from complaints, compliments, stories and patient satisfaction surveys will continue to help us understand how the services it commissions can be improved. Further intelligence is obtained from Patient Groups and feedback of patient stories from practice staff. Patient stories help 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 Local Health watch and the local authorities provide further intelligence which is shared with CCGs.

4.15 **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. Key areas where quality will continue to drive commissioning include:

- Further quality standards will be built into service specifications and contract quality schedules;
- Quality will remain an integral aspect of clinical referral thresholds for secondary care;
- Commissioning for Quality and Innovation (CQUIN) scheme and contract quality schedules will remain closely aligned with the CCGs' strategic initiatives;

- Providers will be held to account for quality through regular quality scrutiny panels;

4.16 **A Commitment to Research:** CCGs will continue to promote and support clinical research within the health and social care community as has been successfully done for years. Research and evidence based best practice will continue to inform the development of service improvement plans and will be used to support the intelligent deployment of non recurrent resources (such as the Transformation Fund) to achieve lasting benefit.

5 *A Difficult Economic Outlook – Commissioners' Financial Assumptions*

5.1 CCGs' Commissioning Intentions are set in the context of a continuing challenging economic environment. In line with Call to Action, "we must anticipate the challenges of the future if we are to improve quality and performance of current NHS Services to live up to the high expectations of service users and the public". CCGs recognise that robust financial planning is a key factor to delivery of this challenge.

5.2 For the purposes of this document, it is assumed in the base-case that local CCGs will receive 2% growth funding from 2014/15 & 2015/16 and 1% growth funding for 2016/17 which will fund recurrent pressure from 2013/14 and the creation of funds in readiness for the Integrated Transformation Fund. Therefore from 2014/15 onwards increases in demographic demands and expectations and the requirements of national policy/Operating Framework will have to be funded through QIPP delivery.

5.3 The inflation assumptions for the three years are shown below in the table at 5.10 with Payments By Results(PBR) and non-PBR net tariff uplift being expected at (1.3%) for 2014/15 and (1%) for the two years thereafter.

5.4 It is also assumed that CCGs will again be asked to create a 2% non-recurrent Transformational to only be deployed non-recurrently and in accordance with the CCGs' Commissioning Intentions.

5.5 Acceleration towards the requirement for £20bn of efficiency savings by 2015 from the NHS nationally will mean that the Nottinghamshire health economy will have to accelerate change locally and that better clinical engagement and innovation will be needed.

5.6 The common underlying priority for the 2014/15 Commissioning Intentions remains the recurrent delivery of financial savings associated with QIPP programmes and continued delivery of quality: all negotiations with providers must be set squarely within this context.

5.7 Specifically, any planned savings not delivered during 2013/14, or any non-recurrent delivery must be made good in 2014/15 and any new investment can only be achieved in the context of transformation that reduces expenditure elsewhere in the health economy. The financial situation in Nottinghamshire forces service transformation pace and urgency.

5.8 CCGs in Nottinghamshire are committed to a clinically-led approach to service commissioning involving patients and carers. Building on the 2013/14 contract negotiations, local CCG clinicians will be asked to continue to engage with provider clinicians to develop Improvement Goals for the coming year that link finance, performance, information and activity.

5.9 The development of new quality and outcome measures will be a feature of the forthcoming contract round. CCG lead clinicians will play a central role in the 2014/15 contract negotiations and will sign off all final agreements.

5.10 The Nottinghamshire CCGs have developed key planning assumptions that may need to be revised once the NHS England Planning Guidance is published. These assumptions have been fed into 3-year financial plans from 2014/15 to 2016/17 for CCGs, developed using the following base case inflation planning assumptions:

	2014/15	2015/16	2016/17
Allocation Growth	2%	2%	1%
Demographic Growth excluding Continuing Care	2%	2%	2%
Demographic Growth – Continuing Care	3%	2%	2%
Service Level Agreements (SLAs) –CQUIN	2.5%	2.5%	2.5%
<u>Uplift Assumptions</u>			
SLAs – Net Tariff	(1.3%)	(1.0%)	(1.0%)
Management & Admin – Inflation	2%	2%	2%
Prescribing - Inflation	0%	0%	0%
Continuing Care	0%	0%	0%

5.11 Combining the funding growth assumptions from 2014/15 onwards with the anticipated continued growth in activity, which will also impact on other areas of spend, means that the financial outlook is very challenging. There will be insufficient resources available to meet the investment requirements to allow CCGs to focus on prevention and quality and continue to meet increasing demands. Delivery of recurrent Quality, Innovation, Prevention and Productivity (QIPP) savings, therefore, is essential for the on-going financial balance of the CCGs and for delivery of the organisation's strategic objectives.

5.12 The required level of savings to be delivered in total through cost improvements and improving QIPP have been identified. The table below shows the QIPP target over the life of the Plan, based on current planning assumptions and organisational structure. Once CCG allocations have been confirmed for 2014/15 and 2015/16 with the planning guidance, organisation-specific Resource Limit and QIPP targets will be identified. There will be differential QIPP targets across organisations, reflecting the relative allocations, distance from target and expenditure plans.

Nottinghamshire CCGs' Resource Limits and QIPP Targets 2014/15 to 2016/17

2014/15

CCG	Notts City	Mansfield & Ashfield	Newark & Sherwood	Nottingham North & East	Nottingham West	Rushcliffe	TOTAL
Resource Limit	£TBC	£TBC	£TBC	£TBC	£TBC	£TBC	£TBC
QIPP Requirement	£TBC	£TBC	£TBC	£TBC	£TBC	£TBC	£TBC
% of total Resources	TBC	TBC	TBC	TBC	TBC	TBC	TBC

2015/16

CCG	Notts City	Mansfield & Ashfield	Newark & Sherwood	Nottingham North & East	Nottingham West	Rushcliffe	TOTAL
Resource Limit	£TBC	£TBC	£TBC	£TBC	£TBC	£TBC	£TBC
QIPP Requirement	£TBC	£TBC	£TBC	£TBC	£TBC	£TBC	£TBC
% of total Resources	TBC	TBC	TBC	TBC	TBC	TBC	TBC

2016/17

CCG	Notts City	Mansfield & Ashfield	Newark & Sherwood	Nottingham North & East	Nottingham West	Rushcliffe	TOTAL
Resource Limit	£TBC	£TBC	£TBC	£TBC	£TBC	£TBC	£TBC
QIPP Requirement	£TBC	£TBC	£TBC	£TBC	£TBC	£TBC	£TBC
% of total Resources	TBC	TBC	TBC	TBC	TBC	TBC	TBC

6 *Strategic Commissioning – Specific Implications for Health and Social Care Sectors*

The following sections describe CCG outline commissioning intentions for different sectors of the heath economy.

6.1 **Acute Hospital Services**

6.1.3 **Reduce Unnecessary Referrals -** For both planned and unplanned pathways of care, we will improve access to ambulatory care, advice and guidance and consultant triage to ensure that only patients who need secondary care intervention will receive it. Primary and community clinicians will continue to monitor referrals to secondary care and take steps to reduce them where clinically appropriate. It is anticipated that this will reduce the level of investment growth in the acute sector in comparison to previous years.

6.1.4 **Improved Discharge Planning and Communication** - CCGs will seek to improve the quality, content and timeliness of discharge and clinical letters, specifically Accident & Emergency discharge communication and co-ordination with Out of Hours (OOH) services. It is our intention to work towards the patients spell Healthcare Resource Group being included on the discharge/clinical letter.

6.1.5 **Commissioning For Outcomes –** As outlined in the commissioning principles outlined above, we will focus contracting on commissioning improved outcomes for frail older people patients.

6.1.6 **Reduced Hospital Stays** – CCGs will continue to develop services in conjunction with Local Authorities that reduce delayed discharges and which actively promote early discharge through community based rehabilitation. The length of stay for people admitted to hospital for medical treatment but who also have mental illness or learning difficulties will be brought in line with

other people admitted for medical conditions. In order to support these schemes, we will continue to explore opportunities to reduce readmissions and to split/unbundle national tariffs.

6.1.7 **Financial Viability through Change** – As the Health Community works to reduce the overall size of the acute hospital sector, we will continue to maintain the financial viability of the local acute trusts by jointly developing and agreeing sustainable strategic models of service. This will include:

- Sensitively and intelligently supporting large scale and nationally prescribed strategic pathway initiatives in services such as stroke, pathology, vascular and major trauma.
- QIPP plans that as best as possible align the delivery of QIPP and the Trusts Cost Improvement Programme (CIP).
- Supporting non-recurrent funding proposals required to pump prime delivery of the agreed QIPP/CIP programme

6.2 **Community Services**

6.2.3 **Improving data, information and outcome measures** - CCGs will work with community service providers to develop appropriate performance metrics and outcome measures to ensure the effort in community services to deliver QIPP gains can be identified and incentivised.

6.2.4 **Reducing Avoidable Hospital Admissions -** There will be growth in community services to enable them to play a vital role in reducing secondary care utilization, in particular avoidable admissions into hospital. Services will be redesigned and new services developed alongside a review of funding flows to ensure appropriate investment. Access issues will be reviewed in order to ensure the most appropriate flexible service response is available including rapid response times and extended or out of hours service availability.

6.2.5 **Developing new community service models -** CCGs will work with community providers to explore different ways of working with a QIPP focus supporting early identification and intervention. In particular CCGs want to develop and embed the use of predictive modelling and assistive technology into services for older people and people with long-term conditions. CCGs will also improve access to and capacity of services for people at the end of their lives.

6.2.6 It will be a priority to improve access and co-ordination of services, in particular reducing fragmentation and duplication in service delivery for both adults and children with complex needs. Personal health budgets will be introduced to support individual tailored service responses for adults or children with complex and continuing care needs. CCGs will look to split/unbundle national tariffs to develop community based rehabilitation across the spectrum of Long-term and musculoskeletal conditions.

6.2.7 **Joint Commissioning -** It will also be important during 2014/15 to continue to ensure that services do not become fragmented as a result of the move of commissioning responsibility to either the Local Authority or NHS England. Therefore whilst needing to develop a better interface between different community providers, including social care, we will also do the same across commissioners to maximise joint commissioning opportunities, reduce fragmentation and improve quality and efficiency across specific pathways.

6.3 **Mental Health Services**

6.3.3 **Dementia –** Commissioners will continue to work with providers to support the early diagnosis of dementia, enabling primary and secondary health and care services to anticipate needs, and for people living with dementia, plan and deliver personalised care plans and integrated services, thereby improving outcomes.

6.3.4 **High quality service provision in Secondary Care -** Reviewing community based services to ensure they adhere to local and national guidelines. Optimising service delivery in primary care and intervening early to manage and reduce the requirement for in-patient admissions.

6.3.5 **Delayed Transfers of Care (DTOC) -** Focus on reducing DTOC by working with our providers and partners across the Health and Social Care system to facilitate safe discharge from hospital. Leading to a reduction in unnecessary lengths of stay and improving patient outcomes.

6.3.6 **Out of Area Treatments -** Following on from previous year's progress commissioners will continue to target a reduction in the number of patients sent out of area for specialist individual placements; by working closely with Health and Social Care colleagues to develop local facilities and services to enable step down and by ensuring the pathway into specialist placements is tightly managed.

6.3.7 **Inpatient Rehabilitation -** The recommendations from the Mental Health Utilisation Review will be implemented helping to redesign the local pathway and enabling timely discharge from hospital and a focus on recovery.

6.3.8 **Learning Disabilities, Secondary Care -** Following the interim Department of Health report which was a consequence of the investigation into Winterbourne View, during 2014/15 we will continue to review the Learning Disability Assessment and Treatment Units and Community Assessment and Treatment Teams and independent sector providers of individual placements. Our review will consider increasing assessment and treatment in the community and avoiding hospital provision.

6.3.9 **Physical Health -** In-line with the Mental Health Strategy (2011) we will continue to work with providers to implement processes that improve the physical health of patients accessing mental health services.

6.3.10 **Primary Care psychological Therapies -** Any Qualified Provider for Primary Care Psychological Therapies was implemented during 2012 and during the 2013/14 the AQP will be re-opened to any other providers. The introduction of new providers into the market will be managed to ensure specified outcomes are achieved. Work will be undertaken with primary care colleagues to promote patient choice within this service to ensure users are given the opportunity to select a provider that best suits their individual needs.

6.4 **Ambulance Services**

6.4.3 **Response Times** – We will continue to monitor and improve response times to requests for ambulance services, working with the local Ambulance Trust to improve services and to reduce the number of avoidable or inappropriate urgent requests from members of the public and local clinicians.

Supporting Care in a Community Setting – We will continue to work with service providers to develop patient pathways and procedures that avoid preventable journeys to hospital. This will include better integration with community based services, strengthening input into health community change programmes (such as the frail elderly programme) and a focus on improved end of life management.

Appendix 1 – Health & Wellbeing Priority Areas

Nottingham City Joint Health and Wellbeing Strategy Priority Areas are to:

- Prevent **alcohol misuse** to reduce the number of citizens who develop alcohol-related diseases.
- Provide more **integrated health and social care services** that will ensure a better experience of care is offered to older people and those with long-term conditions.
- Intervene earlier to increase the number of citizens with **good mental health**.
- Support **priority families** to get into work, improve their school attendance and reduce their levels of anti-social behaviour and youth offending.

Nottinghamshire County Joint Health and Wellbeing Strategy Priority Areas are:

- **Prevention: Behaviour Change and Social Attitudes –** smoking, obesity, drugs and alcohol, and sexual health.
- **Children, Young People and Families –** proposed health and wellbeing areas include integrated children's services for health and wellbeing, early help services, support for children with complex needs or disabilities, and safeguarding.
- **Adult and Health Inequality Priorities –** carers, physical disability and sensory Impairment (Long-Term Conditions), mental health and emotional wellbeing, older people, dementia, learning disability, Autistic Spectrum Disorders.
- **The Wider Determinants of Health and Wellbeing** – community safety and violence – domestic violence and healthy environments in which to live, work and play – housing.