Report to Health and Wellbeing Board

7 March 2012

Agenda Item:

REPORT OF THE CLINICAL LEAD, NOTTINGHAM NORTH AND EAST NHS CLINICAL COMMISSIONING GROUP

1. Purpose of Paper

This paper introduces the draft Nottingham North and East Clinical Commissioning Group Commissioning Plan for Health and Wellbeing Board consideration. It outlines the background to the Clinical Commissioning Group including vision and values, describes the health needs of its resident population and sets out proposed priorities for action during 2012/13.

Comments, feedback and advice are sought from the Health and Wellbeing Board. A further stakeholder consultation programme is also underway during February and March 2012.

2. Information

2.1. Background

In 2011 the government announced plans to reform the National Health Service (NHS). The Health and Social Care Bill 2011 is currently progressing through Parliament and if passed will result in the most extensive reorganisation of the structure of the NHS to date. The Bill proposes to abolish NHS Primary Care Trusts and Strategic Health Authorities transferring a large proportion of the budget for health services to Clinical Commissioning Groups (CCGs). These CCGs will be led by general practitioners using their knowledge and understanding of patients' needs. Commissioning is the process of planning, buying, delivering and monitoring public services. The key principles of the reforms are to put patients at the centre of the NHS, to change the emphasis of measurement to clinical outcomes and to empower health professionals, in particular GPs. Pivotal to the changes is the requirement to make quality and financial efficiency improvements in order to ensure that healthcare resources are used as effectively as possible.

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 organised collectively to commission health services for the patient population based in Arnold, Burton Joyce, Calverton, Carlton, Colwick, Daybrook, Gedling, Giltbrook, Hucknall, Lowdham, Mapperley, Netherfield and Newthorpe. The geographic area covered by the CCG is shown in Appendix 1, Figure 1. Between the practices, we cover a patient population of approximately 145,000, which is just over a fifth of the population of NHS Nottinghamshire County. In order to fully reflect the needs of local populations the GP practices have formed three locality groups, which facilitate clinical and non-clinical practice staff meeting regularly to discuss issues at a local level.

Nottingham North and East CCG received delegated authority from NHS Nottinghamshire County Board in July 2011 and we aim to become a statutory body from April 2013. In establishing our organisation part of the transition process is demonstrating we can achieve the required national competencies for authorisation. These competencies are divided into six domains:-

- Clinical focus and added value
- Engagement with patients and communities
- Clear and credible plans
- Capacity and capability (governance)
- Collaborative arrangements
- Great leadership

This document will form part of a suite of plans we intend to put forward for authorisation.

We have delegated responsibility for a commissioning budget of £168.6 million for 2011/12 to take forward the planning and purchasing of healthcare. Financial plans and budget allocations for 2012/13 are currently under development and will shape our intentions over the coming months. We will be required to find efficiency savings locally to support the government target of £20 billion of savings across the NHS by 2015. In 2011/12 this efficiency requirement was £8.6m and in 2012/13 it is likely to be of a similar magnitude resulting in an even greater need to prioritise spend and investment wisely.

We recognise that predecessor organisations and partners in health and social care have a great body of knowledge and expertise to contribute to the achievement of our ambitions. Indeed, there are many existing policies and priorities which form the evidence base and context for our plan. The central importance of patient and public involvement and partnership working were identified early in our formation. Our local plans and priorities will continue to evolve as we learn from engagement with patients, public, partners and stakeholders.

We are ambitious and enthusiastic about the opportunity presented to CCGs to lead future commissioning of local health services. The health service reforms are designed to unleash the potential for clinical leadership. We recognise that, as clinicians in general practice, we are trusted local community leaders who have the ability to give a voice to the population of patients and communities we serve.

2.2. Understanding the Health Needs of Our Population

2.2.1. Our Population

The population of Nottingham North and East CCG is distributed across six local authority areas within Nottinghamshire, namely Gedling, Ashfield, Broxtowe, Rushcliffe, Nottingham City, and Newark and Sherwood, plus two in Derbyshire. The majority of the population lives in Gedling (63%) and Ashfield (22%). The CCG is establishing good links with local councils and will continue to build on these as an important feature of our partnership arrangements (See section 2.6.3).

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

2.2.2. The Health of Our Population

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

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

With respect to Nottingham North and East, we have reviewed the Joint Strategic Needs Assessment (JSNA) and worked closely with Public Health colleagues in determining our profile, which has helped us to determine our aims and priorities. Levels of deprivation within the CCG vary significantly and although areas such as Ravenshead, Woodborough and Burton Joyce are among the least deprived in England, other areas including parts of Hucknall, Netherfield, Porchester and Killisick Estates experience higher levels of deprivation, identified as being in the 10% of most deprived areas in England (Appendix 1, Figures 3 and 4). This is reflected in differences in life expectancy across the population, with a difference of at least five years for both men and women.

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

Across Nottinghamshire the trend in death rates over time is reducing. However the gap between those experiencing the best health and those who have the worst health is not narrowing as quickly as it should (Appendix 1, Figure 5). The main causes of death for all ages in the CCG are Cardiovascular Disease, Cancer and Respiratory illness (Appendix 1, Figure 6). Death rates under the age of 75 are mainly linked to cancer (lung and prostate in men, breast and lung in women).

Smoking is one of the leading causes of preventable death, closely followed by obesity (Appendix 1, Figures 7 and 8). Alcohol consumption and alcohol related hospital admissions continue to rise. The behaviour choices that people make in their everyday life impact on their health and wellbeing throughout life. Working with the local population to support behavior change will have a considerable impact on long term health. Childhood obesity is a growing problem, with almost one in five children being either overweight or obese. These lifestyle factors are also often linked to deprivation, with deprived communities being most at risk to high levels of smoking and obesity and associated diseases.

In order to tackle the root causes of ill health and health inequalities across the area Nottingham North and East CCG is committed to working in partnership with the local authorities, police, schools and associated organisations and groups. Joint approaches to tackling issues will aim to have a positive impact on the long-term health of the population.

2.3. Vision and Values

Our vision is:

"Putting Good Health into Practice"

We will implement this vision by:

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

Our clinical leadership shaped the values that will guide our actions and decisions. These values are presented using the acronym for **HEALTH:**

Putting Good Health into Practice

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

2.4. Our Aims and Priorities for 2012/13

Early in the life of the CCG, the Board held a facilitated development session to explore the health needs of Nottingham North and East. This discussion was formative in structuring how we have organised the activities of the CCG. The information used was derived from the existing JSNA supplemented with further analysis from our public health colleagues. The JSNA is the foundation stone of our activities and we will continue to reassess our activities as it is refreshed, with the support and guidance of public health. What we considered and how we have aligned our clinical and managerial resource are outlined in this section.

2.4.1. Our Aims

Our aims take into consideration our population profile and groups with the greatest need, whilst ensuring that we continue to maintain focus on the wider population. They also reflect where, as clinicians, we felt we could more directly affect change and where the majority of our resources are deployed.

For 2012/13 our key aims are to:

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

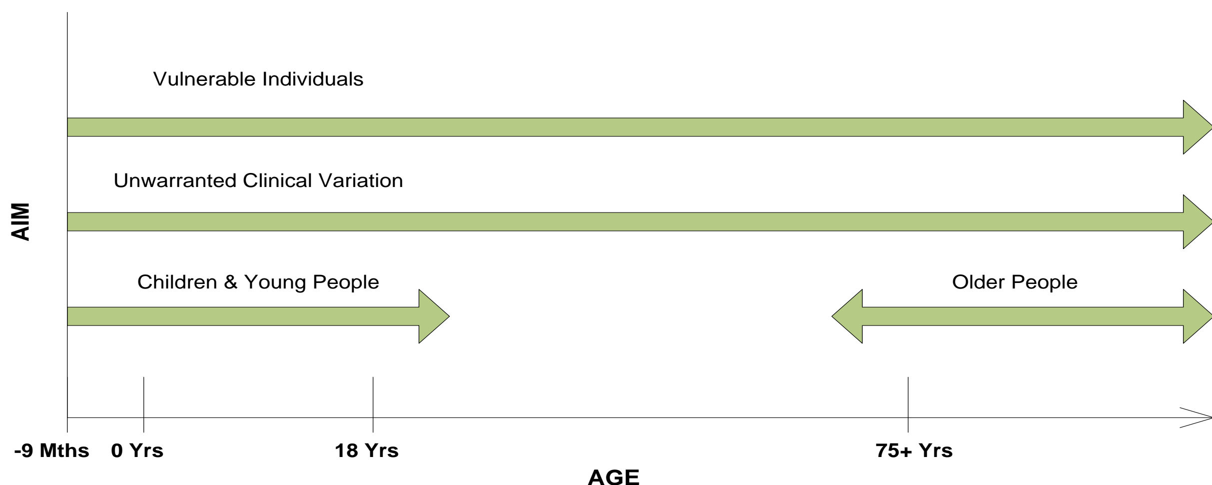


Diagram 1: Aims relative to the population demographic

2.4.2. Commissioning Framework

Following consideration of our public health profile (including disease prevalence, age groups, care pathways and existing programmes of work), we defined nine broad clinical groupings and five enabling strategy areas to use as the framework for our commissioning approach. The clinical groupings we have termed 'strategic building blocks' and the enabling strategies as 'enabling building blocks'; each has a Board-level champion (see Table 1). Board ownership facilitates shared corporate responsibility for our commissioning decisions. The strategic building blocks provide clinical focus and leadership, whilst the enabling building blocks underpin our commissioning processes to achieve high quality responsive services.

Strategic Building Blocks	**Champion**
Long Term Conditions (including Cancer and End of Life Care)	Dr James Hopkinson
Unplanned, Urgent & Emergency Care	Dr Tony Marsh
Planned Care	Dr Paramjit Panesar
Mental Health & Learning Disabilities	Dr Paul Oliver
Health & Wellbeing for All (including Tobacco & Obesity)	Dr Sylvester Nyatsuro
Children, Young People & Maternity	Dr David Hannah
Effective Medicines Management	Adrian Kennedy
Primary Care & Practices	Alastair Wood
Older People, Community Care & Re-ablement	Sister Sheila Price
Enabling Building Blocks	**Champion**
Patient & Public Engagement /Partnership Working	Mike Wilkins / Adrian Kennedy
Equality & Diversity	Adrian Kennedy
Information Management	Jonathan Cummins
Education, Workforce & Research	Jonathan Cummins
Safeguarding & Clinical Governance	Mike Wilkins

Table 1: Strategic and Enabling Building Blocks

2.4.3. Our Priorities

We identified our 12 strategic priorities by considering how to deliver our aims, relative to each strategic building block. The targeted methodology also applied health needs and how to maximise health outcomes within the resources available (see Diagram 2).

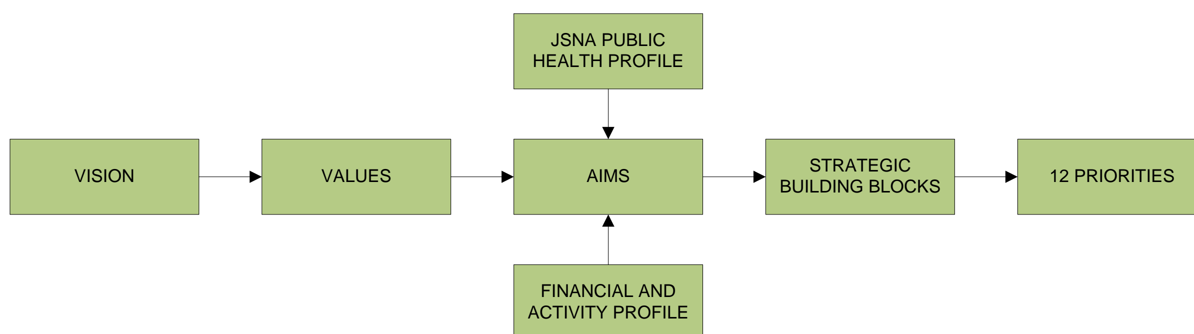


Diagram 2: Commissioning Framework Methodology

Our strategic priorities, relevant to our aims, are described in Table 2 below including:-

- Why this is important
- What we will do
- How this will improve health outcomes for our population

<table>
<tr><td colspan="2">Aim 1: Drive up quality of care in order to improve health outcomes and reduce unwarranted variations in services</td></tr>
<tr><td colspan="2">Priority 1: Smoking
Why this is important
Smoking is one of the leading causes of preventable illness and deaths, contributes to 30% of all cancers, 90% of lung cancers and 25% of heart attacks and strokes. In Nottinghamshire adult smoking prevalence is close to national average at 21.1%. Nottingham North and East has areas higher than the national average (Ashfield = 32%). Research has demonstrated that smoking prevalence increases as children and young people get older, markedly around the age of 14 years. Smoking is Public Health enemy number 1.</td></tr>
<tr><td>What we will do</td><td>How this will improve health outcomes for our population</td></tr>
<tr><td>• Review the role of General Practice in smoking cessation to develop means of supporting the existing infrastructure and extending advice (working in partnership to reduce prevalence)
• Link actions around smoking cessation to specific disease groups, in particular COPD
• Work with partners, including patient groups, on how to target children and young people, aligning messages and actions with General Practice</td><td>• Contribution to an increase in the smoking quit rate
• Supporting healthy behaviours in order to deliver real and sustainable improvements to health and wellbeing
• Contribution to increased life expectancy and quality of life
• Contribution to a reduction in smoking related sick days and loss of productivity
• Contribution to a reduction in the number of under 24s who start smoking</td></tr>
<tr><td colspan="2">Priority 2: Obesity
Why this is important
It is estimated that levels of obesity in Nottinghamshire are higher than the national average with one in four adults estimated to be obese (JSNA). Obesity is rising in children, is common in people over 45 and rates are higher in deprived areas. It is linked to an increased risk of heart disease, diabetes and some cancers. Obesity reduces life expectancy by an average of nine years. In some areas in Nottingham North and East more than 24.8% of children are not within a healthy weight range. Obesity is Public Health enemy number 2.</td></tr>
<tr><td>What we will do</td><td>How this will improve health outcomes for our population</td></tr>
<tr><td>• Directly target unhealthy diets and physical inactivity in adults and children in primary care by reviewing and expanding on</td><td>• Supporting an integrated community approach can contribute to a reduction in premature deaths and disability linked to</td></tr>
</table>

Aim 1: Drive up quality of care in order to improve health outcomes and reduce unwarranted variations in services	
existing pathways and learning materials available • Work with partners on joined-up programmes using existing services and campaigns	obesity • Provides an opportunity for improved quality of life, including emotional well-being, by changing lifestyle factors • Contribution to a reduction in the prevalence of chronic and severe medical problems
Priority 3: Diabetes **Why this is important** One third of annual deaths of people with Diabetes are classed as preventable. Improved chronic and planned management of diabetes could reduce mortality rates. Diabetes is a major improvable risk factor for coronary disease and myocardial infarction. There is a rising prevalence of undiagnosed diabetes. The direct costs of type 2 Diabetes are estimated to be around 7–12% of total NHS expenditure. Education is central to support management of the disease including necessary lifestyle changes and side effects.	
What we will do	How this will improve health outcomes for our population
• Target partnership working on exercise schemes (as with obesity). Continue to support local exercise schemes with effective primary care promotion • Define a preventative approach relevant to the “year of care” model and by using community resources more effectively • Reassess diabetes pathways and treatment to ensure that Nottingham North and East follows the latest NICE guidance and quality standards • Upskill practices relating to prevention and care of patients with diabetes • Target self-care resources appropriately to local populations, including working with patients and carers on knowledge levels and confidence	• Contribute to a reduction in other medical conditions that are directly attributable to poor self-management in individual patients, in particular cardio-vascular disease (overall risk doubles in individuals with Diabetes) • Contribute to increased life expectancy (Diabetes can reduce life expectancy by 7 years) • May enable individual patients to change behaviour allowing for improved functional ability and increased physical activity • May provide improved access to services supporting lifestyle changes • May contribute to improved quality of life for this cohort of patients and their carers (including confidence through education)
Priority 4: Avoiding inappropriate admissions **Why this is important** In order to ensure right care, right place, right time. At risk cohorts include individuals over 75, those with physical frailty, chronic conditions or multiple impairments, residents in care homes, residents in sheltered housing. Older people with complex conditions are at risk of medicines-related harm and are three times more likely to be admitted to hospital with an adverse reaction to their medicines than younger patients. A greater number of patients are currently attending secondary care for Ophthalmology appointments than necessary.	
What we will do	How this will improve health outcomes for our population
• Support the integration between health, social care and the voluntary sector (inc Nottingham North and East Crisis Intervention Community Support Service) • Comprehensive admission avoidance/early discharge programme using evidence based strategies • Review patient flow to establish where efficiencies can be gained • Medicines Management – audit of risk	• Contribute to improved rehabilitation from conditions • Provide of services that can contribute to the maintenance of independence for individuals • Help to support self-management of complex conditions • Reduce medicines related harm and avoidable admissions (to hospital)

Aim 1: Drive up quality of care in order to improve health outcomes and reduce unwarranted variations in services	
groups and prioritisation for level 3 medication review • Community based pathways for Opthalmology (options around cataract referrals, glaucoma suspects and retinal changes)	• Improve support for carers through the provision of clear pathways, improved discharge procedures and the provision of education and confidence
Priority 5: Chronic Obstructive Pulmonary Disease (COPD) **Why this is important** Nottingham North and East as a Practice Based Commissioning Consortium, invested considerable resources into a pathway for COPD aimed at achieving prevention, early identification and recognition of symptoms, good quality early diagnosis, high quality care following diagnosis and access to end of life care services. National evidence supports a 25%-30% reduction in unplanned admissions following full implementation of the pathway.	
What we will do	How this will improve health outcomes for our population
• Develop a strategy to identify undiagnosed or misdiagnosed cases of COPD • Improve the accuracy of diagnosis through education • Improve support and information for patients and carers • Establish 'managed clinical networks' to include membership from all partners involved in the care of patients with COPD • Work with secondary care to reduce readmissions • Enhance existing clinical support in primary care • Review pulmonary and rehabilitation services and access • Implement a comprehensive oxygen assessment service.	• Contribute to a reduction in the number of patients and/or carers with depression and/or anxiety disorder • May allow for improved self-management and independence • Contribute to a reduction in disabling breathlessness for individual patients and therefore enhanced quality of life • Provide the opportunity for individuals to increase quality of life through the capability to participate in socially important activities; for example gardening • Provide the opportunity to improve quality of life for carers • Improved patient safety
Priority 6: Trauma & Orthopaedics (T&O) **Why this is important** T&O is the highest activity area in Nottingham North and East for both total referrals and GP initiated referrals. A reduction in unwarranted variation will drive up quality of care. Managing chronic pain is vital to health-related quality of life. There is evidence to improve the patient pathway for orthopaedics in relation to Right care, Right time, Right place due to the number of patients that can be treated in primary care instead of being referred to secondary care for an outpatient appointment.	
What we will do	How this will improve health outcomes for our population
• Extension of the provision of joint injections in GP practices • Assess access to diagnostics and their role in assessment of common conditions • Review referral criteria and patient pathway, including pain management services • Implement wider assessment and treatment through community clinics • Assess the viability of improving waiting times to community physiotherapy	• Contribute to improved quality of life for patients and carers through improved pain management and timely care • Improved functional ability • Improved recovery from injuries and trauma • Individuals supported to recover their independence

Aim 1: Drive up quality of care in order to improve health outcomes and reduce unwarranted variations in services	
Priority 7: Depression **Why this is important** Depression is the leading cause of disability. Depression occurs in persons of all genders, ages, and backgrounds. It can be reliably diagnosed in primary care. Antidepressant medications and brief, structured forms of psychotherapy are effective for 60-80 % of those affected and can be delivered in primary care. Barriers to effective care include the lack of resources, lack of trained providers, and the social stigma associated with mental disorders including depression.	
What we will do	How this will improve health outcomes for our population
• Review current community services and tools available to practices, distinguishing between appropriate support for social problems and a diagnosis of depression • Review patient pathways and medicines management, establishing treatment protocols, best practice and problem areas • Link in with Improving Access to Psychological Therapies (IAPT) to provide training for clinicians on the diagnosis and management of patients with depression • Link IAPT to chronic disease pathways • Review referral/take-up of IAPT by older people	• Contribute to improved physical and mental health through the management of depression • Improved quality of life and economic success for patients and/or carers

Aim 2: Commission appropriate models of care for older and vulnerable people with complex needs, ensuring all patients are treated with dignity and respect	
Priority 8: Dementia **Why this is important** In Nottinghamshire there are 8,686 people over 65 estimated to have dementia and a further 184 under 65 but less than half have a formal diagnosis. Prevalence of dementia is expected to rise across Nottinghamshire, particularly in some black and minority ethnic groups. The East Midlands, along with the South West, faces the most significant challenge in England. Direct costs to the NHS and social care are set to treble by 2030. The key national drive for improving Dementia Services is the National Dementia Strategy 'Living Well With Dementia' (2009). The strategy has three themes: improved awareness; early diagnosis and intervention; high quality care and support.	
What we will do	How this will improve health outcomes for our population
• Improve diagnosis rates through the implementation of the Memory Assessment Service • Review capabilities and opportunities within General Practice • Support the integration of services/sectors including investigating the opportunity to develop a local mental health intermediate care team • Review of all patients with dementia on antipsychotics for inappropriate use • Support awareness campaigns to help early diagnosis	• Enhanced quality of life • Improved support for carers • Greater understanding of the condition by patients and carers allowing for improved decision making and confidence in capabilities

Aim 2: Commission appropriate models of care for older and vulnerable people with complex needs, ensuring all patients are treated with dignity and respect	
Priority 9: Care Home Admissions **Why this is important** Patients in care homes continue to have a high incidence of admissions to hospital, including inappropriate admissions. This can be significantly detrimental to patients, both clinically and psychologically, and also against the wishes of their families. Inappropriate admissions result in an additional and unnecessary cost.	
What we will do	How this will improve health outcomes for our population
• Implement a Nottingham North and East Primary Care Service specific to improving the quality of healthcare to care homes and avoidance of unnecessary hospital admissions. • Working in partnership with health care agencies, hospitals, East Midlands Ambulance Service and the Local Authority	• Contribute to improved chronic-disease management in care homes • Patient and family confidence in the care being provided • Provide for efficiencies in advanced directive setting supporting dignity and respect
Priority 10: End of Life (EOL) **Why this is important** There is the opportunity for CCGs to work together to enhance EOL services. Unplanned EOL care can often result in unnecessary and expensive trips to A&E with crisis admissions to hospital. These are distressing for individuals and can have a detrimental effect on the bereaved. NHS Nottinghamshire County surveys found that patients and patient groups identified choice of preferred place of death as a priority. Only 44% of patients die in their usual residence when up to 80% say they want to, if given a choice.	
What we will do	How this will improve health outcomes for our population
• Pilot end of life Care Co-Ordinator • Continue training practices on the end of life pathway and the importance of timely identification on palliative care registers • Continue to work with other CCGs and partners on the Nottinghamshire EOL strategic plan to meet pathway gaps (locality register and coordination centre, rapid response, carer support) • Review communication by Nottingham North and East practices with Out Of Hours and East Midlands Ambulance Services	• Improved experience of care by patients and carers • More choice in place of death, in particular an increase in the proportion of deaths that occur at home • Decrease in emergency admissions within last year of life

Aim 3: Secure improved chances of a healthy life by targeting our prevention programmes for children and young people	
Priority 11: Targeting Early Years **Why this is important** The early years of a child's life are the most important. Children develop more rapidly during these years than at any other time in their lives, and the evidence is very clear that early influences in a child's life play a major role in their future health and wellbeing.	
What we will do	How this will improve health outcomes for our population
• Ensure Pharmacy First is available across Nottingham North and East, particularly during out of hours • Actively improve performance against	• Contribute to a reduction in health inequalities • Contribute to a reduction in childhood diseases

immunisation and vaccination targets in Nottingham North and East • Improve joint working between midwifery teams and GP practices • Active CCG participation in re-established Maternity and Newborn Network Group • Influence the development of the maternity care service specification • Improve joint working between Health Visiting Teams, Early Years Services and GP Practices: increasing awareness and understanding of relevant roles and services. This includes those provided by the Children's Centres and supporting best practice similar to a Family Nurse Partnership Scheme and wider cross organisational family support initiatives. • Improve continuation rates of breastfeeding by exploring opportunities with the voluntary sector and others	• Increased health benefits for mother and baby through breastfeeding, through reducing the incidence of gastroenteritis, chest, urinary tract and ear infections, diabetes in childhood and childhood obesity. • Contribute to a reduction in health, social and education problems in later life • Improved health and wellbeing
Priority 12: Children and Adolescent Mental Health Services (CAMHS) **Why this is important** National studies have shown that the emotional health and wellbeing of children has deteriorated in the last 25 years. CAMHS helps to address health inequalities and supports children at risk including those with a physical illness or disability, difficult family circumstances, socio-economic issues and traumatic life events.	
What we will do	How this will improve health outcomes for our population
• Work with partners and influence the development of CAMHS through attendance at the Nottinghamshire CAMHS Joint Commissioning Group (JCG) • Work through CAMHS JCG to support development of transitional plans for your people moving from CAMHS to adult mental health services • Develop a wider social marketing campaign with our partners	• Contribute to improved physical health for individuals supported by CAMHS • Opportunity to support a decrease in substance misuse in young people in the Nottingham North and East community • Opportunity to contribute to improved family circumstances allowing for overall improvements in physical and emotional health • Provide individuals with continuity in care through the efficient transition to adult services

Table 2: Aims and Priorities

These aims and priorities will be further tested by wide engagement with patients, public, partners and stakeholders from February to March 2012. Our plan will then take into account the outcome from these consultations. Once finalised a further process will take place to identify SMART[1] outcomes, to determine how we will know we have made a difference.

2.5. Quality, Innovation, Productivity and Prevention

The tighter economic climate means the NHS overall needs to make efficiency savings. The Quality, Innovation, Productivity and Prevention (QIPP) programme is a national Department of Health strategy involving all NHS staff, patients, clinicians and the voluntary sector. It aims to improve the quality and delivery of NHS care while reducing costs to make £20 billion

[1] SMART – Specific, Measurable, Achievable, Realistic, Timebound

efficiency savings by 2014/15. 2012/13 is a significant year for the NHS as the service faces multi-faceted challenges of financial constraints, QIPP delivery, organisational transformation and a strong requirement to maintain or improve service performance levels.

NHS Nottinghamshire County, the Primary Care Trust (PCT), has an overall revenue resource limit of approximately £1,080m. In 2011/12 in order to balance its financial position the PCT has an overall QIPP efficiency target of £46.4m. Each of the five CCGs with delegated responsibility from the PCT has been tasked with delivering a proportion of this target resulting in a challenge for Nottingham North and East for 2011/12 of £8.6m. This equates to a 5.1% reduction against our historical spend. The target for 2012/13 is currently being calculated and will be of a similar magnitude. The requirement to achieve efficiency savings of this level means that we must ensure that quality and best value services are commissioned for our patients and that each investment is made with all four of the QIPP factors taken into account.

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

2.6. Collaborative Commissioning with our Partners

2.6.1. Clinical Commissioning Groups

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

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

Working collaboratively like this allows us to flex our commissioning control appropriately. For example, we work as Nottingham North and East practices at local level for our specific local needs and then scale up when it is more advantageous to commission as a group of CCGs. We feel this combines much needed local sensitivity with greater purchasing power resilience and significantly reduces risk.

We are also working with our colleague CCGs to develop a service level agreement with the Nottinghamshire Commissioning Support Hub. The hub provides a range of services including: procurement support, technical finance, information governance, legal services, estates and human resources.

2.6.2. Joint Commissioning

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

assuming lead responsibility for the commissioning of health services for the specific joint commissioning service areas.

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

2.6.3. Partnership Working

Operating in a challenging landscape, we recognise that working in partnership will be a crucial success factor to address health and social need. This includes effective engagement with borough/district councils. We have a range of arrangements in place and some under development including:-

- An officer of Nottinghamshire County Council sits on our Board
- The establishment of a Partnership Committee with district council colleagues as a sub-committee of our Board. It will determine areas for collaboration and to ensure alignment/consistency of messages.
- Integrated working opportunities through co-location with Gedling Borough Council
- Clinical Lead is integral member of the Health and Wellbeing Board
- Chief Operating Officer is a member of the Gedling Leaders' Forum
- Active members of the Hucknall and Gedling Partnership Forums
- Represented on the Local Involvement Network (LINk) Executive Board

Through collaborative working we are committed to actively supporting priorities identified by our partners, for example substance misuse and domestic violence. Our Board composition, which includes representatives from local authority, Nottinghamshire Healthcare NHS Trust, Nottinghamshire University Hospitals NHS Trust and lay membership ensures that complex issues can be considered with the benefit of a wide range of experience and perspectives.

We recognise that to tackle health inequalities and deliver improved services we must work in partnership with local authorities, local people, voluntary organisations and other key partners, for example working with the British Royal Legion to improve the management of veterans' health.

2.6.4. Productive Notts

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

2.7. Patient and Public Involvement

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

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

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

2.7.1. Patient and Public Reference Group

The Nottingham North and East CCG has a well-established Patient and Public Reference Group. This group is instrumental in supporting us with patient and public involvement, engagement and consultation. Its membership has been strengthened significantly with invited representation from our practices' Patient Participation Groups (see below).

2.7.2. Patient Participation Groups

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

2.7.3. Board Level Representatives

The Nottingham North and East CCG Board has two patient representatives. One was appointed via the Patient and Public Reference Group and the second is one of our two appointed Non- Executive Directors, who is also a patient at one of our constituent practices.

2.7.4. Securing Additional Capacity

We are currently renegotiating our contract with Gedling Community and Voluntary Services (CVS) to secure additional resource to support our patient and public engagement activities.

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

2.7.5. Engagement Plan

Our Engagement Plan is being developed in partnership with our Patient and Public Reference Group and help from the CVS. We will also continue to work closely with Nottinghamshire County LINk until HealthWatch is established. The engagement plan will cover the full commissioning lifecycle, patient experience, quality of care in our practices and lay down specific measurable objectives.

We believe meaningful stakeholder engagement will be integral to our success and will continue to build on current engagement activities by raising awareness with key groups and identifying appropriate new stakeholders – persons or groups with a direct interest, involvement or investment in our activities.

2.7.6. Seldom Heard Groups

It is our aim to seek and take into account the views of **all** patients, their carers and others when designing, planning, delivering and improving health care services. However we realise that the views of some are more difficult to determine and require us to seek them out. Our activities include working with local groups of people with protected characteristics, as defined in the Equality Act 2010, to ensure that we are meeting their needs and working towards reducing inequalities. We value difference and promote equality to ensure that all individuals, whether patients or staff receive a high quality of care.

2.8. Statutory and Policy Context

There are a number of other national and local drivers which will also influence the direction and ambition of our local strategic priorities. These include:-

2.8.1. NHS Operating Framework

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

2.8.2. NHS Outcomes Framework

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

2.8.3. Equalities Act

At Nottingham North and East CCG we are committed to ensuring that equality and inclusion is a central to all business planning, staff and workforce experience, service delivery and community and patient outcomes. To this end all commissioning intentions within this plan have undergone an Equality Impact Assessment and the development of these plans will be considered alongside the Procurement Inclusion Product that fully integrates Equality and Diversity into the stages of procurement and commissioning processes.

2.8.4. CCG Inequality Duty (Health & Social Care Bill)

In the exercise of our functions we will have a duty to have regard to, the need to:-

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

We will also have a duty to integrate services, with a view to:-

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

2.8.5. Regional Commissioning Framework

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

2.8.6. Nottinghamshire Health and Wellbeing Strategy

The strategy is currently being developed by the Nottinghamshire County Health and Wellbeing Board. We will ensure that our Commissioning Strategy and Plan are updated to reflect any changes in the final version of the Health and Wellbeing Strategy in order to maintain consistency and alignment.

2.8.7. Any Qualified Provider

Department of Health policy requires that commissioners include additional providers for discrete services in order to introduce greater choice for patients and service users. The intention of this initiative is to increase the quality of services offered through competition. The initiative is being managed on a “whole county” basis.

2.8.8. Reablement Funding Framework

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

2.8.9. NHS Constitution

Nottingham North and East CCG is fully committed to the rights and pledges to patients and staff within the NHS Constitution.

2.8.10. National Tariff for Mental Health

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

2.8.11. Authorisation

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

2.8.12. Safeguarding

The safety and welfare of children and vulnerable adults is of paramount importance to Nottingham North and East CCG. We work closely with other CCGs across Nottinghamshire to ensure that all of the services we commission ensure high quality safe effective care. The CCGs are represented at executive level on both the Nottinghamshire Safeguarding Children and Adult Boards

2.8.13. Innovation Health and Wealth

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

organisations are delivering the high impact innovations set out in the document in order to pre-qualify for CQUIN payments. This will take effect from 2013/14.

3. Recommendations

Members of the Health and Wellbeing Board are invited to comment on the Nottingham North and East Commissioning Plan for 2012/12.

Name of Report Author(s)

Samantha Walters
Chief Operating Officer

Dr Tony Marsh
Clinical Lead

For any enquiries about this report please contact:

Appendix 1

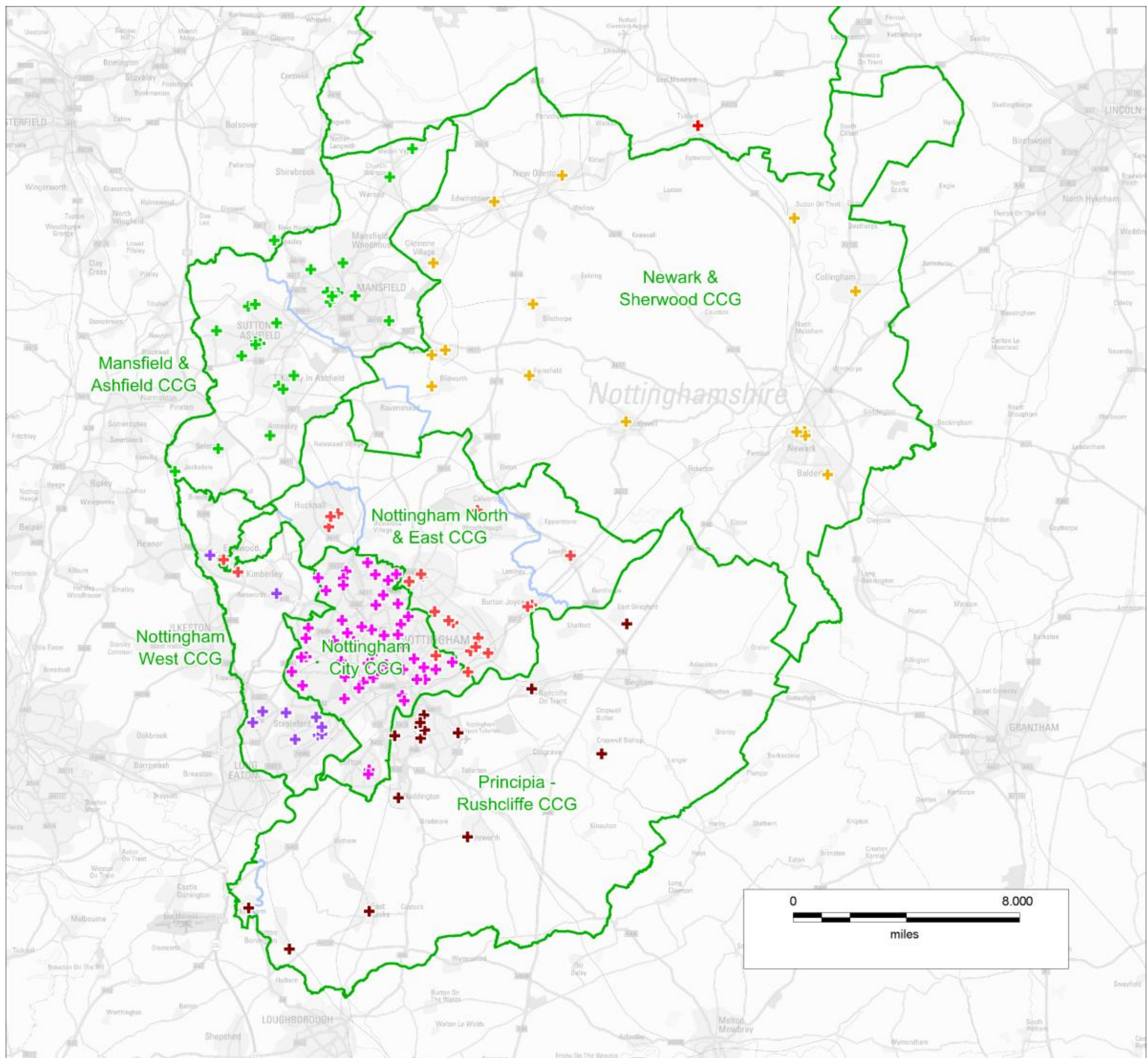


Figure 1: CCGs within Nottinghamshire County Council (excluding Bassetlaw)

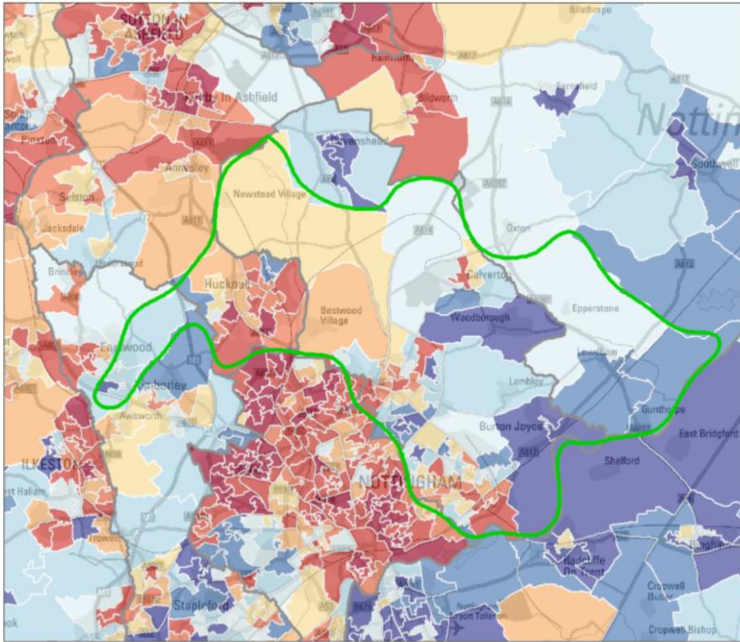


Figure 2: Population Deprivation

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

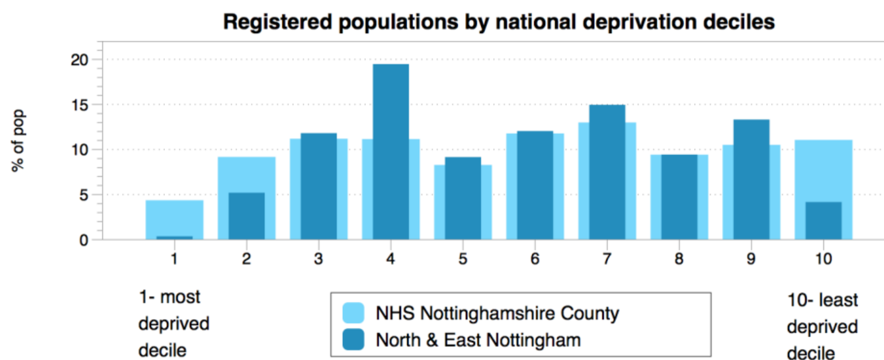


Figure 3: Deprivation levels compared with Nottinghamshire County overall

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

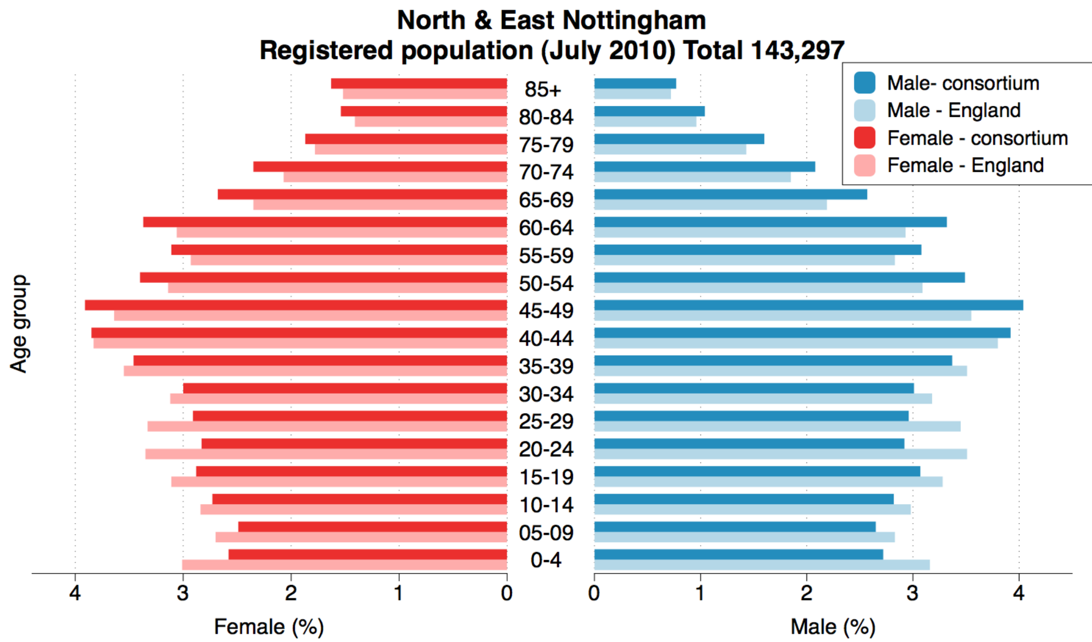


Figure 4: Population age distribution

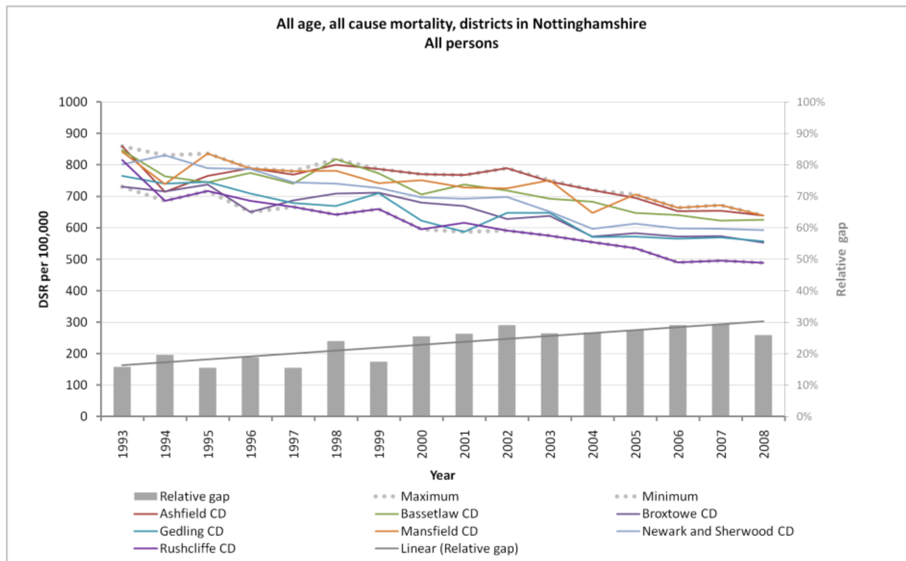


Figure 5: Mortality trend by District

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

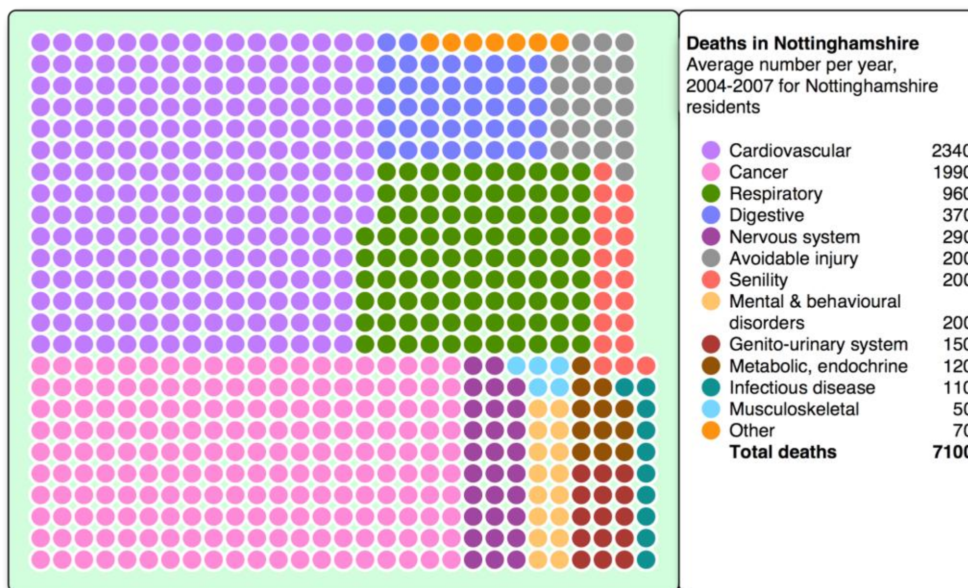
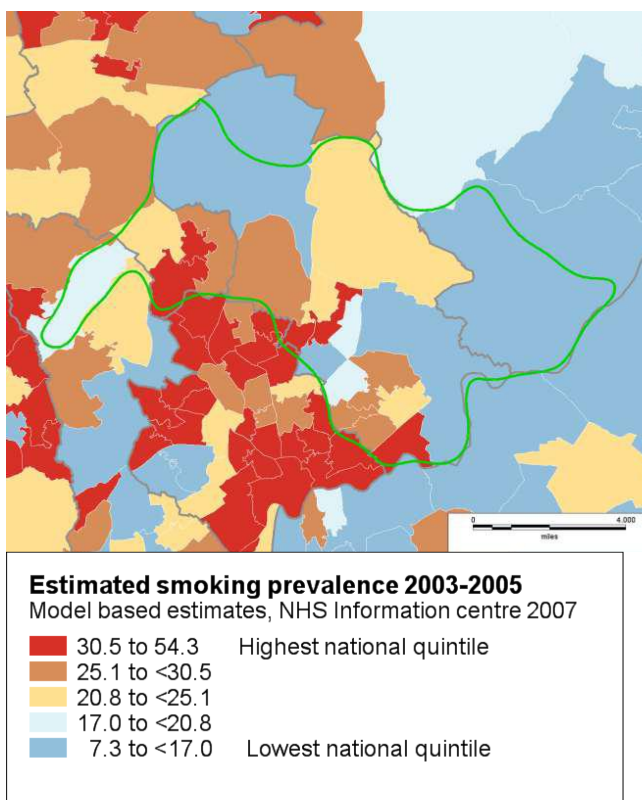


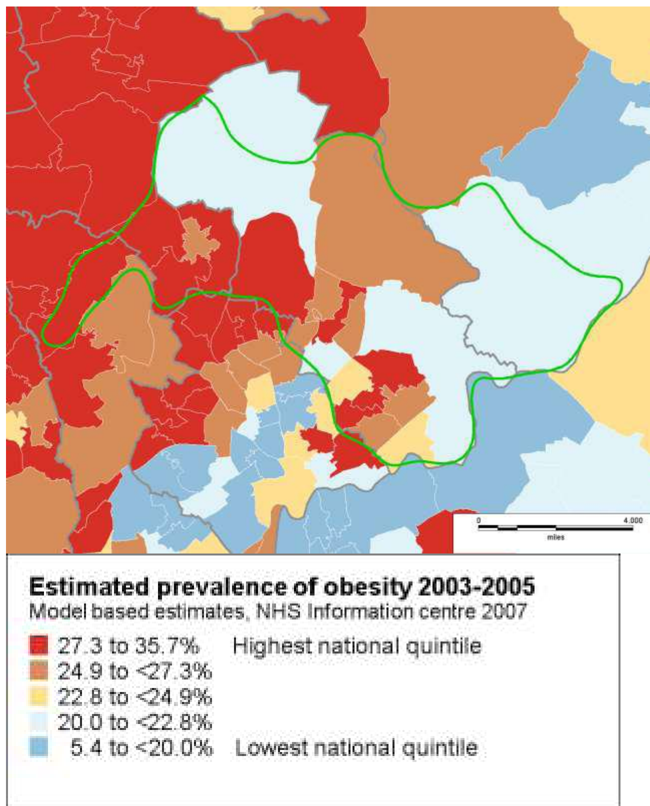
Figure 6: Main causes of death across Nottinghamshire (each dot represents 10 deaths)



Smoking significantly contributes to top 3 main causes of death and explains 50% of the difference in life expectancy across the county

Smoking prevalence Follows the pattern of deprivation…

Figure 7: Smoking prevalence in Nottinghamshire



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

Figure 8: Obesity prevalence in Nottinghamshire

Glossary/Abbreviations

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

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

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

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

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

Health and Social Care Bill 2011
Proposals for a Health Bill were included in the Queen's Speech for the first Parliamentary session of the coalition Government. The Health and Social Care Bill will bring forward the legislative changes required for the implementation of the proposals in the White Paper: Equity and Excellence, Liberating the NHS which includes the establishment of Clinical Commissioning Groups.

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

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

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

IAPT (Improving Access to Psychological Therapies)
Improving Access to Psychological Therapies (IAPT) is a Department of Health project. Psychological therapies have been shown to be an effective intervention for people with common

mental health problems such as depression and anxiety disorders, including posttraumatic stress disorder and obsessive-compulsive disorder. Within Nottinghamshire the service is called "Let's Talk Wellbeing" and individuals can self-refer or be referred through their GP.

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

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

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

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

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

NICE (National Institute for Health and Clinical Excellence)
The National Institute for Health and Clinical Excellence (NICE) was set up in 1999 to reduce variation in the availability and quality of NHS treatments and care - the so called 'postcode lottery'.
NICE evidence-based guidance and other products help resolve uncertainty about which medicines, treatments, procedures and devices represent the best quality care and which offer the best value for money for the NHS. NICE also produce public health guidance recommending best ways to encourage healthy living, promote wellbeing and prevent disease. NICE public health guidance is for local authorities, the NHS and all those with a remit for improving people's health in the public, private, community and voluntary sectors. (NICE site)

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

OOH (out of hours service)
Commissioned service to provide primary care medical attention during times when GP practices are closed.

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

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

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

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

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

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

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

Resident population
Resident population refers to residing in a geographic area.

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

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

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

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

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