NHS
Nottingham North and East
Clinical Commissioning Group

Commissioning Plan 2014/15 - 2015/16

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Putting good health *into practice*

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Foreword

Welcome to Nottingham North and East Clinical Commissioning Group's Commissioning Plan for 2014/15 – 2015/16.

Nottingham North and East Clinical Commissioning Group (NNE CCG) is an ambitious, innovative, confident and dynamic NHS organisation. The CCG is responsible for planning and buying NHS services and ensuring the quality of local healthcare for a patient population of approximately 147,000. The CCG covers a wide geographical area stretching from Newthorpe in the west to Lowdham in the east, with its patient population mainly being based within the Gedling and Hucknall areas. With greater local control of decision-making the CCG is already delivering better outcomes for patients, improved services, and effective public participation and involvement.

The CCG aims to improve the health of the community, reduce health inequalities, secure the provision of safe, high quality services, and achieve financial balance and value for money. This Commissioning Plan 2014/15 – 2015/16 sets out what the CCG plans to deliver in the first two years of implementation of its longer term five year strategic vision, informed throughout by robust and on-going public and patient engagement.

Key to this is the statutory requirement placed on the CCG to achieve financial balance and for 2014/15 – 2015/16 this poses an increasing and significant challenge.

We thank you for reading this Commissioning Plan and would welcome any feedback you may have. We hope you will wish to support us in the delivery of our vision to improve the health of our population and to help our work to shape the delivery of health care services for the population of Nottingham North and East.

Dr Paul Oliver, Chair

Samantha Walters, Chief Officer

1. Introduction

NHS Nottingham North and East Clinical Commissioning Group (NNE CCG) has been a statutory NHS organisation, responsible for commissioning health services for the population covered by the CCG area, since 1 April 2013. The CCG is led by general practitioners using their knowledge and understanding of patients' needs, with the key principles of putting patients at the centre of the NHS and focussing on clinical outcomes. Pivotal to the success of the CCG is the requirement to continuously improve the quality and safety of care whilst ensuring that the available healthcare resources are used as effectively and efficiently as possible. This is at a time when the CCG, along with the wider NHS, is facing a significant financial challenge.

This document sets out Nottingham North and East CCG's commissioning plans and priorities for 2014/15 – 2015/16.

1.1. What is NHS Nottingham North and East Clinical Commissioning Group?

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 147,000, 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 GP Practices that make up the CCG are organised into three localities as follows:

Locality Group 1

- Oakenhall Medical Practice, Hucknall
- Om Surgery, Hucknall
- Whyburn Medical Practice, Hucknall
- Torkard Hill Medical Centre, Hucknall
- Giltbrook Surgery, Giltbrook
- Newthorpe Medical Practice, Eastwood

Locality Group 2

- Calverton Practice
- Stenhouse Medical Centre, Arnold
- Daybrook Medical Centre
- Jubilee Practice
- Apple Tree Medical Practice, Burton Joyce
- Highcroft Surgery, Arnold
- The Ivy Medical Group

Locality Group 3

- The Willows Medical Centre, Carlton
- Peacock Healthcare, Carlton
- Trentside Medical Group (Netherfield & Colwick Vale)
- Unity Surgery, Mapperley
- West Oak Surgery, Mapperley
- Westdale Lane Surgery, Mapperley
- Plains View Surgery, Mapperley
- Park House Medical Centre, Carlton

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

H **onesty**, openness and integrity are central to everything we do

E **mpowering** and communicating with our patient community

A **ppropriate** use of our resources to deliver best value

L **eadership** that is strong and visible

T **ogether** with our partners, strive to improve the health of our community

H **igh quality** is our standard

1.2. Our aims

NNE CCG's aims reflect its population profile and groups with the greatest need, whilst also ensuring that focus on the wider population is maintained.

For 2014/15 – 2015/16, 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
- 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.

1.3. Our business model

Our business model covers our strategic objectives, priorities and the components utilised to organise the deliverables for our commissioning plan.

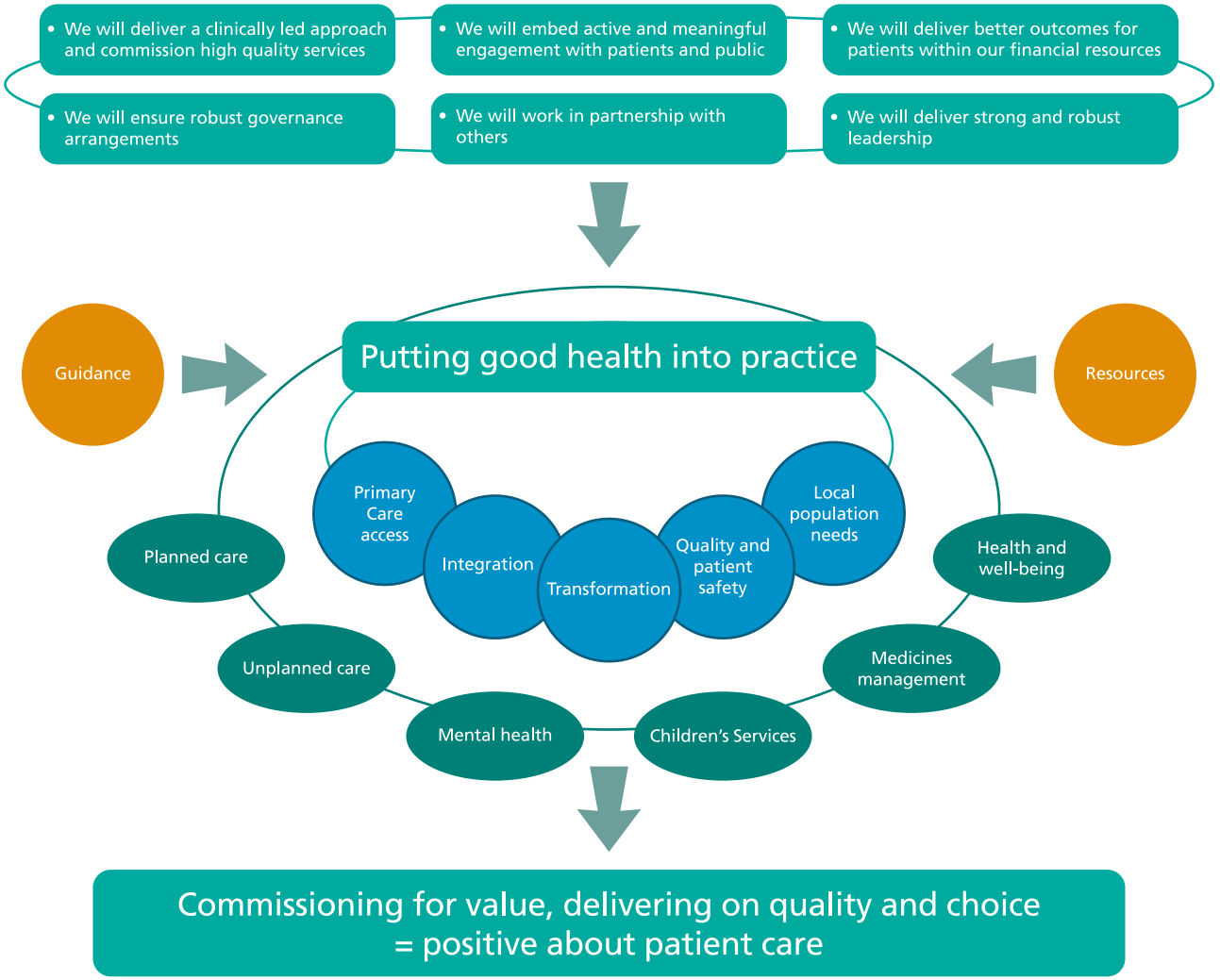

Figure 1: Our business model

1.4. Our strategy for primary care

The CCG is currently developing and refining its Primary Care Development Strategy for the next five years. The CCG's vision is to have sustainable primary care that delivers high quality, efficient, and accessible primary care that is clinically effective for its patient population. One of the key elements of this will be to improve quality in primary care, where quality is expressed in terms of three core areas; patient safety, patient experience and effectiveness of care. Where appropriate, innovation, new technologies, and new ways of working will be embraced to enable the delivery of the above. Continuous improvement will be supported through education and peer support.

Some of the key principles of the CCG's approach to the on-going development of primary care are:

- Ensuring primary care provision and access across the CCG matches the needs of the population and is available for everyone
- Encouraging innovative ways of working and sharing examples of good practice.
- Development of a workforce with the capability and capacity to deliver high quality care and work in different ways to meet increasing demand
- Collaborative working across the whole health care system including other primary care providers, secondary care, community care 3rd sector, out of hours medical services, ambulance and 111 services and patients
- Development of systems, processes and pathways that will ensure effective and efficient working not only within organisations but also between organisations
- Effective use of financial resources to ensure value for money and sustainability for the future

- Information Management and technology systems that make best use of current technology to enable efficient and effective working and shared information

During 2014/15 – 2015/16 a key focus for the CCG will be to test a GP same day/urgent care pilot as part of the Prime Minister's Challenge Fund aimed at improving the patient experience, reducing hospital admissions, improving access to services, and 'freeing-up' GP time to focus on case management of people with long-term conditions.

In addition the CCG will work collaboratively with GP practices to:

- reduce unwarranted clinical variation
- reduce variation in patient outcomes
- reduce variation in patient experience
- address health inequalities
- promote prevention and self-management
- support and deliver care closer to home
- support reduction in the number of unnecessary hospital admissions
- support patients to not remain in hospital for longer than necessary
- ensure that services are fully accessible.

In order to deliver against its Primary Care Development Strategy the CCG will work closely with the NHS England Derbyshire and Nottinghamshire Area Team (AT), as it is recognised that it will not be possible for either organisation to implement the necessary changes in primary care by working independently. The CCG has therefore identified a number of areas for which the AT has responsibility, but with which the CCG would wish to work collaboratively with the AT to make the necessary changes. These are identified as 'enablers' and include the following:

- Development of premises that will enhance patient experience and which have capacity to meet growing demand and suitable to accommodate integrated services
- Contractual arrangements, levers, and flexibilities
- Education and training

A copy of the CCG's Primary Care Development Strategy is available on request.

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 Borough, Ashfield district, Broxtowe Borough, Nottingham City, and Newark and Sherwood District. 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 has established 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 pop'n
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 1: Population of NNE CCG by Local authority area

Compared with other areas in England, the population of Nottingham North and East CCG has a higher percentage of both men and women aged 45 and older, and a lower percentage aged less than 30.

The registered population of NNE CCG in April 2014 is 147,700 (HSCIC). This is projected to grow by 8.6% by 2025, to 161,000 (Based on ONS projections for Gedling, Ashfield, and Broxtowe).

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 see 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 86,500 adults aged 20-64 registered with GP practices in NNE CCG in April 2014 (HSCIC). Based on the projected population growth described above, this is expected to grow to nearly 90,000 by 2025.

19.6% of the registered population of NNE CCG is over the age of 65 years (HSCIC April 2014), higher than the average across all South Nottinghamshire CCGs (including Nottingham City) of 15.6%. An increase of 18% is expected in the older population by 2025, rising from 28,900 to 34,800 people aged 65 or older, particularly in the 75-79 age group, and with a greater number of females than males (18,800 and 16,000 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

Nottingham North and East CCG has reviewed the Nottinghamshire Joint Strategic Needs Assessment (JSNA) 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.

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.

2.2.2. Key health issues

Long term conditions

The prevalence of long term conditions among adults is similar to the national average. In NNE 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 NNE 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.

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.

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 1,300 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%).

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).

Immunisation and vaccinations

NNE 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%. NNE CCG 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%).

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.

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. 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, NNE 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. What our patients are telling us

The views and comments of patients and the public are very important to NNE CCG. During 2013/14 we enhanced our processes and strengthened our relationships with the local community in order to ensure that we were listening and acting on patient and carer feedback at all stages of the commissioning cycle. As a result, the feedback we have received has directly informed the decisions that have been made.

The CCG also welcomed the opportunity to take forward the Call to Action agenda alongside the national events. Call to Action provided the framework to gain feedback on the key issues faced by patients and carers and to understand how they felt their NHS could be improved going forward. The feedback has been instrumental in informing the plans and strategies for the CCG. The key messages that came out of the Call to Action include the following:

- The vision in order to meet the challenges of the future includes patients taking greater control over their own health, through an emphasis on education and prevention and improved self-management. There is a clear shift towards individuals taking responsibility for their own health.
- Patients and the public support more care in the community, and recognise the benefits in integrated care and partnership working.
- Improved access in primary care is crucial.
- Values can be maintained by focusing on dignity, respect and compassion as key outcomes, whilst maintaining the current waiting times.
- It is important to reduce complexity in the NHS and use resources efficiently.

In addition, NNE CCG carried out Voice for Health events which provided patients and carers with more information on the way forward and the structure and priorities of the CCG. Alongside the key themes mentioned above, feedback during these events demonstrated the importance of having the right services locally, partnership working, ensuring people know who to contact to raise concerns and comments, and ensuring that the senior leadership at the CCG were accessible and listening.

Specific engagement activities were carried out relevant to service changes. These were tailored according to the type of information required, the type of condition, illness or treatment, the target audience, and proportionality in relation to patient and/or financial impact. Below are some examples of engagement activities and how the information has directly influenced the decisions taken.

1. At a Voice for Health event, strong feedback was received on the need to ensure that mental health is a priority area and that there are adequate services in the community.

   NNE CCG organised a mental health workshop for patients and carers where providers presented the local services and received feedback on any issues patients had. Patients felt further informed of the services available and concerns were either addressed during the workshop or a separate meeting was arranged.

2. At a Voice for Health event, GP access was raised in relation to both urgent appointments and seeing a named GP for an on-going condition.

   In receiving the strong feedback in relation to both urgent appointments and effective case management, NNE CCG developed the urgent care model for piloting. The urgent care model provides easier access for urgent appointments, providing GPs with more time for case management.

3. NNE CCG held an event on diabetes care, which was also attended by Diabetes UK. The event provided the feedback that patients would like more education and understanding of their condition in order that they could manage their lifestyle accordingly.

   Individuals at the event strongly supported the 'Juggle' programme, and, as such, the CCG have committed to increasing awareness and attendance. Additional funding will be provided in order to accommodate further sessions.

4. The CCG held an engagement exercise on support for patients when discharged from hospital. Feedback strongly supported a non-clinical service that ensures the patient and carer have everything needed following their discharge from hospital.

   Following the feedback, NNE CCG continued to commission the Home from Hospital service.

5. At an NNE CCG working group on dementia, carers fed back that they would appreciate a comprehensive pack of information detailing the different services and support networks.

   The CCG has produced a comprehensive pack of information that has been made available through GP practices. NNE CCG has also commissioned a specific web-site which will provide detail on case studies and signpost individuals to local services. In addition, NNE CCG also funded additional day centres on the basis of the feedback.

3. Looking Forward: our Commissioning Strategy 2014/15 – 2018/19

3.1. National context

In December 2013 NHS England published planning guidance 'Everyone Counts: Planning for Patients 2014/15 to 2018/19'. The guidance responds to the Call to Action national consultation and the government mandate to the NHS. The mandate is based around delivery against the NHS Outcomes Framework, which describes five main categories of better outcomes that the NHS as a whole is committed to deliver. These are:

- We want to **prevent people from dying prematurely**, with an increase in life expectancy for all sections of society.
- We want to make sure that those people with long-term conditions, including those with mental illnesses, get the **best possible quality of life**.
- We want to ensure patients are able to **recover quickly and successfully** from episodes of ill-health or following an injury.
- We want to ensure patients have a **great experience** of all their care.
- We want to ensure that patients in our care are **kept safe** and protected from all avoidable harm.

Working with stakeholders, NHS England has defined seven specific ambitions:

- Securing additional years of life for the people of England with treatable mental and physical health conditions
- Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital
- Increasing the proportion of older people living independently at home following discharge from hospital
- Increasing the number of people with mental and physical health conditions having a positive experience of hospital care

- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community

In order to deliver the outcomes and ambitions NHS England has identified that any high quality, sustainable health and care system in England will have the following six characteristics in five years:

- A completely new approach to ensuring that citizens are fully included in all aspects of service design and change, and that patients are fully empowered in their own care
- Wider primary care, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care
- Specialised services concentrated in centres of excellence

3.2. Five Year Strategy 2014-2019

As a key requirement of 'Everyone Counts: Planning for Patients 2014/15 to 2018/19' and Call to Action, a five year strategy has been developed by the South Nottinghamshire health economy which comprises twelve partner organisations across health and social care. This includes the four CCGs in the area – Nottingham North and East CCG, Nottingham City CCG, Nottingham West CCG, and Rushcliffe CCG, and other key organisations including key local providers of health services (Nottingham University Hospitals NHS Trust, Nottinghamshire Healthcare Trust, and community services providers) and the local authorities. All twelve organisations, known as the 'Unit of Planning', have agreed to work collectively over the next five years to support improvement in health and social care outcomes.

The strategy recognises that the NHS is at a critical point in its history. It acknowledges and responds to the ever increasing demands being placed on health and social care services as a result of a rapidly ageing population (often with multiple complex mental and physical health needs) and in the context of pressures on limited NHS and social care resources going forward. This is coupled with rising citizen and patient expectations which will become increasingly more difficult to meet.

The strategy also recognises that if we are to continue to provide safe and effective care for our patients and citizens unprecedented changes will need to be made across all services to meet the enormous future challenges. Organisations will need to work together collaboratively to redesign systems and streamline services. Services will need to be commissioned in a way that maximises the use our collective resource, focuses on improving patient and citizen outcomes and shares risk equitably between organisations.

The strategy therefore identifies how the local health community plans to transform health services across South Nottinghamshire to deliver care within the available resources and to meet the requirements set out in the planning guidance. This will be supported by a shift of resources from secondary care to primary and community care to help ensure a sustainable NHS for future generations.

Key priority areas for transformational change identified in the strategy are primary care, urgent care, elective care, proactive care and children's services.

3.3. Nottinghamshire Health and Wellbeing Strategy

The Nottinghamshire Health and Wellbeing Board (HWB) was established in response to the Health and Social Care Act 2012. The Board brings together key local stakeholders including CCGs, local councils and the public with a shared aim of working together to improve health and wellbeing. The main responsibility of the Health and Wellbeing Board is to identify current and future health and wellbeing needs, and to develop a Health and Wellbeing Strategy. During 2013 a process of consultation was undertaken on the draft strategy, and the final strategy was approved at a meeting of the Health and Wellbeing Board in March 2014.

In summary the strategy has four ambitions:

1. **A good start** – for everyone to have a good start in life
2. **Living well** – for people to live well, making healthier choices and living healthier lives
3. **Coping well** – that people cope well and that we help and support people to improve their health and wellbeing, to be independent and reduce their need for traditional health and social care services when we can
4. **Working together** – to get everyone working together

The Health and Wellbeing Board is also responsible for developing, approving and delivering plans associated with the Better Care Fund (BCF). The BCF was announced in June 2013 within the Government's spending review. It was described as creating a national £3.8 billion pool of NHS and local authority monies intended to support an increase in the scale and pace of integration and promote joint planning for the sustainability of local health and care economies. The fund is described as 'a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities'.

The Better Care Fund will:

- provide an opportunity to transform care so that people are provided with better integrated care and support
- help deal with demographic pressures in adult social care
- assist in taking the integration agenda forward at scale
- support a significant expansion in care in community settings.

The fund is made up of a number of different **existing** funding streams to Clinical Commissioning Groups and local authorities. There is no new or additional funding. Details of the BCF funding for NNE CCG are included in Section 5 of this plan.

NNE CCG is an active member of the Nottinghamshire Health and Wellbeing Board and has had a lead role in the development of the BCF plan for the South Nottinghamshire County CCGs. The CCG will continue to work in collaboration with the HWB over the coming years to ensure delivery of shared priorities.

4. But for now: delivery of our CCG commissioning priorities for 2014/15 – 2015/16

The previous section describes the CCG's longer term commissioning strategy and priorities, whilst also describing the end state and vision to be delivered collaboratively across the South Nottinghamshire area.

This section outlines the commissioning plan for NNE CCG and sets out how the CCG will deliver against its strategic vision over the next two years. This has been informed throughout by robust and on-going public and patient engagement, and is described in the context of the NHS Outcomes Framework.

4.1. Delivery against NHS Outcomes Framework

4.1.1. Preventing people dying prematurely

NNE CCG 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 maximised by continuing to promote 'every contact counts'. Much of our efforts will be promoted through the Health and Well Being Board, but also through NNE CCG's Partnership Group, membership of which includes representatives from all district/borough councils included within the CCG area.

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. The CCG will work with the local authority and partner CCGs 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. We will support efforts to improve early diagnosis of dementia and support patients and carers whose lives are affected by the disease.

4.1.2. Enhancing the quality of life for people with long term conditions

The CCG will prioritise the effective management of long term conditions in the community through on-going implementation and refinement of integrated health and social care delivered through locality community teams. This will include improved support and advice to patients, their families and carers, and GPs, and greater use of the voluntary sector and other community services.

The CCG will work with patients and carers to improve self-care and patient responsibility, and reduce dependency on health and social care. This will be supported through the continued development of our patient and public engagement capacity.

The aim is to deliver a reduction in the number and severity of relapses experienced by patients, resulting in fewer hospital admissions, reduced length of stay when patients are admitted to hospital, and fewer beds required for the treatment of patients with common chronic illnesses.

4.1.3. Helping people to recover from episodes of ill health or following injury

NNE CCG will continue to work with hospital providers to reduce avoidable readmissions. Working in partnership with our community and hospital providers, social care, and other local CCGs, we will develop 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 our comprehensive geriatric assessment programme.

We 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 out-reach services whilst reducing the need for acute hospital beds by reducing the average length of stay for hospital admissions.

4.1.4. Ensuring that people have a positive experience of care

NNE CCG's ambition is that patients, their families and carers will experience a seamless transition between health and social care services where required. This will be achieved by far closer integration of community health services and also between health and social care services and will support our plans to improve delivery of rehabilitation, long term conditions, NHS continuing care, end of life, and mental health care.

Integration of care will also be supported by the ambulance service, which will have an increasing role in ensuring patients receive high standards of care without emergency admissions to hospital.

We will continue to improve access to clinical services. This will include facilitating improved access to primary care, commissioning waiting times for acute care in line with commitments and pledges set out in the NHS Constitution, and enhancing the availability of locally accessible services for diagnostics and specialist opinion where appropriate.

Treatment of mental health issues will increasingly focus on early intervention and effective treatment and recovery in a community setting, reducing the need for inpatient treatment and rehabilitation. Where 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 we will continue to increase the number of service providers available where this will have a positive impact on service quality. People receiving NHS continuing care and some patients with long term conditions will be able to manage their own healthcare budgets where they would like this.

4.1.5. Treating people in a safe environment & protecting them from harm

Working with care homes, providers of community services and hospital providers, NNE CCG 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.

We will continue to drive up standards of care by all providers, and will use CQUIN flexibilities to incentivise best practice. This will further support our intention 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.

4.2. Our CCG priorities for 2014/15 – 2015/16

Development of this plan has been 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.

In addition the CCG has used the recently published Right Care Commissioning for Value insight pack to identify priority areas which offer the best opportunities to improve healthcare for our population. This is both in terms of improving the value that patients receive from their healthcare and improving the value that populations receive from investment in their local health system. The pack has supported the CCG to:

- identify local opportunities for improvement in health outcomes, patient experience or spend
- access, analyse and understand relevant clinical data
- understand how the CCG compares when outcomes are benchmarked against similar populations elsewhere
- identify the most beneficial intervention and service change opportunities through clinical, financial and workforce modelling.

The plan has also been informed by feedback from the public and patients, and GP member practices through an on-going process of involvement and engagement.

Table 2: CCG priorities (below)

Area	What are the identified issues	What we plan to do	Timescales	Expected outcomes
Planned care				
General	There are significant variations between GP practices in the CCG in respect of the number of patients who are referred to a hospital to receive the care they require, suggesting that some referrals could be avoided	Implement the Right Care programme to reduce unwarranted variation in referrals	Right Care programme to be implemented via a phased approach during 2013/14 and 2014/15	A greater number of patients will receive care closer to home An increased range of services will be available to ensure patients receive the most appropriate care Fewer patients will need to go to hospital to receive the care/treatment they require
	It is believed that if patients are more informed about the treatment options available to them some may choose not to go ahead with the treatment on offer	Develop and Implement a 'shared decision making' approach to referrals	Project to be developed during 2014-15	Patients will be more informed when making decisions about the treatment they are being offered Increased patient satisfaction and improved patient reported positive outcomes following treatment Fewer referrals to hospital for treatment
	There is a risk that unwarranted and inappropriate changes in clinical thresholds continue to increase There is a need to maximise value by delivering the right care, at the most appropriate time to the right person	To review the procedures of limited clinical value/guidelines policy	Nov 2013	Patients will be more informed when making decisions about the treatment they are being offered Increased patient satisfaction and improved patient reported positive outcomes following treatment Fewer referrals to hospital for treatment
		To implement a revised policy/guidelines alongside shared decision making	2014-15	
	An improved understanding of the use of healthcare by high risk patient groups will help target resources more effectively	eHealthScope - an interactive and responsive system that supports GP practices and assesses the impact of clinical decisions and interventions	On-going throughout 2014-15	Improved identification and subsequent case management of patients
Musculo-skeletal	There are currently high levels of referrals to hospital in the CCG when compared with other areas in England	Implement the Nottingham MSK Assessment and Treatment Service (NMATS)	Service commenced April 13	Improved access to the most appropriate care/treatment

Area	What are the identified issues	What we plan to do	Timescales	Expected outcomes
	Not all patients who have musculo-skeletal problems need to be referred to hospital to receive the treatment they need Some secondary care services could be provided in a community setting	Implement minor procedures in the community based on	2014-15	Improved patient satisfaction Increased quality of care Fewer referrals to hospital for treatment
Dermatology	There are currently high levels of referrals to hospital in the CCG area Not all people with skin lesions need to be referred to hospital to receive the treatment they need	Reduce the number of referrals of people with skin lesions to hospital by increasing diagnosis in primary care Reduce the number of 2 week wait basal cell carcinoma patients referred to hospital by confirming clinical suspicion in primary care	Nov 2013	Improved access to the most appropriate care/treatment Improved patient satisfaction Increased quality of care Fewer referrals to hospital for treatment
		Reduce the number of people attending hospital dermatology services through the development of a community based dermatology service	On-going throughout 14-15	
		Reduce inappropriate referrals to the Treatment Centre through working more collaboratively with treatment centre clinicians	2014-15	
Endoscopy/ Gynaecology	Integration between primary and secondary care around planned care areas to improve diagnosis and appropriate referral and treatment.	Reduce the number of endoscopy referrals through the adoption of improved guidelines to support dyspepsia management in primary care	May 2014	Reduces the rate of first outpatient attendances following a GP referral
		Improved pathways in gynaecology to be designed and piloted.	2014-15	
		Direct access to consultant advice by phone, Monday to Friday, for GPs to improve gynaecology referrals	March 2014	

Area	What are the identified issues	What we plan to do	Timescales	Expected outcomes
Cancer	The Right Care Commissioning for Value Pack for NNE CCG identified cancer as an area where quality of care and cost effectiveness could be of better value.	To undertake a *deep dive* of the cancer data to examine pathways in more detail to identify evidence of opportunities for improvements within specific pathways To consider post cancer care and discharge to the community opportunities To explore secondary/tertiary care pathways and impact on outcomes	May 2014	Fewer referrals to hospital for treatment Improved access to the most appropriate care/treatment Increased quality of care
	Improve access to cancer pathways identified through collaborative working between primary and secondary care	To pilot a direct to test colonoscopy: GP direct referral for colonoscopy To reduce unwarranted variation through the application of referral guidelines To improve EOL decision making and planning Commission the Prostate Cancer Service Community monitoring of patients with stable prostate cancer		To reduce the cancer pathway by 2 weeks To reduce the number of outpatient attendances
Circulation	There are currently a significant number of patients in the CCG receiving their care/treatment in a hospital setting that could possibly be managed in primary care	Develop the ECG monitoring service to include 24hour ECG monitoring across NNE CCG	Pilot commenced in Nov 2013	Improved access to the most appropriate care/treatment Improved patient satisfaction Increased quality of care Fewer referrals to hospital for treatment Fewer patients receiving long-term treatment in a hospital setting
	Not all people with cardiac problems need to be referred to hospital to receive the treatment they need	Reduce the number of vascular referrals through the use of practice based ABPI measurement	Practice based training Feb 2014	
	The Right Care Commissioning for Value Pack for NNE CCG identified Circulation as an area where quality of care and cost effectiveness could be of better value.	To undertake a review of circulation data to examine pathways in more detail to identify evidence of opportunities for improvements within specific pathways	May 2014	
Pain management	There are high numbers of people in the CCG area that are referred to a range of pain management services.	To implement the back pain management pathway	Jan 2014	Increased quality of care Improved self-management of pain Fewer referrals to hospital for treatment
	There are limitations to the clinical effectiveness of many pain management treatments.	To review referrals into secondary care following changes in pathway	2014-15	

Area	What are the identified issues	What we plan to do	Timescales	Expected outcomes
Diabetes	One third of annual deaths of people with diabetes are classed as preventable.	Implement the year of care model for diabetes	April 2014	Improved access to the most appropriate care/treatment More people are able to manage their own condition Improved patient satisfaction Increased quality of care Fewer referrals to hospital for treatment
	Improved chronic and planned management of diabetes could reduce mortality rates.	Review community pathways for diabetes care in NNE CCG	On-going	
	Only 12% of the NNE CCG diagnosed population access structured education for type 2 diabetes	Address the Quality Premium Local Priority - people with diabetes diagnosed less than a year who are referred to structured education through a review community diabetes education approaches in NNE CCG To implement the telehealth approach 'Flo'	2014-15	
Chronic obstructive pulmonary disease (COPD)	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	Reduce the number of patients who do not have a formal diagnosis of COPD by 30%	On-going	Improved access to the most appropriate care/treatment Improved patient satisfaction Increased quality of care Fewer referrals to hospital for treatment
		Reduce the numbers of patients who are inappropriately prescribed oxygen	2013-2015	
		Develop the COPD Master class for local clinicians to support diagnosis and treatment	April 2014	
Respiratory	The Right Care Commissioning for Value Pack for NNE CCG identified respiratory as an area where quality of care and cost effectiveness could be of better value.	To undertake a *deep dive* of the respiratory data to examine pathways in more detail to identify evidence of opportunities for improvements within specific pathways	May 2014	Fewer referrals to hospital for treatment More people are able to manage their own condition
End of life	Unplanned EOL care can often result in unnecessary and expensive trips to A&E with crisis admissions to hospital	Commission an Electronic Palliative Care Coordination System (EPaCCS)	May 2014	Improved patient satisfaction Increased quality of care More people are supported to die in their preferred place of death Fewer referrals to hospital for treatment
	Ensuring choice of preferred place of death is a priority.	Increase the number of patients who die in their preferred place of death		
Ophthalmol-ogy	Reducing our population's dependency on secondary care for conditions that can be managed in the community.	To commission a range of ophthalmology services in the community to support care closer to home and to avoid inappropriate outpatient attendances	April 2014	Improved patient satisfaction Increased quality of care Fewer referrals to hospital for treatment

Area	What are the identified issues	What we plan to do	Timescales	Expected outcomes
Neurology	There are currently a significant number of people in the CCG receiving their care/treatment in a hospital setting that could possibly be managed in the community There is the need to ensure effective use of acute medical and acute rehabilitation unit beds to ensure rapid throughput. There is a need to ensure a stronger emphasis on earlier preventative intervention by both health and adult social care services The Right Care Commissioning for Value Pack for NNE CCG identified neurology as an area where quality of care and cost effectiveness could be of better value.	Reduce the number of people with Parkinson's disease being managed in secondary care through the development of a specialist community nurse service. To undertake a deep dive of the neurology data to examine pathways in more detail to identify evidence of opportunities for improvements within specific pathways	June 2014 May 2014	More people are able to manage their own condition Improvements in quality of life. Increased opportunities for people with Parkinson's disease to participate and contribute to society and improved social inclusion
IV Antibiotics	A number of patients have their hospital stay unnecessarily extended solely because they need to complete a course of IV antibiotics	Increase the number of patients receiving IV antibiotics through the OPAT service by 25%	Oct 2013	Increased quality of care Reduced length of stay Improved patient satisfaction
Self-Management	More people, particularly those with long term conditions, could be involved in the management of their condition if they were supported to do so	Maximise the use of appropriate telehealth mediums for people with long-term conditions Work with GP practices and community services to implement the 'Flo' model of telehealth	Throughout 2014-15	More people are able to manage their own condition Reduction in A&E attendances Reduction in emergency admissions Reduction in elective admissions Reduction in bed days
Diagnostic tests	A significant number of diagnostic tests are requested by GP practices each year. Ensure the availability of a single electronic solution for requests, result and e-documents within GP Surgeries	Roll out of the Integrated Clinical Environment (ICE) system across NNE Monitor the impact of the ICE system	2014-15	Reduction in duplication of tests Reduction in the number of tests requested
Phlebotomy	Community phlebotomy services are facing increasing capacity issues across clinic and home based services.	To commission appropriate community phlebotomy services to maintain the provision.	2014-15	Increase in care provided closer to home

Area	What are the identified issues	What we plan to do	Timescales	Expected outcomes
	Current providers are reporting concerns that current capacity cannot meet the demand for requests	To review the provision of community/primary care phlebotomy services to provide recommendations for the future provision of these services in 2015.	April 2014	
Unplanned care				
Crisis Response at NUH	There is evidence to suggest that effective crisis avoidance and community rehabilitation services have a positive impact on the care pathway and outcomes for all service users	To commission an in-reach crisis response service which works as part of the Care Coordination team at the front door at NUH to support the priority area of Choose to Admit	Oct 2013	Reductions in unnecessary admissions to hospital and residential care homes Improved outcomes for patients Increased staff competencies to improve the holistic approach to intervention
Alcohol related long-term conditions	People with alcohol problems and alcohol related illness form a substantial proportion of admissions to hospital and the majority of avoidable readmissions occur within a relatively small population of high volume service users.	To improve the levels of patient care resulting in a reduction in readmission rates for High Volume Service Users (HVSU) through the appointment of a co-ordinator To improve the co-ordination of services across Nottingham University Hospitals NHS Trust (NUH) and set up a system to identify and case manage HVSU with alcohol related problems.	April 2014	Improving the co-ordination of services across NUH Increased identification of High Volume Service Users so that appropriate referrals can be made to other support and treatment services. Reduction in readmissions and attendances at ED.
GP Access	Analysis of GP appointments, validated by GPs, indicates that 50% of the same day/urgent demand could have been dealt with by another appropriate qualified health and social care professional rather than the GP. It has been estimated that this will free up about 29 hours of GP time per practice each week. There is a need to release general practitioner (GP) time and enable	To implement an Urgent Care/Same Day Pilot across 2 GP practices	April 2014	Improved access to urgent/same day GP appointments A reduction in attendance at ED Improving patient confidence in accessing GP services which will reduce the need for patients to access emergency services for non-emergencies Promotes integration across primary, secondary, community and social care – reduces duplication and reduces the amount
		To roll out an agreed model of urgent care management across 1 locality	2014-15	
		To test an approach to achieving 7 day working across 1 locality	2014-15	
		To implement a chronic care management approach	2014-15	
		Agreement of access standards	June 2014	

Area	What are the identified issues	What we plan to do	Timescales	Expected outcomes
	increased proactive management of more complex patients and public health activity Standardisation of access to GP services Removal of variation in access to GP services Reduction in variation of Patient Experience	To support GPs to work collaboratively across localities to improve access and implement 7 day working		of time the patient repeats their story Improves access and the length of time of appointment for patients with complex needs
0-18 attendances at ED	A significant number of attendances at and admissions through Nottingham University Hospital (NUH) Emergency Department (ED) in the 0-18 year age group have been identified. It is suggested that a proportion of these could be managed in the community through appropriate community support.	To review all attendances at ED and subsequent emergency care admissions in children and young people (0-18 years) across all GP practices in the Nottingham North and East locality.	2013-14	Identification of strategies and service options could be implemented to reduce attendances and admissions at NUH ED.
		To identify avoidable attendances and admissions.	2013-14	
		To recommend a revised service offer including strategies and services to be employed to reduce attendance at and admissions through NUH ED	April 2014	
Appropriate use of A&E	Patients who do not need the facilities of A&E should have direct access referrals to the appropriate specialty (e.g. gynaecology referrals direct to gynaecology). This should include redirection away from hospital if this is more appropriate	To review GP triage and streaming at the front door of ED	2014-15	Improved access to the most appropriate care/treatment Improved patient satisfaction Increased quality of care Fewer referrals to hospital for treatment Fewer patients receiving long-term treatment in a hospital setting
		To review the process navigation into the Acute Medical Receiving Unit at NUH from GP practices	2014-15	
		On-going communication and marketing of messages to ensure patients access the most appropriate services for their healthcare needs	2014-15	

Area	What are the identified issues	What we plan to do	Timescales	Expected outcomes
Falls Response	Falls comprise the largest proportion of 999 calls demand for the East Midlands. There is increasing demand of 'green' (non-life threatening) falls patients coming through via 999 calls	To commission an Integrated falls rapid response service	May 2014	Reduce number of falls transported to A&E Reduce number of acute admissions for falls Increase number of falls patients treated at home, supported by referral to and use of care pathways and community services. Reduce number of repeat falls Reduce admissions to residential care as a result of falls Reduce hip fracture rates per 1000 population over 65
Babies, children and young people				
Breastfeeding	Breastfeeding protects the health of mothers and babies both in the short and long term. Continuation rates in Nottingham North East CCG are poor. Breastfeeding services are a cost effective intervention, contributing to savings from reduced admissions for gastro-intestinal, respiratory illness and ear infections.	Implement a Breast Feeding Support programme to co-ordinate peer support volunteers and targeting young mothers, mothers living in areas of deprivation and areas of low level initiation.	Feb 2014	Improved breastfeeding rates at 6-8 weeks
Children's Commission-ing arrangements	There is a requirement to improve the commissioning arrangements through embedding integrated commissioning for children's health services and interventions across the local NHS and local authority organisations.	Develop outcome based service specifications Agree and develop quality and performance schedules and monitoring processes across all children's health services and contracts Establish clear governance arrangements for decision making by April 2014 and reviewed by December 2014		To improve commissioning and contract management of services for children and young people

Area	What are the identified issues	What we plan to do	Timescales	Expected outcomes
Complex needs and disabilities		Commission integrated pathways and services for children and young people with complex needs or disabilities. Implementation of the Education Health and Care (EHC) Plan Pathway by September 2014 Implement the recommendations and priorities in the Integrated Community Children and Young People's Healthcare Programme	2014-15	To improve health outcomes for children and young people with complex needs or disabilities Reduce duplication Improve care planning
Maternity Services		Implement maternity services review • Complete the SFHFT Maternity Service review by April 2014 and implement key recommendations from May 2014 • Complete the NUH Maternity Service review by March 2014 and implement key recommendations from April 2014 • Develop Maternity Service specifications (by March 2014)	2014-15	Improved outcomes for patients Improved in patient satisfaction
Community paediatric services	There is a requirement to determine whether services are fit for purpose and represent value for money. Ensure outcome based service specifications, including robust quality and performance monitoring processes, are in place.	Review elements of Community paediatric services	2014-15	Improved outcomes for patients Improved patient satisfaction
Older people				
Integrated care	The reconfiguration of Adult Community Services has been completed and three integrated teams are now in place across the 3 NNE CCG localities. On-going review in place to assess impact on emergency admissions and case management	Mainstream the Adult Community Care Service and promote access to services via the Community Hub. Continue to improve management of patient care across primary and community settings Implement phase 2 of the integrated care approach with integration with social care	2014-15	Reduced emergency admissions for adults aged over 65 People are supported to live as independently as possible in their own homes Reduced numbers of patients attending A&E that could have been managed in the community

Area	What are the identified issues	What we plan to do	Timescales	Expected outcomes
	Increasing numbers of people are being admitted/readmitted to hospital Improved discharge planning and facilitation of timely community based post discharge follow up and appropriate support are key elements in avoidance of readmissions and to ensure quality transitions for returning patients back into their own home.	Implement the 48 hour Post Discharge Assessment and Support project This service development will be delivered via the NNE CCG IHSC project Service Scope: • 65 - 74yrs focus on cases with 4 more meds: receive phone call review (as per agreed clinical protocol) and assessment of need for face to face visit, face to face visit as required • 75 yrs receive phone call assessment and face to face visit as required • 85 yrs receive introductory phone call and face to face visit	April 2014	10% reduction in admissions People are supported to live as independently as possible in their own homes
	A number of local pilots have demonstrated that unnecessary hospital admissions could be avoided through the provision of community support to people in crisis.	To implement a crisis response service to provide intense and focused health and social care (including personal care) to assist people through a worsening health crisis to remain living in their own home and maintain independent living skills (Crisis Intervention and Community Support Service (CiCSS)) To support early discharge from Lings Bar Hospital To review the provision of intermediate care services (residential and bed based services) to enable improved management of patients in the community (work as part of a south commissioning approach)	On-going in 2014-15	Patients are supported through a time of crisis, or a crisis is prevented, as evidenced through capabilities pre and post referral Unnecessary admissions to hospital/care homes are avoided in a minimum of 70% of referrals Practice and community clinicians are supported in providing care in individual's homes People are supported to live as independently as possible in their own homes
Community geriatrician	NNE CCG has the second highest percentage of older people over the age of 65yrs (16.9%) compared with all Nottinghamshire CCGs. The CCG has a high rate of emergency admissions from people who are over 65.	Reduce admissions of older people with complex care needs through proactive management by the Community Geriatrician Service. Ensure comprehensive geriatric assessment is routinely included as part of case management of older people	On-going in 2014-15	Improved patient experience with access to the right services at the right time Reduction in avoidable admissions and readmissions to hospital or institutional care A reduction in emergency department attendances A reduction in delayed in transfers of care

Area	What are the identified issues	What we plan to do	Timescales	Expected outcomes
Enhanced support to care homes	Older people resident in care homes (Residential and Nursing) often have complex needs requiring a range of healthcare services. These needs are commonly associated with cognitive impairment, dementia, depression, pain management, palliative care, nutritional risk and medication management. A recent report by the British Geriatrics Society (BGS) 'Quest for Quality' (July 2011) highlighted that despite the multiple long term conditions, significant frailty and disability of many care home residents, healthcare for this group remains insufficient, resulting in inappropriate admissions to hospital.	To implement a community based, multi-disciplinary in-reach service (which compliments healthcare delivered in the core GP contract) which proactively addresses the health needs of residents in residential and nursing care homes. To provide on-going support to nursing and care home staff to maintain patients in the community	April 2014	Holistic assessment and timely responsive support to meet the health and end of life care needs of residents. Improved collaborative working between the care home, primary care and community services. Improved case management that focuses attention away from reactive care, emergency call-outs and crisis management. Reduction in readmissions, attendances at ED and admissions.
Intermediate Care – residential capacity	Capacity work undertaken across the health community indicated a need for additional short term residential capacity to support timely discharge from hospital for a period of rehabilitation before returning to normal place of residence	To pilot an intermediate care residential model for short term placement in a care home to facilitate early discharge from hospital or prevention of hospital admission	Dec 2013	A reduction in Delayed Transfers of Care at NUH A reduction in readmissions
		To review the provision of intermediate care capacity and provide recommendations for commissioning of services	June 2014	
Personalised care	As part of a commitment to more personalised care for patients with long-term conditions, all patients aged 75 and over will have a named, accountable GP with overall responsibility for their care.	To support the implementation of tailored care for vulnerable and older people - a comprehensive and coordinated package of care for over 75s	2014-15	An increase in patients cared for in the community A reduction in emergency admissions

Area	What are the identified issues	What we plan to do	Timescales	Expected outcomes
Mental health				
Mental health	The Right Care Commissioning for Value Pack for NNE CCG identified mental health as an area where quality of care and cost effectiveness could be of better value.	To undertake a *deep dive* of the mental health data to examine pathways in more detail to identify evidence of opportunities for improvements within specific pathways	April 2014	To understand where quality and value improvements can be made
Dementia	Significant numbers of people may not be receiving the treatment they require or would benefit from because a diagnosis of dementia has not be made	Increase dementia diagnosis rates and improve services Develop early intervention, assertive management and balanced risk early supported discharge for patients with dementia	Throughout 2013-14	People are supported to live as independently as possible in their own homes
Access to psychological therapies	Improve access to psychological therapies for anxiety and depression	Increase referrals into the IAPT service from primary care Implement a communication and engagement plan to raise the profile of IAPT services locally	2014-15	Improved patient experience with access to the right services at the right time
CAMHS	To improve the mental health and well-being of all children and young people through effective and meaningful multiagency partnership working	Review of CAMHS and establish if there is a need for a new operating plan and delivery model Implementation of the new model from July 2014 onwards if appropriate	June 2014	Improved patient experience with access to the right services at the right time

Area	What are the identified issues	What we plan to do	Timescales	Expected outcomes
	There is a need to ensure that people with a mental illness receive care in the most appropriate environment	Implement Mental Health Intermediate Care MHUR Rehabilitation Utilisation Review – Implement the recommendations from the review, work with partner agencies to enable effective discharge and redesign of patient pathways using modelling tool Scenario Generator. Stepped reduction in the number of beds that are commissioned Mental health services for older people bed configuration – develop enhanced community provision and reduce inpatient beds Reduce the rate of hospital admissions for people with learning disabilities Locked rehabilitation – reduce number of patients in placements and increase community provision in line with Winterbourne View review recommendations Reduce admissions of patients with advanced dementia Provide additional support for carers	Throughout 2014-15	People are supported to live as independently as possible in their own homes Patients receive their care in the most appropriate environment Increased quality of care A reduction in the number of admissions and length of stay Improved patient experience
Carers				
	To provide greater support and information to carers of all ages	To provide a dedicated resource centre in all GP practices with information to help carers. To support this with a named representative in each practice who can help with any questions To provide a website with information on services and advice for carers for individuals with dementia To run a pilot with Gedling Homes to identify the needs of individuals who are caring, for themselves and the person they are caring for, and provide dedicated resource in the home	Throughout 2014-15	Individuals feeling more confident and accessing services available Improvements in carers' health Addressing any concerns on isolation Improved health and wellbeing for individuals being cared for

5. Our financial plans 2014/15 and 2015/16

5.1. Introduction

This Commissioning Plan 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.

The two year financial plan for Nottingham North and East CCG supports the operational and strategic aims of the CCG in respect of an increased focus on developing primary and community models of care and greater integration of services with the local authority and other community partners.

This development in primary and community care is set alongside the ever increasing pressure on NHS budgets and resources, and a continued need to deliver increased quality, productivity and efficiency savings via our QIPP (Quality, Innovation, Productivity and Prevention) programmes is required in order to deliver a balanced budget for each financial year. QIPP is the national NHS initiative that seeks to address the predicted funding gap that the NHS will face over the future years. Its focus is on achieving the right treatment in the right setting as a way of achieving better quality care that should in turn deliver financial benefits.

The CCG's financial plans for 2014/15 and 2015/16 include a substantial and challenging QIPP target.

5.2. Our resources and spending plans

Nottingham North and East CCG is set an allocation by the Department of Health (DH), via NHS England, for each financial year. For 2014/15 and 2015/16 allocations have been set and notified to the CCG for both years, aiding the financial planning process.

The allocation is split into two main components. These are the programme allocation, out of which the CCG purchases the healthcare it requires for its population, and the running costs allocation against which all CCG operational costs are funded. For 2014/15 the CCG received a 2.14% uplift over its 2013/14 programme allocation (with a further 1.7% in 2015/16). Some CCGs, whose 2013/14 allocation was significantly below the average 'head of population' funding, received an additional amount. However, this does not apply to NNE CCG.

Running cost allocations remain broadly static in 2014/15 but in 2015/16 are reduced by 10% reflecting the DH squeeze on running costs.

In 2015/16 the CCG will also receive a further allocation of £3.1m in relation to establishing the Better Care Fund. This fund is a national initiative for NHS monies to be pooled with local authority resources to enable better working and integration of health and social care services. The £3.1m allocation is also required to be 'topped up' by circa £6.0m existing CCG resources/budgets and the process of jointly agreeing with the local authority how it will be invested to improve health and social care services is on-going.

Current allocations are summarised as follows:

Resource Allocations £000	2013/14	2014/15	2015/16
Recurrent Programme	160,541	163,977	166,765
Recurrent Running Cost	3,570	3,565	3,201
Recurrent Better Care Fund	0	0	3,124
Non-recurrent surplus c/f	1,742	1,013	1,699
Other NR	-720	0	0
Total Allocations	**165,133**	**168,555**	**174,789**

Table 3: Resource allocations

Spending plans reflect the move from secondary to community and primary care services. Programme reserves that the CCG is required to set aside (Transformation Funds and Call to Action in 2014/15 and Transformation Funds and the Better Care Fund in 2015/16) will support the changes required to the health system for this transition to take place. The CCG is also required to deliver a c1% surplus (which it receives back the following year when delivered).

Our high level spending plans, and associated QIPP targets, are as follows:

£000	2013/14	2014/15	2015/16
Total Gross Planned Spend	168,444	171,078	177,373
Planned Surplus	1,013	1,699	1,748
QIPP requirement	-4,324	-4,222	-4,332
QIPP %age of RL	2.6%	2.5%	2.5%
Memorandum (incl. in above gross spend)			
Contingency	808	843	877
Transformation Fund	3,232	2,462	1,669
Call to Action Fund	0	1,640	0
Better Care Fund	0	0	9,115

Table 4: High level spending plans and QIPP targets

As the tables show, the QIPP requirement in each of the next two years is around 2.5% of the CCG's gross spending plans which represents a challenging target that must be achieved to deliver financial balance. The table below shows how the QIPP is allocated over the key spend areas. This is primarily focussed on acute spend with little or no QIPP focussed on community care in line with the CCG's investment strategy.

2014/15 Opening Budgets £000			
Budget area	**Gross budget**	**QIPP**	**Net Budget**
Acute	91,021	-2,868	88,153
Mental Health	14,610	-373	14,237
Community	12,896	-66	12,830
Continuing Care	11,885	-330	11,555
Primary Care	24,156	-552	23,634
Other Programme/Reserves	12,102	-63	12,039
Contingency	843	0	843
Total Programme Costs	167,513	-4,222	163,291
Running Costs	3,565	0	3,565
Total Expenditure Plans	171,078	-4,222	166,856
Planned surplus budget	1,699	0	1,699
Total Budget	**172,777**	**-4,222**	**168,555**

Table 5: 2014/15 opening budgets

The net budget spend across the two financial years is as follows:

Spending Plans £000	2013/14	2014/15	2015/16
Acute	89,864	88,153	88,443
Mental Health	15,157	14,237	14,083
Community	12,117	12,830	12,174
Continuing Care	11,508	11,555	11,584
Primary Care	23,007	23,634	23,818
Other Programme	9,053	12,039	18,836
Total Programme Costs	160,706	162,448	168,938
Running Costs	3,414	3,565	3,201
Contingency	-	843	874
Total Budget	**164,120**	**166,856**	**173,013**

Table 6: Spending plans

As the table above demonstrates, there is a reduction in acute spend whilst community, primary care and other programme spend have a degree of investment. The increase in Other Programme costs reflects the creating and holding of the Better care Fund.

5.3. Risks and mitigations

The CCG recognises that the implementation of robust risk management procedures is key to delivery of 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 its ability to deliver its financial strategy. These risks, the potential impacts and mitigating actions are identified in the CCG's Risk Register and Finance Risk Register and will be monitored and managed by the CCG's Finance and Information Group which is a formal sub-committee of the Governing Body. This group will monitor and escalate up to the Governing Body any key issues or risks in year that are identified. In addition, the CCG has an established Service Improvement Group whose responsibility is to identify and implement QIPP schemes to deliver the required QIPP targets.

The key area of financial risk for the CCG is achieving financial balance with an underlying recurrent surplus based on a number of risks around:

- requirements of the 2014/15 – 2018/19 Planning Guidance
- 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 local authority spending plans
- agreement of a risk pooling agreement.

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 financial risk, the PCT provided for a contingency reserve in each year. In addition, agreed risk pooling arrangements have been in place during the financial year 2013/14 and will continue during 2014/15 – 2015/16. 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.

In 2014/15, and perhaps more so in 2015/16, there will be increasing pressure on the CCG resulting from cuts in local authority budgets. Work to quantify the scale of the impact of this is continuing. Discussions with the local authority and other partners around the deployment of the Better Care Fund in 2015/16 are underway.

5.4. Next steps

Financial plans are in the process of being signed off by NHS England and have already been through the Governing Body for approval. The 2014/15 plans will be transacted into operational budgets and the CCG will commence the process of in year financial management.

6. Quality

6.1. Quality framework and priorities

Commissioning is a tool for ensuring high quality, cost–effective care which relies on adequate and meaningful data. Quality underpins the work undertaken by NNE CCG. The CCG works in partnership with the other Nottinghamshire Clinical Commissioning Groups 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.

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)
- Effectiveness of care (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.

6.2. Quality strategy

NNE CCG has developed a five year quality strategy. This strategy provides an overarching framework for quality covering across four key areas: leadership, culture, capacity and capability, and measurement for improvement. The last decade has seen a number of key publications that have informed and shaped the quality strategy and provide the foundations from which the quality priorities have been developed.

NNE CCG's ambition is to commission excellent, safe and cost effective healthcare for its population.

6.3. Quality priorities

The CCG's priorities for improving quality over the next two years are:

6.3.1. Patient safety

Aim: To commission safe services for our local community.

Patient safety will be the CCG's highest priority.

Priority areas are:

- Safeguarding vulnerable adults and children
- Reduction of health care acquired infections (HCAI)
- Improve the quality of care home services
- Reduction of avoidable pressure ulcers
- Reduction of falls and harm from falls

In addition focussed quality initiatives will be driven through Commissioning for Quality and Innovation (CQUIN):

Reduction in harm through CQUIN development to include:

- Transfers of care
- Falls
- Medicines management
- Emergency surgery
- The deteriorating patient
- Reduction of avoidable pressure ulcers

The CCG has developed an innovative approach to CQUIN. For our commissioned services we have developed a five-year plan to develop a smaller number of CQUIN that allows provider organisations to work together to improve the outcomes of our local population. The CCG has undertaken a gap analysis against the 290 recommendations of the 'Francis Report' and as a result an action plan is in place to ensure it is fully compliant as a commissioning organisation.

6.3.1.1. Safeguarding children and vulnerable adults

'Safeguarding Adults: The Role of NHS Commissioners' (Department of Health (DH) 2011) outlines commissioners' role in preventing and responding to neglect, harm and abuse to children and adults in the most vulnerable situations, including the commissioning of services for women and children who experience violence or abuse. NNE CCG will prioritise the safety and welfare of children and vulnerable adults across all commissioned and contracted services.

The Children Acts 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' (DH 2013).

The CCG will therefore:

- take into account the views of children, young people and carers to influence the commissioning of services
- comply with statutory requirements and national and local and quality standards set by the Care Quality Commission and NHS Midlands and East
- provide leadership for safeguarding across NHS and partner organisations
- have sound monitoring and accountability arrangements for safeguarding across the organisation.

In addition the CCG will focus on being compliant with the Winterbourne View review (2012) which sets out specific actions for the care of patients with learning disabilities and provides a salutary reminder of the failings in care for this group of vulnerable people. NNE CCG is therefore a member of a county-wide multi agency project group which is leading this work to ensure that those patients identified as being ready to move from hospital accommodation are supported to do so. To this end the CCG is:

- reviewing placements and supporting those that are inappropriately in hospital to move to community based support. Locally agreed plans to ensure quality care and support services based on the model of good care

- working with local authorities to commission a range of local health, housing and care support services to meet the needs of people with learning disabilities in the CCG area
- involved with on-going development of pooled budgets between health and social care.

6.3.1.2. Care homes

The quality of care delivered to residents in care homes is a focus for the CCG. The recent Care Quality Commission (CQC) publication 'The state of health care and adult social care in England in 2012/13' (Nov 2013) demonstrated failings in a number of areas.

As a result the CCG is working in partnership with the CQC and local authority and have set up a strategic review of the care home sector.

The CCG will:

- work closely with other agencies and stakeholders to improve the quality of care for older people
- work proactively to prevent deterioration in quality
- take an active part in shaping the future market in order to provide consistent high quality care homes for our citizens.

6.3.1.3. 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.

NHS England has set out a 'zero tolerance' approach which is explicitly targeting zero cases of MRSA blood stream infections. 'Everyone Counts: Planning for Patients 2014/15 to 2018/19' endorses this.

IPC is a crucial component of safe systems providing health and social care. The CCG's priorities in this area over the next two years are:

- to ensure the CCG has a robust whole health economy IPC agenda in order to drive HCAI numbers down
- to work with other commissioners, and provider organisations to share learning and ensure robust and effective communication between organisations
- to commission appropriate high quality services that are compliant with all guidelines and standards.

6.3.2. Patient experience

Aim: To commission patient-centred services that meet patient expectations

The key priority areas for the next two years are:

- to improve patient experience of care, and to improve the quality of complaints management.

Patient experience allows any organisation to understand what it does well and what it can do to improve. Triangulation of data from complaints, compliments, stories and patient satisfaction surveys help organisations understand how they can improve the services they deliver.

The Patients Association is a charity established following the first Francis Inquiry in 2010. The association has been instrumental in driving forward change such as the Care Campaign. This joint campaign by Nursing Standard magazine and the Patients Association aims to tackle poor care and the causes of poor care. The Health Foundation 'Speaking Up' project was established in 2012 to pilot a new methodology for managing complaints.

In order to deliver against the priority patient experience areas the CCG will:

- implement the Patients Association complaints management methodology for its own services and those it commissions through CQUIN

- actively work to improve the experience of patients (and their carers) by seeking users' feedback from the consulting room to the board room and using this to improve the services it commissions
- support clinicians in primary care to use patient feedback constructively.

6.3.3. Effectiveness of care

Aim: To commission safe, effective and evidence-based care that delivers the best health outcomes across a range of conditions as set out in NHS Outcomes Framework and NICE quality standards.

Effectiveness of care is about delivering the best possible care for patients through timely and appropriate treatments but also ensuring the right outcome for patients. It incorporates a range of quality improvement activities and initiatives including evidence, guidelines and standards to identify and implement best practice and quality improvement tools (such as clinical audit, and evaluation). These are used 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.

6.4. Governance for quality

Although individuals and clinical teams are at the frontline and responsible for delivering quality care, it is the responsibility of the CCG's 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. As a result the CCG is able to reflect, 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 has redeployed staff to bring added rigour to this process. The CCG combines business intelligence, survey results, patient feedback, complaints, incidents and PALS contacts in order to give gain an overall picture of provider quality issues.

Quality is already driving the CCG's commissioning processes in several key areas:

- 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 our strategic initiatives and include innovate schemes to improve the safety and experience of patients.
- Providers are held to account for quality through regular quality scrutiny panels.

In line with NHS England's 'Draft Framework of Excellence in Clinical Commissioning: for CCGs' (Nov 2013), over the next two years the CCG will strive for excellence by:

- ensuring it can demonstrate that it learns from patients' experience and complaints and acts upon them
- ensuring that our provider organisations have effective systems for identifying and minimising risk to clinical quality, handling safety incidents and managing concerns over professional performance
- ensuring that everyone in the CCG understands their safeguarding responsibilities.

The CCG's Governing Body's Assurance Framework provides a single process for managing local priorities, standards and Integrated Governance arrangements. Quality is scrutinised at a number of levels from Governing Body down to provider scrutiny panels. The CCG actively encourages patient and lay people to take part in our quality reviews and quality visit programmes.

The CCG seeks multiple levels of assurance about the services it commissions. It has early warning systems/dashboards in place for its commissioned services and undertakes a comprehensive programme of quality visits. Patient stories and complaints are presented at Governing Body meetings to enable reflection and learning. In addition, the CCG works closely with its local partners such as the CQC, local authority and Healthwatch to share intelligence, and is an active member of the NHS England Area Team Quality Surveillance Group, where quality information is shared.

7. Glossary/abbreviations

Better Care Fund (BCF)

The BCF was announced in June 2013 within the Government's spending review, and is described as 'a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities'.

Clinical Commissioning Group (CCG)

The term given to a number of GP practices that work together within a defined geographical area to plan and pay (commission) health services for the local population.

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 Information Centre (HSCIC)

Formerly the NHS Information Centre, HSCIC was designed to be England's central, authoritative source of health and social care information.

Health and Wellbeing Board

Local authorities 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 are 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 intervention or series of interventions, regardless of whether such an intervention was intended to change health status. Interventions may include government policies and consequent programmes, laws and regulations, or health services and programmes, including health promotion programmes.

Improving Access to Psychological Therapies (IAPT)

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.

Joint Strategic Needs Assessment (JSNA)

The purpose of JSNA is to pull together in a single, on-going 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

NNE CCG practices have formed into three groups according 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 cannot 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.

National Institute for Health and Clinical Excellence (NICE)

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)

Out of hours service (OOH)

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 Participation Group

Patient Reference Groups and Patient Participation Groups bring together groups of patients with the aim of involving them in decisions about the range and quality of services provided and 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.

Registered population

Refers to those people registered with a GP practice, or those people registered with one of a group of practices, for example all the people registered with practices in NNE CCG.

Resident population

Refers to those people residing in a specified 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).

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.

Unwarranted variation

The most widely accepted definition of unwarranted variation is:

> 'Variation in the utilization of health care services that cannot be explained by variation in patient illness or patient preferences.' Wennberg JE (2010) Tracking Medicine. A Researcher's Quest to Understand Health Care, OUP.

Variation could be clinical, in terms of quality (and hence outcomes) of clinical practice, or in terms of the amount of service delivered to different populations. Variation could also be due to non-clinical factors such the time it takes to get an appointment, or the ease of access of locations where services are provided.