North Derbyshire Clinical Commissioning Group

What we want to do

Clinical Commissioning Strategy 2013-2016

Document Information

Document location :

This document is only valid on the day it was printed.

Authorship:

This document has been prepared by:

Name	Designation	Organisation
Jennifer Stothard	Head of Strategy	NHS ND CCG

Revision history:

The current version of this document supersedes all previous versions.

Revision date	Summary of changes	Version
		V 1.0
07/09/2012	Amendments following comments from Chief Officer	V 1.1
14/09/2012	Amendments following comments received at GB developmental session	V 2.0
18/09/2012	Chief Officer comments	V 3.0
19/09/2012	Amendments to section 6	V 3.1
21/9/2012	Amendments to section 3.3	V 3.2

Approvals:

This document requires the following approvals:

Name	Signature	Date taken	Version
NHS ND CCG Governing Body in DRAFT form		27/09/2012	

Distribution:

This document has been distributed to:

Recipient	Date of Issue	Version
Chief Officer	6/9/12	V 1.0
NDCCG Governing Body	12/9/12	V 1.1
Chief Officer	17/9/12	V 2.0

Date for review:

Date of review	Name	Designation and Organisation
July 2013	Jennifer Stothard	Head of Strategy NHS ND CCG

CONTENTS

Section One – The Purpose of this document

1.1 What is a Clinical Commissioning Strategy?

The clinical commissioning strategy sets out our vision and values as an organisation, documents the local needs of our population and details the external drivers we face and to which we need to be responsive. The strategy shows what we are aspiring to achieve, and guides how we intend to allocate our resources both to commission services for our population and to effectively manage and run our organisation.

The clinical commissioning strategy will form the framework upon which we will review our performance, shape our priorities and service improvement proposals, make strategic decisions, create our annual delivery plans and develop commissioning intentions. The clinical commissioning strategy sets the strategic direction for North Derbyshire Clinical Commissioning Group (ND CCG) and in line with our governance structure and constitution the plans to deliver this strategy will be determined by each of our localities.

The strategy is influenced by the Derbyshire Joint Strategic Needs Assessment, the draft Health and Wellbeing Strategy and the part that the CCG can play in delivering those objectives but also to very local needs that can be identified by GPs working in neighbourhood areas. This is what clinical commissioning adds to previous structures within the NHS, the ability to identify and deal with very local issues.

We know we work in a changing environment. Whilst we have tried to anticipate future challenges we understand that there may be many changes during the next three years which we cannot foresee at this stage. We know that the NHS Mandate and the Planning and Commissioning Outcomes Frameworks have not yet been finalised and therefore not only have we tried to make this clinical commissioning strategy as flexible as possible we will also be reviewing the strategy regularly to ensure it remains appropriate.

The strategy has been discussed with our Clinical Reference Group and our Governing Body and then we will have discussions with our locality groups and practices, partners and stakeholders, patients and the public to ensure our priorities are recognised and supported by others. It is intended that this process will culminate in a presentation of this strategy to the Derbyshire Health and Wellbeing Board in January 2013 and then to the CCG Governing Body for final approval in February 2013.

Underpinning the delivery of the Commissioning Strategy are a series of “Making it Happen” documents which, for example, describe how we will change the culture and

ways of working in the CCG and member practices (Organisational Development Plan), the resources we will have available to do this (Financial Plan), the quality changes we wish to see and how we will monitor them (Quality Plan) and our Communications and Patient and Public Engagement Plans which outline how we will genuinely seek views from the public and act upon them. None of these elements are covered in detail within this high level strategy document.

Section Two – Our Clinical Commissioning Group

2.1 Who We Are

The coalition Government white paper Equity and excellence: Liberating the NHS[1] set out the vision for the NHS of the future with patients and clinicians at the heart of commissioning decision making. To enable this vision Clinical Commissioning Groups within Derbyshire were established in shadow form during 2011, have evolved and developed since this time ready to take on statutory duties from April 2013.

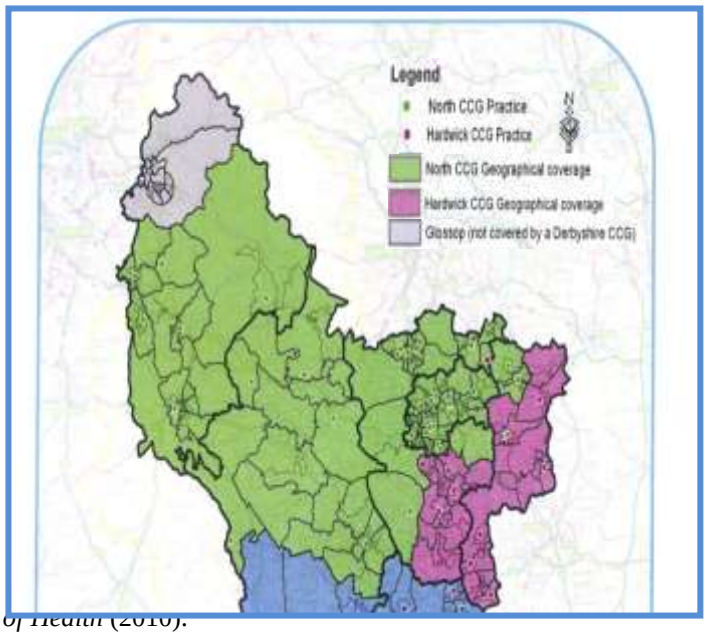
The core role of our CCG is to use the resources we have to commission (procure and contract for) health care which provides high quality, safe and effective care to meet the health needs of the population we serve.

The Clinical Commissioning Group Governing Body is chaired by a GP and includes four additional GP's from each geographical area, two lay members, a nurse, a specialist doctor from outside the area, a representative from the County Council a Public Health Specialist, an Accountable Officer and a Chief Finance Officer.

The constitution we have agreed with our member practices sets out how we will work within the following areas:

- The governing structure (including the Governing Body membership and sub-committees)
- The roles and responsibilities of the Governing Body members and member practices
- Standards of business conduct

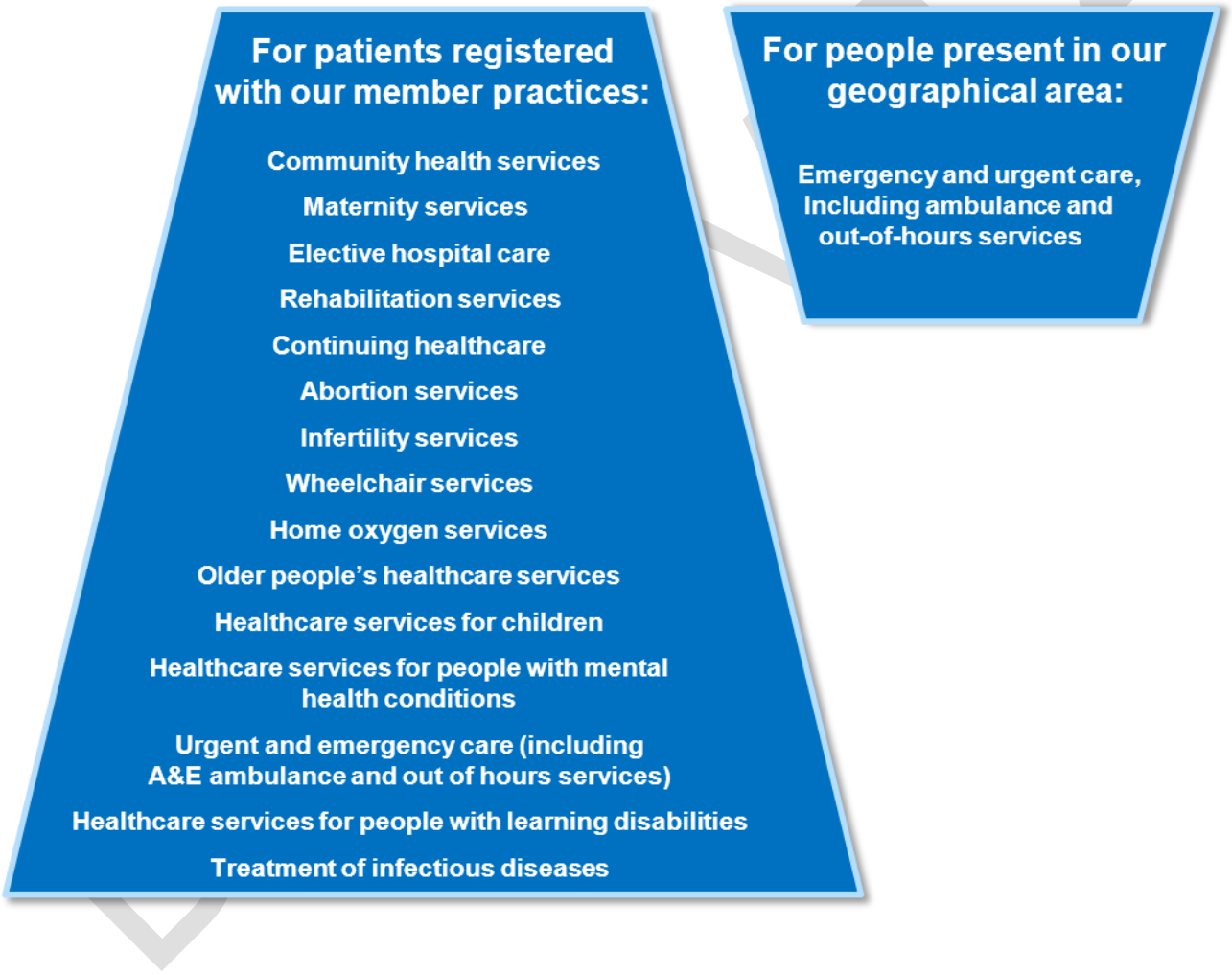
The NHS North Derbyshire Clinical Commissioning Group (NDCCG) comprises 38 member practices with a registered population of 288,000 and covers five geographical localities, Chesterfield, Dronfield, High Peak, North East and North Dales.



[1] Equity and Excellence: Liberating the NHS. *UK Department of Health* (2010). http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf [accessed 6/9/12]

The list below details the commissioning responsibilities of our clinical commissioning group.

This list has been determined by the Department of health[2] and shows the statutory responsibility of our organisation to commission the following health services for patients registered with our member practices and for patients unregistered; however present within our geographical area:



[2] The Functions of Clinical Commissioning Groups. *UK Department of Health* (2012) http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134569.pdf [accessed 10/8/12]

2.2 Our Values

Our values, as determined by our member practices, define our culture and will shape our decision making. They are;

2.3 Our Vision

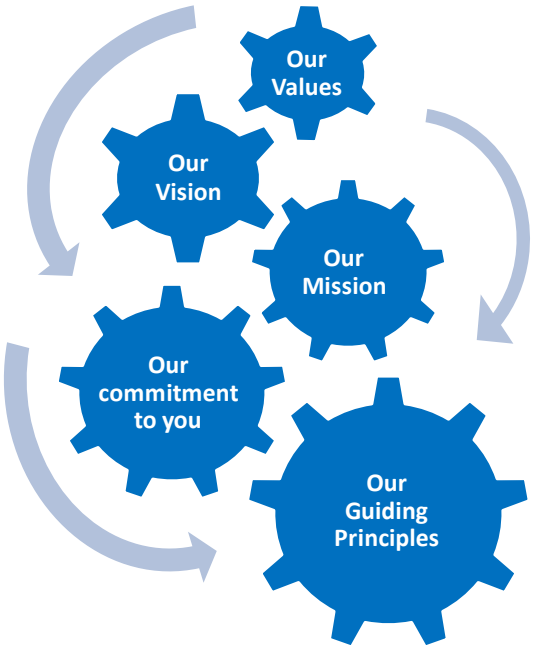
Our vision is to work in partnership to deliver a patient centred, clinically led, evidence based approach to service commissioning

2.4 Our Mission

Our mission is to improve the health and wellbeing of our population by commissioning high quality services through effective use of our resources

2.5 Our Commitment to You

We will behave with integrity, energy and enthusiasm. Our drive is to deliver improvements through innovation and the empowerment of individuals; be that patient, partner or colleague.



2.6 Our Guiding Principles

We actively seek feedback from our patients, our members, our partner colleagues and the general public both to help us plan services and monitor the performance of the services we commission.

During the spring of 2012 we held a series of events across the North Derbyshire health community to discuss with our patients, staff and the general public both the changes taking place in the NHS, the current challenges we face and how we need to approach the difficult decisions we need to make. The feedback we received at these events has shaped our guiding principles and will be used as a basis to guide our decision making on behalf of our population.

All services will be person-centred

We will work in partnership with people needing care and their families and carers to provide care as close to the person's home as possible, and when appropriate support them to access the right care away from home.

Care will be provided flexibly

We will listen to and understand the person's complete needs and meet them by using all services and resources available. We will ensure that we will co-ordinate care across health, social care and voluntary services to ensure people receive the right care from the right service at the right time.

Assumptions will be challenged

We will have the courage to make changes for the better that will improve the patient experience and obtain the best value for money. We will embrace innovation and find new approaches to care based on sound evidence. We will commit to monitoring and publishing patient experience data to be accountable to those who use our services.

People will be treated with dignity and respect

We respect and value the people who use and work in health and social care services in Derbyshire and we will invest resources to support the health and well-being of our communities.

We will plan and deliver services partnership

We will actively seek and listen to the views of people who use and work in health and social care in Derbyshire so that we can plan and deliver services in partnership and be accountable to them.

Healthy lifestyles will be promoted

We will support people to help them to make an informed choice about lifestyle and services and identify and provide extra support for those who need and want to make positive lifestyle changes.

Section Three – What Do We know?

Within this section of the clinical commissioning strategy we will detail the current health needs of our population identified by the Joint Strategic Needs Assessment (JSNA) and other profiles, the national drivers to which we need to respond, the local drivers affecting us and our partner organisations, the financial climate in which we currently work and our expectations in relation to financial allocations for the coming years.

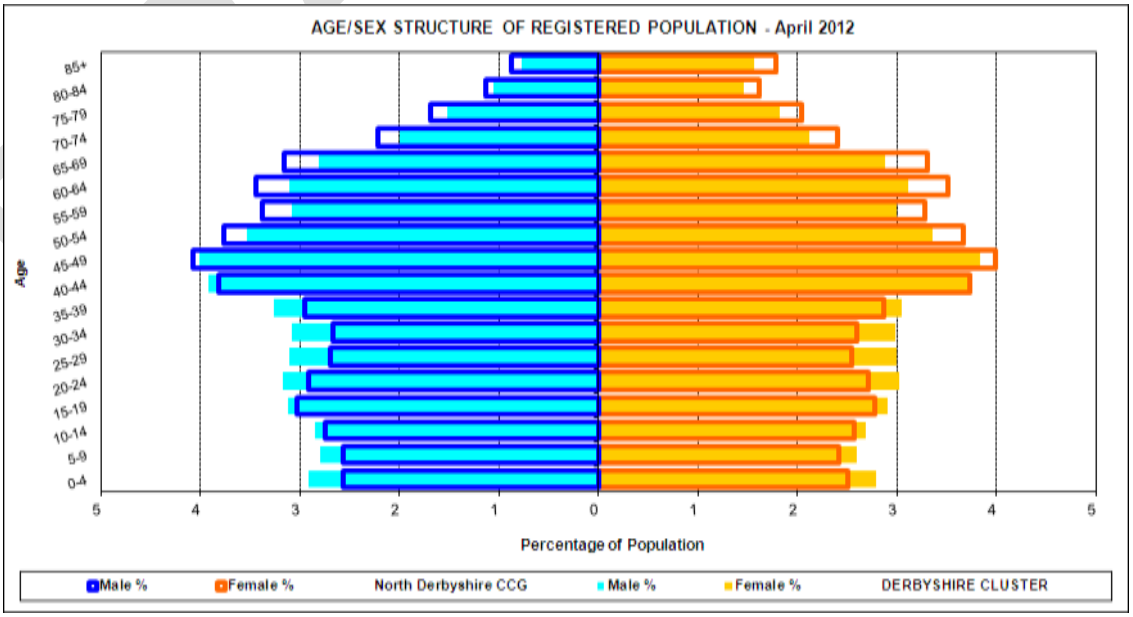
3.1 Local Needs

The JSNA and public health profiles for North Derbyshire CCG show a picture of variation across our geography. Our CCG covers a mixture of urban and rural areas each with their own unique characteristics, cultures and health challenges.

Our CCG is ranked 128 out of 212 CCGs in relation to levels of deprivation (where 1 is the highest) however within that are masked pockets of high levels of deprivation at locality and sub-locality levels. The higher levels of deprivation are found in the east of the CCG where there are high levels of unemployment following the demise of the mining industry, whilst the rural deprivation in the west must also be considered.

3.1.1 Demography

The following chart shows the age / sex structure of our member practices registered population compared to the Derbyshire average.15.4% of the registered population are under 15 years which is lower than the Derbyshire and national average for that age group. However 9.1% of the registered population are over 75, which is greater than both Derbyshire and national averages.



The age sex profile, ethnicity and measures of deprivation can give a good indication of future pressures on the health and social care system as well as in part explaining some of the current variation in certain measures seen across North Derbyshire.

As the chart shows for the CCG there are higher numbers of people over 65 than in Derbyshire with lower numbers of working age adults, young people and children. This is a challenge economically but also indicates a high dependency ratio of working age to older people which is more marked in some localities and projected to grow.

The ability of the system to manage demand is very dependent on unpaid carers and as the dependency ratios change maintaining the health of the carers takes on added relevance. This has been recognised nationally through the publication of the Care and Support White Paper and the Draft Care and Support Bill and is something on which we will need to work closely with our colleagues in Derbyshire County Council.

The table below shows the current population of NHS North Derbyshire CCG and the expected population growth.

Whilst the CCG is expecting lower than national average levels of total growth the expected growth in the over 75 population is higher than the national average and will be a major driver for the CCG to ensure we meet the health needs of our aging population.

Year	Population	Population +75
2011	287,697	26,129
2015	292,740	28,919
2020	299,744	33,852
2025	307,959	41,074
Average annual growth rate (2011 -2020)	0.5%	2.9%
England average annual growth rate (2011 -2020)	0.7%	2.3%

Within the working age population, there are higher levels of benefit claimants in a number of areas in particular Chesterfield (11.3%), Bolsover (15.3%) and parts of North East Derbyshire and High Peak. The levels of incapacity due to chronic ill health in the working age population will play through into later life and highlights the importance of quality disease management and equipping people with the confidence to manage their own condition and live independently.

This is reflected in the GP patient survey (2011/12) that shows the CCG has a greater than national average number of patients who identify as having “some problems walking or confined to a bed and also some problems with usual activities or unable”, which may reflect the demography and levels of deprivation across the CCG.

This signifies a key challenge to the CCG particularly to those member practices serving the more deprived communities. The measure of success in the future is less about further extending life expectancy but more about the quality of later life. Currently for example there is a twofold variation (5.8 to 10.4) in the number of years men of 65 years of age can expect to live free from disability This ageing profile also highlights the emphasis of quality end of life care for the CCG and the need to work seamlessly with colleagues in caring services.

The following chart shows the challenges for the adult population within the North Derbyshire CCG population, produced as part of the JSNA process.

NORTH DERBYSHIRE CCG

Joint Strategic Needs Assessment Adult Profile 2012

Key

Selection Rate:

- Significantly Worse than the Cluster Average
- Not Significantly Different from the Cluster Average
- Significantly Better than the Cluster Average
- Significance not assessed
- Localities

Supp. = Data Suppressed where number <5

Practices within the selection

Worst Rate — Best Rate

Cluster Average

	Indicator	North Derbyshire CCG Number	North Derbyshire CCG Rate	Cluster Rate	Worst Practice	Range of Practices	Best Practice
Life Expectancy	Life expectancy at 65 - Male		**18.4**	18.3	16.2		22.4
	Life expectancy at 65 - Female		**20.9**	20.7	19.1		26.8
Lifestyle	Alcohol related admissions to hospital	7,124	**1863.7**	1918.2	2803.0		1136.7
	Patients with a Long Term Condition who smoke	10,659	**14.9**	16.2	21.1		6.9
	Patients who had stopped smoking at 4 wk F/Up per 1000 population	1,750	**7.3**	8.7	0.0		13.3
	Recorded diabetes	14,307	**6.0**	6.2	8.4		4.1
	Excess weight in adults - reported obesity in General Practice	26,401	**11.3**	11.6	17.9		3.4
Health Protection	Flu Vaccine Uptake in 65+ years	41,649	**74.3**	74.3	65.8		84.1
	Take up of the NHS Health Check programme by those eligible	6,872	**65.1**	58.2	0.0		121.7
	Access to non-cancer screening programmes: Diabetic retinopathy	9,777	**70.7**	74.1	61.6		81.2
	Cancer screening coverage: Cervical	59,285	**86.5**	84.7	83.0		92.5
	Cancer screening coverage: Breast	29,667	**75.7**	77.2	67.6		83.6
Living with a long tem condition	Patients aged 18+ diagnosed with depression	29,018	**12.5**	11.2	22.2		2.4
	Dementia and its impacts	1,659	**0.6**	0.5	1.6		0.2
	Mental Health register	2,298	**0.8**	0.7	1.5		0.3
	Contacts with CPN, Psychologist, OT, Physio, or Psychotherapist, <65 years	47,358	**20.5**	17.1	2.8		44.4
	Contacts with CPN, Psychologist, OT, Physio, or Psychotherapist, 65+ years	11,784	**20.9**	24.9	5.8		42.6
	Unplanned hospitalisation for chronic ambulatory care sensitive conditions	554	**167.2**	159.2	401.8		86.4
Healthcare	Patient experience of primary care: GP services	9,669	**91.5**	90.3	79.4		98.7
	Patient experience of primary care: GP Out of Hours services	451	**60.3**	59.4	35.3		92.0
	Emergency admissions for acute conditions that should not usually require hospital admission	1,464	**415.0**	390.2	855.6		197.2
	Emergency readmissions within 30 days of discharge from hospital	5,518	**12.9**	13.8	16.9		9.9
	Hospital admissions as a result of self-harm	680	**2.6**	2.6	5.5		0.5
	Acute hospital admissions as a result of falls or falls injuries for over 65s	1,083	**15.4**	15.6	35.9		6.9
	Hip fractures in over 65s	366	**5.0**	5.8	10.1		1.2
Mortality	Under 75 mortality from all cardiovascular disease (inc. heart disease and stroke)	652	**57.9**	64.2	88.5		28.7
	Under 75 mortality from all cancers	1,098	**98.0**	101.3	183.0		46.7
	Under 75 mortality from lung cancers	241	**20.8**	23.7	65.8		0.0
	Under 75 mortality from liver disease	117	**11.4**	11.9	50.9		0.0
	Under 75 mortality from respiratory diseases	199	**17.3**	22.0	45.1		0.0
	Suicide	42	**4.7**	6.4	22.0		0.0
	Deaths in usual home	1,774	**20.5**	20.2	11.4		33.9
	Excess winter deaths	344	**19.2**	21.1	85.4		-20.0

The child population profile shows lower numbers of children under 5 however certain areas of North Derbyshire are showing higher birth rates than the rest of Derbyshire although not out of line with the England average. This will be important for future planning of maternity and health visiting services.

The following charts shows the challenges for the child population within the North Derbyshire CCG population, produced as part of the JSNA process.

NORTH DERBYSHIRE CCG

Joint Strategic Needs Assessment Child Profile 2012

Key

Selection Rate:

- Significantly Worse than the Cluster Average
- Not Significantly Different from the Cluster Average
- Significantly Better than the Cluster Average
- Significance not assessed
- Localities

Supp. = Data Suppressed where number <5

Practices within the selection

Worst Rate — Best Rate

Cluster Average

	Indicator	North Derbyshire CCG Number	North Derbyshire CCG Rate	Cluster Rate	Worst Practice	Range of Practices	Best Practice
Birth & Pregnancy	Low Birthweight Births (<2500g)	391	**7.0**	7.6	17.4		0.0
	Births to women <20 yrs	294	**22.7**	31.0	47.6		0.0
Health Protection	Diphtheria/Tetanus/Pertussis/Polio vaccine by 1st birthday	3,287	**98.1**	95.9	90.7		100.0
	Haemophilus influenza type B/Meningitis C booster	2,821	**96.3**	94.4	89.5		100.0
	Pneumoccocal Infection booster by 2nd birthday	2,789	**95.2**	93.9	83.3		100.0
	Measles, mumps and rubella vaccine by 2nd birthday	2,774	**94.7**	91.3	89.3		100.0
	Diphtheria/Tetanus/Pertussis/Polio booster by 5th birthday	2,642	**95.2**	91.2	65.0		100.0
	Measles, mumps and rubella booster by 5th birthday	2,564	**92.4**	88.6	65.0		100.0
Hospital Activity	A&E Attendances (<5 Years)	6,297	**439.0**	527.0	797.0		250.9
	A&E Attendances (5-18 Years)	13,595	**306.7**	307.2	567.4		174.8
	Admissions: Asthma (<5 Years)	129	**300.5**	293.6	1035.8		0.0
	Admissions: Asthma (5-18 Years)	199	**153.6**	169.3	430.3		0.0
	Admissions: Gastroenteritis (<1 Year)	304	**380.2**	260.0	902.8		0.0
	Admissions: Alcohol Specific Conditions (<18)	120	**64.1**	60.0	176.4		0.0
	Emergency Admissions: Injuries (<18 Years)	624	**71.3**	76.2	135.8		10.3
	Emergency Admissions: Accidents (<18 Years)	468	**51.8**	53.3	90.9		10.3
	Emergency Admissions: Assault (<18 Years)	50	**28.2**	31.9	87.6		0.0
	Emergency Admissions: Self Harm (<18 Years)	263	**134.0**	138.6	291.7		0.0
Mortality	Child Mortality (Age 0-19 Years)	58	**11.1**	12.4	51.0		0.0
Deprivation	Index of Multiple Deprivation (IMD) 2010		**19.0**	20.4	31.2		7.1

The health challenges facing the CCG vary across the localities and are best tackled in different ways and at different levels.

Some of the challenges may be better dealt with at CCG level through the commissioning route such as pathway development and tackling length of stay in a hospital. Others at the locality level, such as unwarranted variation in clinical quality when comparing to peers and the rest of the CCG. Some are best delivered at practice level such as improved recording of data. Some of the challenges require a partnership approach and reflect the priority areas identified by the JSNA and Health and Wellbeing Strategy and will involve collaboration and engagement with other local District and Borough Councils and other agencies whether for lifestyle support, integrated care or keeping people independent in safe and warm affordable housing.

However reflecting the CCG ethos the most important asset often overlooked are the people themselves who we can support to become more resilient and confident in managing their own health putting them at the centre of everything we do.

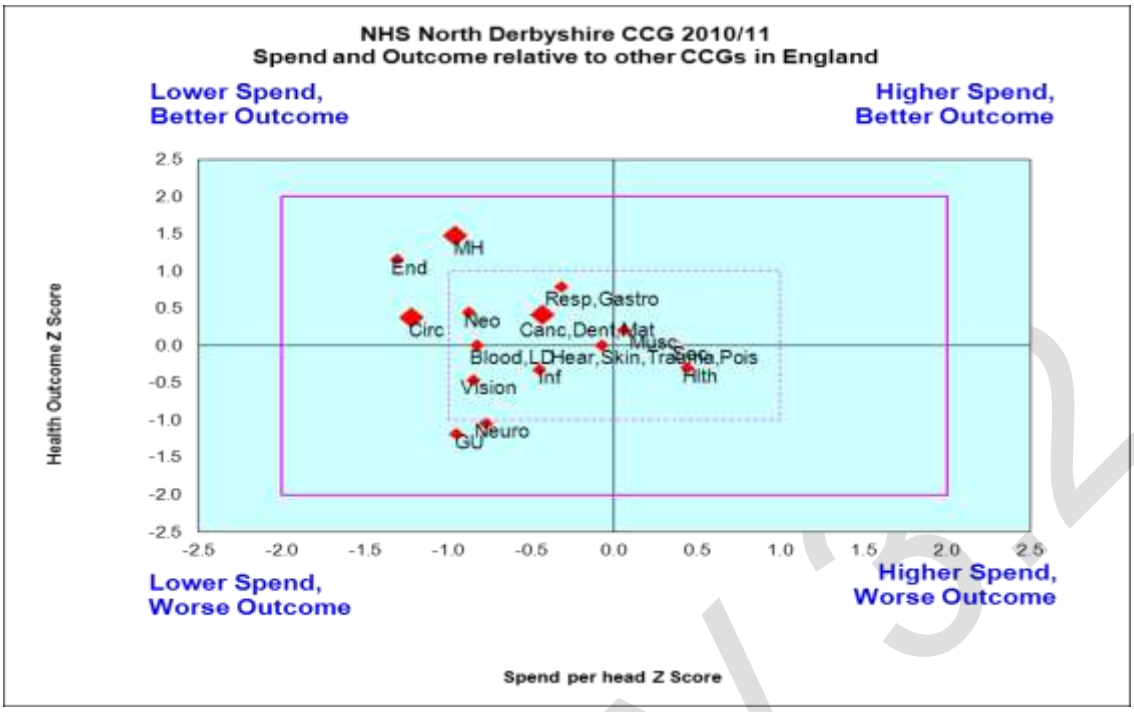
3.2 Evidence of what works

3.2.1 Commissioning for Value

Over the last six months the CCG has been working with national leads to understand the health profile of our population against the current commissioning position. We have been utilising the Programme budgeting tool and methodology to bring together information on needs, spends and outcomes to provide detailed analysis of where we vary from national averages and the areas on which we should focus to deliver the greatest health improvements for our population.

This work is called “Commissioning for Value” and underpins the strategic priorities of the CCG over the next three years and how we will plan to deliver the quality, innovation, productivity and prevention (QIPP) requirements.

The following SPOT (Spend and Outcomes) quadrant analysis tool details the performance of our CCG in relation to the health outcomes we are achieving for the money that we are spending, in comparison to similar CCGs within the county.



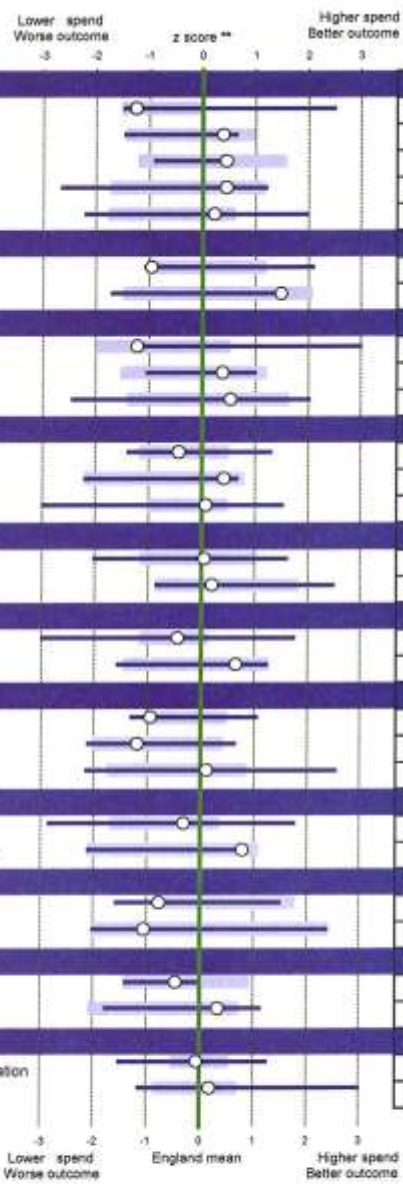
The analysis tool shows that we are achieving better outcomes with a lower level of expenditure on many clinical programme areas however there is still scope for improving the management of patients and reducing unwarranted clinical variation within the programme areas and across the CCG localities and member practices.

The following analysis shows the variation in spend and outcomes for our CCG compared to similar CCG's within England. This information enables us to understand our commissioning performance for our population and the areas we need to focus on for improvement.

YHPHO
YORKSHIRE & HUMBER PUBLIC HEALTH OBSERVATORY

NHS North Derbyshire CCG
Manufacturing Towns
East Midlands SHA

NHS Commissioning Board
A special health authority



	CCG 09/10	CCG 10/11	2010/11 values ONS Cluster	SHA	England	Notes
Overall						
Overall spend per weighted head of population	£1,552	£1,620	£1,686	£1,650	£1,751	1
All age all cause mortality	552	534	604	556	552	8
Deprivation - Index of Multiple Deprivation 2010	18	18	25	20	22	7
Slope Index of Inequality in Life Expectancy (males)	7.5	7.5	9.6	8.5	8.8	5
Slope Index of Inequality in Life Expectancy (females)	5.3	5.4	6.9	6.4	5.9	5
Mental Health						
Mental Health spend per weighted head of population	£157	£158	£191	£189	£209	1
Mortality from suicide and undetermined injury, DSR*†	6.2	5.0	8.4	7.2	7.8	8
Circulation						
Circulation spend per weighted head of population	£120	£109	£127	£124	£133	1
Mortality from circulatory diseases, DSR*, under 75 years	65	64	76	67	67	8
Patients with CHD whose last blood pressure < 150/90	90%	91%	90%	91%	90%	4
Cancers and Tumours						
Cancer spend per weighted head of population	£101	£98	£106	£103	£108	1
Mortality from all cancers, DSR*, under 75 years	105	106	120	109	110	8
% cancer patients receiving treatment within 2 months	87%	87%	85%	85%	86%	3
Musculoskeletal system						
Musculoskeletal spend per weighted head of population	£91	£96	£97	£97	£96	1
PROMs* EQ-5D Hips Health Gain		0.42	0.42	0.42	0.41	6
Gastrointestinal Disease						
Gastrointestinal spend per weighted head of population	£72	£78	£83	£77	£84	1
Mortality from gastrointestinal disease	18	16	22	20	20	8
Genitourinary system						
Genitourinary spend per weighted head of population	£72	£73	£76	£79	£86	1
Genitourinary deaths within 30 days of admissions, ISR*	2537	3216	3041	2896	2686	6
% CRF* with hypertension on ACE*/ARB* therapy	91%	91%	91%	90%	90%	4
Respiratory Disease						
Respiratory spend per weighted head of population	£74	£76	£83	£79	£82	1
Mortality from Bronchitis, Emphysema & COPD*, DSR*, u75	9	9	14	11	12	8
Neurological Disease						
Neurological spend per weighted head of population	£62	£68	£78	£80	£78	1
Mortality from epilepsy, DSR*, under 75 years†	2.4	2.0	1.6	1.3	1.4	8
Maternity						
Maternity spend per weighted head of population	£58	£58	£56	£59	£67	1
% Low birth weights	7.5%	6.9%	7.8%	7.6%	7.3%	2
Other						
Primary Care GMS*/PMS* spend per weighted head of population	£148	£144	£136	£145	£146	1
Miscellaneous spend per weighted head of population	£132	£168	£150	£150	£154	1

**** z scores**

A z score essentially measures the distance of a value from the mean (average) in units of standard deviations. A positive z score indicates that the value is above the mean whereas a negative z score indicates that the value is below the mean. A z score below -2 or above +2 may indicate the need to investigate further.

CCG value
SHA range
ONS Cluster range

Notes

1. Department of Health 2010/11 ‡
2. NCHOD 2008 - 2010 data ‡
3. Healthcare Commission 2009/10 ‡
4. Quality and Outcomes Framework 2010/11
5. SHA and Cluster values are PCT averages
6. Information Centre 2009/10 ‡
7. Population weighted average of LLSOA IMD 2010
8. YHPHO 2007 - 2010 data
9. Significant changes were introduced to the Programme Budgeting data collection methodology in 2010/11. Expenditure in 2010/11 should not be directly compared to expenditure in 2009/10. CCG mortality DSRs have been calculated using a methodology which assigns a geography to a CCG. These rates are subject to change either through further refinement to the methodology used or through changes to the CCG configuration. The metadata is available from YHPHO.

‡ CCG values based on PCT values

ONS Cluster

Clusters are used to group LAs together according to key characteristics common to the population in that grouping. The Office of National Statistics derive these groupings, known as clusters, from census data. CCG values have been derived from LA values.

† Rates based on small numbers.

*ACE - Angiotensin converting enzyme inhibitor
*ARB - Angiotensin receptor blocker
*COPD - Chronic Obstructive Pulmonary Disease
*CRF - Chronic Renal Failure
* DSR - Directly Standardised Rate per 100,000
*GMS - General Medical Services contract
*ISR - Indirectly Standardised Rate per 100,000
*PMS - Patient Medical Services contract
*PROMs - Patient Reported Outcome Measures

3.2.2 GP Practice Profiles

The CCG Practice Profiles are an online resource that will be used to assist GPs and practices in identifying whether they are providing adequate levels of effective and appropriate healthcare services for their local population. This will further inform the CCG if there is a requirement to commission additional services for currently unmet needs.

The profiles bring together indicators on population, Quality and Outcomes (QOF) disease prevalence and primary prevention, modelled disease prevalence, emergency hospital admissions and mortality across Coronary Heart Disease, Stroke, Diabetes, Chronic Kidney Disease, Mental Health, Cancer, Asthma, Chronic Obstructive Pulmonary Disease, Epilepsy, End of Life Care, Sexual Health and Vaccinations & Immunisations.

The practice profile tool datasets are presented at GP practice, Clinical Commissioning Group, Locality and former PCT level and can be viewed individually or across the whole of the Cluster.

Our CCG will work closely with our member Practices to ensure that the practice profile data is reviewed as part of the peer review process to ensure a better understanding of unwarranted clinical variation is achieved at practice, locality and CCG level.

3.2.3 NICE Guidance

Our CCG will ensure both our member practices and the providers we commission services from will comply with all mandatory NICE requirements. NICE audit tools will be used following identification of areas in which a member practice or the CCG is an outlier, to review local practice against recommended best practice and to recommend changes required.

3.2.4 Evidence Base Reviews

Our CCG will always use a sound evidence base in its decision making where this is available. We will be an active member in the Derbyshire wide clinical effectiveness and policy group and Joint Area Prescribing Committee. We will have clinically led discussions in our Clinical Reference Group to identify best practice and will ensure access to data sources such as knowledge management services and the Collaboration for Leadership in Health Related Research and the emerging Academic Health Sciences Network.

We will promote innovation with all providers and in what we do.

3.3 Resources and Multi Organisational Working

As a CCG we fully recognise that the new health and care system is complex and that collaborative working across many different organisations will be necessary. For example public health specialists within the Local Authority, specialised services commissioners within the NHS Commissioning Board Local Area Teams (NHS CB LAT) in Lincolnshire and Leicester, Cheshire, Wirral and Warrington and South Yorkshire and Bassetlaw (due to our diverse patient flows for tertiary and specialised services), primary care commissioners in the Derbyshire and Nottinghamshire NHS CB LAT as well as information from Commissioning Support Services on benchmarking of services and utilisation reviews.

We will also work with colleagues in County and District and Borough Councils to look at care services and the wider determinants of health e.g. leisure, housing and adult and children's services.

To ensure effective and joined up care pathways for people; we will work hard across this whole spectrum of commissioners and providers to provide the system leadership required. We will support our provider organisations and partner agencies to work in collaboration with shared visions and goals. Our GP clinical leaders will foster a culture of openness and joint working with a drive and determination to ensure that all of our population have a positive experience of care.

We have a clear memorandum of understanding with our CCG partners across Derbyshire which details the areas in which we will collectively commission and manage contracts, share key services, co-ordinate approaches to designated service providers, collaborate at a strategic level which includes a coordinated strategy and approach to system wide transformation and service reconfiguration and improvements.

Section Four – The Context In Which We Work

4.1 National Drivers

Our CCG will ensure delivery of the nationally determined improvement areas as detailed within the Department of Health *Our* NHS Care Objectives [3] draft mandate; within the following five domains:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term condition
- Helping people to recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

Delivery of better health outcomes within these domains underpins the strategic priorities of the CCG.

The CCG is also committed to the delivery of regionally mandated service improvements where they are shown to improve patient outcomes or reduce inequalities.

The CCG will work with its providers and local authority commissioning colleagues to deliver the quality and productivity improvements as detailed within the high impact innovations as detailed within Innovation, Health and Wealth document published by the Department of Health[4].

4.2 Local Drivers

Our CCG is a key member of the Derbyshire County Health and Wellbeing Board and is signed up to working in partnership to deliver the Derbyshire Health and Wellbeing strategic priorities which are:

- To improve health and wellbeing in the early years – because giving our children the best start in life will help them to achieve their full potential and benefit them throughout their lives
- To promote healthy lifestyles – because individuals and communities need the right support in order to make the best choices for their health

[3] Our NHS Care Objectives – A draft Mandate to the NHS Commissioning Board. *UK Department of Health* (2012). http://www.dh.gov.uk/health/files/2012/07/A-draft-mandate-to-the-NHS-Commissioning-Board.pdf [accessed 6/9/12]
[4] Innovation, Health and Wealth, *Department of Health* (2011) , http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_134597.pdf [accessed 6/9/12]

- To improve emotional and mental health – because good emotional and mental health is everyone's business and a fundamental building block for individual and community wellbeing
- To promote the independence of people living with long term conditions and their carers – because helping people to manage their condition better can significantly improve quality of life and reduce the need for hospital or emergency care
- To improve health and wellbeing of older people – because giving older people the right support in the right environment will help them enjoy good quality, active, health and fulfilling lives[5]

Derbyshire County Council is embarking on a radical journey to transform the care they provide to our population. This strategy to improve care, accommodation and support will be underpinned by a £200m investment and will encompass the development of specialist dementia friendly community centres alongside extra care housing and support.

Our CCG is committed to working closely with our Derbyshire County Council Adult Care colleagues to support these developments, which includes ensuring services are joined up wherever possible; including sharing of facilities, and ensuring that both health and social care services are redesigned together to meet the changing needs of our population.

4.3 Financial Climate

Our health community has an excellent track record of financial management. We have consistently maintained a prudent approach to risk whilst utilising our financial allocation to support the promotion of better health, the reduction of health inequalities and the commissioning of the best healthcare possible. The adoption of this approach will ensure that our CCG is in the best position to maintain that track record.

However, the current NHS financial climate which faces us all will nevertheless still be challenging for the CCG. The costs of delivering healthcare are constantly rising, due to the introduction of new drugs and technology alongside an aging population and increased expectations of the population we serve. Whilst we expect that our annual financial allocation provided by the Government will increase, we do not expect that it will increase in line with the rising costs; as such we will need to find ways to commission an increasing level of service with the same financial resources.

[5] Derbyshire Health and Wellbeing Strategy 2012-2015. http://www.derbyshire.gov.uk/images/Derbys%20HWB%20Strategy%20DRAFT%20June%20v3%201_tcm44-206119.pdf

Our clinicians are committed to achieving this by ensuring all of our resources are utilised effectively through close working of primary, community and secondary care clinicians and care colleagues to streamline the patient pathway and remove waste; by working with our population to support healthy lifestyle choices which will reduce the need for health services; through all professionals working together to ensure the services delivered are evidence based and improve outcomes for patients.

Within the Quality, Improvement, Innovation and Prevention (QIPP) section of this plan we will outline the specific areas we are focusing on over the next three years to ensure that we can continue to commission high quality care for all our patients within the current financial climate.

We know it will be a challenging time for our upper tier local authority, Derbyshire County Council. In terms of social care and support services both Adult and Children's services are under significant short and medium term financial pressure. Within Adult Care this stems from increased demand for care and support due to increased numbers of older people and people with complex care needs. The recent White Paper Caring for Our Future outlines the clear plans for the future of Adult Care Services but also includes financial risks. In particular this concerns new responsibilities to meet carers' identified needs. Within these constraints the CCG and Adult Care are working closely on agreed joint commissioning priorities including aligned investments.

It will also be a challenging time for the District and Borough Councils which are under significant financial pressure with budget savings planned for the foreseeable future. The CCG needs to be aware of and plan for increased population and planned housing developments but also the large part that District and Borough Councils play in terms of keeping people healthy through leisure and other related services. The CCG has already established a strategic group with the Chief Executives of all the authorities it covers and locality level contacts have been established to take forward very local issues.

4.4 21st Century Health and Social Care

The NHS System was designed 65 years ago to support people who in the main had short term health problems. There were some people using services for long term conditions but hardly any frail and elderly patients with multiple health conditions and social needs.

Due to this change in demography and all of the drivers as outlined above we know that we need to change our NHS to provide a health care system fit for the 21st century which provides high quality, safe and effective care, treating patients with compassion, dignity and respect[6].

[6] Our NHS care objectives – a draft mandate to the NHS Commissioning Board. *Department of Health* 2012.

To understand the priorities for our population we held a series of engagement activities which resulted in the coproduction of our guiding principles (see section 2.6) which we will use to inform our decision making in relation to how we will ensure the services our patients use are fit for the 21st century.

Our predecessor Primary Care Trust initiated work around transforming our community services to support the delivery of care at home or as close to home as possible and to ensure the buildings in which care is provided are safe and meet all the national regulations in relation to infection control and decontamination as well as an environment which allows care to be delivered with dignity and respect. Our CCG is committed to continuing this work ensuring that the community services we commission are transformed to meet the needs of our population.

We believe that when necessary our patients should have access to healthcare services provided by highly trained specialists, experts in their fields who see a sufficient number of people each year to maintain their high level of competence. We understand that this may mean that our patients may need to travel further to receive care in a specialist centre and we will work closely with our clinical networks to ensure that the care received is linked to local services to ensure our patients receive seamless care. Due to our unique geography we appreciate that our patients wish to receive care within geographical centres which represent multiple clinical networks (East Midlands, North Trent, Greater Manchester), our CCG will ensure we link closely with all the relevant clinical networks to ensure our patients are not disadvantaged.

We also believe that primary medical services need to be fit for the 21st Century so one of our key areas of work will be to focus on those services delivered by general practice to ensure they are also responsive to patients needs and deliver a good patient experience and outcome. It is fundamental to ND CCG that general practice should be resourced properly to deal with additional workload but also that it should work effectively and efficiently. The CCG is adopting the Productive General Practice scheme from the NHS Institute for Innovation and Improvement as the beginning of this work.

http://www.dh.gov.uk /health/search?q=our %20nhs%20care%20objectives [accessed 5/9/12]

Section Five – The Patient Focus Lens

We are keen that all of the planning and service redesign work that our CCG undertakes is done from the perspective of the person wherever possible rather than the requirements of the system or service. The public engagement events we ran linked to the 21st Century Healthcare principles used Mr and Mrs Taylor as fictitious individuals to walk through pathways of care to ensure they worked for real people. We have used real patient stories (told through the lens of Mr or Mrs Taylor) with our practices, localities and partners to illustrate where things have not worked well and how they could be better.

We will ensure that patient input and feedback is actively sought across all aspects of our healthcare system to ensure that the North Derbyshire health and care community is built on a culture of customer care and responsiveness.

Our CCG is committed to ensuring public engagement and involvement in the elements of the commissioning cycle namely:

- Assessing Need
- Design services to meet needs
- Procuring designed services
- Monitor effectiveness (ref NHSI engagement cycle)

We will achieve this in a number of ways which are set out in greater detail in both our Quality Plan and our Patient and Public Engagement Plan:

- Establishing close working relationships with LINk/Healthwatch to access intelligence gathered from our community ensuring we maximise the benefits we can obtain from the services they provide (for example Enter and View)
- Through strengthening the patient participation groups within our member practices to ensure that primary care issues and concerns are fed back to the Governing Body
- Making co-production a reality in service redesign
- Building on the public engagement activity to ensure openness and transparency in the working of the CCG
- Establishing structures to support network of our patient groups and key stakeholder organisations supported by a stakeholder forum to facilitate feedback direct to our Governing Body in relation to all of the health care services provided to our population

Section Six – Our Strategic Framework

The previous section of the clinical commissioning strategy highlighted the greatest health needs for our population, the national and local drivers and our patient focus. Within this section we will describe how our CCG will work differently to improve the lives of the population we serve.

Everything we plan to do can be classified under four overarching themes which are covered in more detail below. There are many overlapping actions between the themes and we have not repeated the detail under every section. Reference should also be made to the supporting suite of "Making it Happen" plans that the CCG has for Quality, Patient and Public Engagement, Communications and Finance as well as the draft commissioning intentions for 2013/14.

- Reducing unwarranted clinical variation
- Improving patient outcomes, health and wellbeing
- Improving patients' experiences
- Reducing unnecessary expenditure

6.1 Reducing Unwarranted Clinical Variation

We will use the commissioning for value locality packs to identify areas where localities are outliers against the Derbyshire and national averages. We already know that it is difficult to pick four areas at CCG level as the diversity of our population means that the priority areas change a lot at locality level. Clinical commissioning was introduced to allow for very local issues to be identified and resolved. We will ask all localities to review where they are outliers and we will agree priorities for action within their locality plans for 2013/14. The CCG embedded educationally focused Referrals and Medicines Management Team will assist with this process through peer review and support as necessary.

We will continue to work with secondary care colleagues to ensure that variation within hospital services is understood and acted upon where no justifiable reason can be found. This may be the number of follow up appointments offered or may be outcomes from particular operations performed. We will use all available data including for example the clinical outcomes framework and the patient safety thermometer to identify areas for focused work.

The CCG is made up of 38 member practices and we are passionate about the quality of primary care. We will use the information available to ensure people with long term

conditions are identified where appropriate and a care plan produced with the patient and their carer. We will agree after looking at the options a standardised risk stratification tool for use in primary care to identify people most likely to suffer a crisis or escalation in their condition and ensure that proactive care is put in place to minimise this where possible. His will include empowering people to take control of their own care as the "expert"

A continued focus on good quality prescribing will be maintained with all practices and prescribing colleagues in other provider services. We will agree between care setting the best use of medicines to minimise waste and ensure good patients outcomes.

We are also keen to reduce unwarranted differences in lengths of stay within a hospital setting or under the care of a community specialist. We are developing a pilot based on the QFI Jonah discharge planning tool that uses the theory of constraints to ensure that people are treated appropriately and in a consistent and timely manner.

6.2 Improving Patient Outcomes, Health and Wellbeing

It is not always possible to improve the outcome for every patient but we will strive to do this wherever possible within the resources we have available with the overall aim of reducing inequalities. As set out above we will further improve our management of people with long term conditions and use risk stratification tools to ensure people are provided with proactive care plans.

Our CCG will seek to secure continuous improvement in the quality of the health care services we commission through working closely with providers to ensure that services are clinically led, both in design and delivery and are regularly and rigorously reviewed to ensure they are not only safe and effective but deliver patient, family and carer satisfaction.

We will achieve this by gathering information from three main sources:

- Patient, family and carer feedback on the services they receive
- Clinician feedback with regards to the care provided
- Provider information relating to the performance provided

Only by putting the data together from all three sources will we truly understand the quality of the services provided for our population.

This information will be used to ensure we are holding our providers to account for the quality of the services they provide, informing procurement decisions in relation to quality standards required and shape our strategic priorities to ensure we are focusing on the areas which will make the greatest difference.

Within the governance structure of our CCG we have established a Quality Committee which gathers the information sources outlined above and reports directly to our Governing Body with regards to the quality of the services we commission. We have GP clinical leads who chair the clinical quality meetings with all of the providers in which we are lead commissioners and we have nominated GP leads for many clinical areas.

We are committed to the principles detailed within the national Dignity in Care[7] campaign and will ensure they are enshrined within the culture of the organisations we work with. Through the establishment of the Derbyshire Dignity and Respect[8] programme, jointly backed by Derbyshire County Council Adult Care and NHS organisations, teams from all sectors have been taking the challenge to ask themselves '"Is this the best we can do?". Through this system of self-review and challenge practical improvements have already been made across services and will enable continuous review and improvements.

We strive to promote innovation within the providers of the services we commission and encourage and support the research on all health related matters.

6.3 Improving Patients' Experience

In addition to improving patient outcomes, health and wellbeing, we will strive to take action on the feedback given to us, which will include the national and local GP patient surveys, community and secondary care provider patient surveys. From these we are aware that we need to improve access to primary medical services in some practices which includes telephone access, access to appointments and to timely clinical advice. We want to embark on a programme of customer care within the CCG and its member practices.

We also know that patients who attend some of our main acute hospitals wish to see improvements in those services and we will work in a supportive way through the contracting process to ensure that happens.

We will review the patient survey responses alongside what messages we receive from staff within the national staff surveys to ensure access, appointments, LINKs survey. We know we have areas in which we need to improve the experience of care for patients, their families and carers. We believe that the biggest single impact for patients and carers will be to ensure we commission and deliver care in an integrated way.

[7] http://www.dignityincare.org.uk/

[8] http://www.derbyshire.gov.uk/Social_health/adult_care_and_wellbeing/how_adult_care_works/what_you_can_expect/dignity_and_respect/default.asp

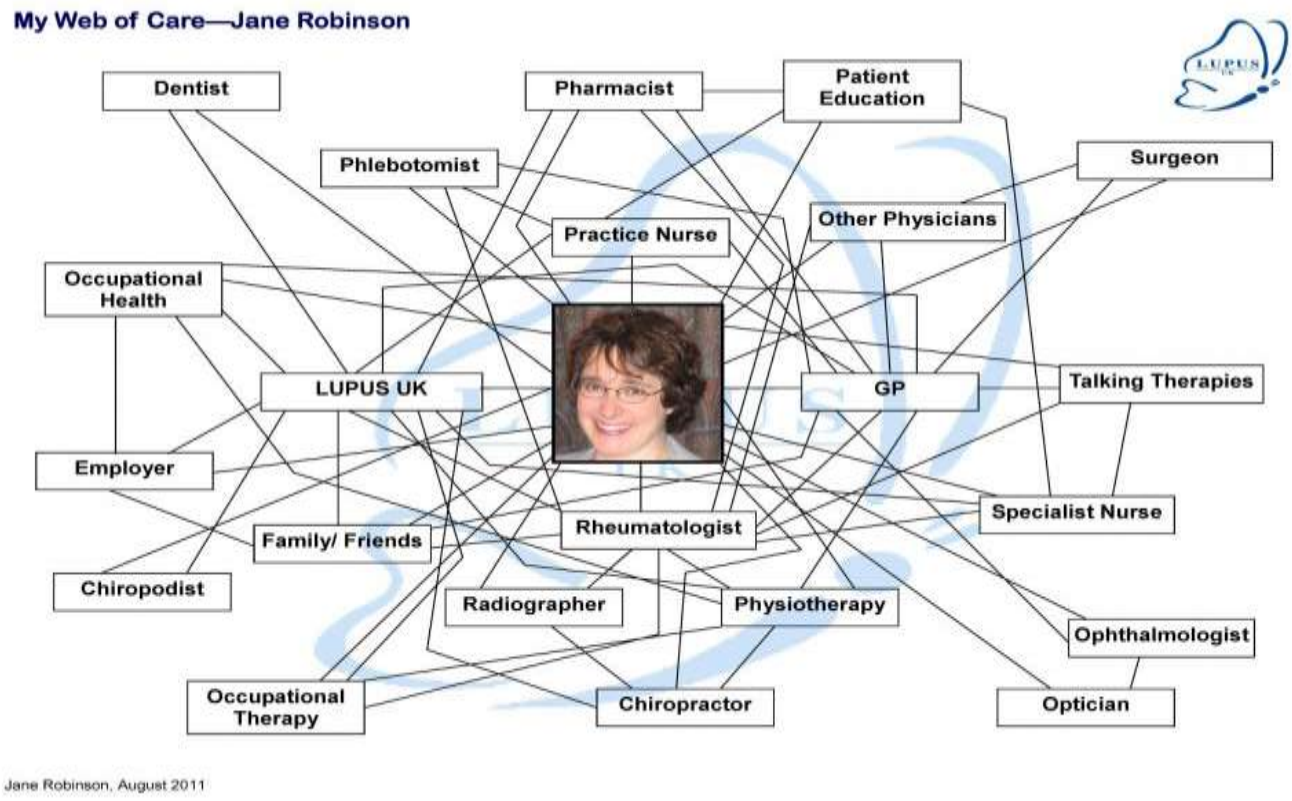
We believe that care should be delivered in an integrated manner that meets the overall needs of the person not just the immediate needs of the presenting condition.

To achieve this our CCG is committed to working with our providers and partner organisations to facilitate greater levels of coordination of care, to synchronise working practices across organisations to enable the standardisation of processes and documentation wherever possible and to work together to improve communication and close working.

We know that for too long across the NHS and social care we have been expecting patients to work their way through our systems which don't communicate effectively with each other and create duplication and frustration for patients, families and their carers as well as staff.

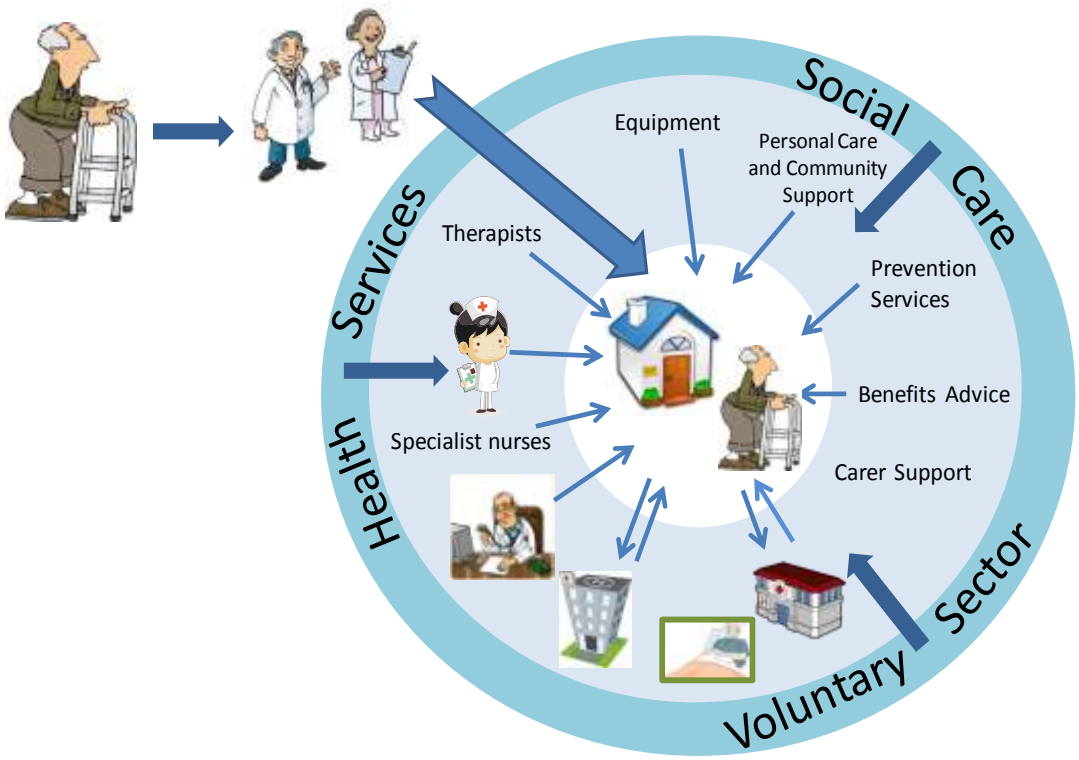
We want to create a joined up system in North Derbyshire which works together to deliver the care that patients need in the right place at the right time.

We want to go from this:



http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/images/janelupusweb_20110819_final_pdf.jpg

To this:



Our CCG is leading a programme of work with our partner organisations in health and social care that provide services to the population of North Derbyshire. The focus of this work is to develop a shared set of values and drivers for the health and social care community centred around the concept of *Mrs and Mrs Taylor* ensuring each time we discuss services and clinical pathways at the forefront of our mind is *Mr and Mrs Taylor* and whether the services we provide are good enough for them.

We are focusing on the barriers and blockages across the systems which prevent us providing services in a more integrated way. Through collaborative working with our partners we will remove each barrier as we identify it to ensure we are constantly striving towards our goal of greater integration between and across health and social care services.

We will coordinate quality and performance standards and incentives across the contracts we hold with our providers to ensure priorities are aligned and all organisations are focussed on pulling in the same direction.

We will facilitate the adoption of common principles and working practices underpinned wherever possible through the introduction of information systems which have the ability to link up and communicate effectively.

We will support the health and social care community to utilise innovative solutions to ensure joint analysis of demand and capacity requirements to enable activity planning across the whole system.

We will lead on public engagement and consultations to discuss and shape the changes we need to make across our health community to ensure the services our patients use are fit for the 21st century.

6.4 Reduce Unnecessary Expenditure

Our CCG will strive to ensure that value for money is obtained in all the contracts we let. This will be reflected in our approach to the commissioning and contracting of services, the service levels that we specify alongside the contractual tools which will use to incentivise our providers.

We will actively work with our partner organisations to share functions where appropriate to obtain the benefits derived from economies of scale. This will include lead commissioning arrangements with our partner NHS organisations as well as joint commissioning arrangements with our Derbyshire County Council Adult and Children's services partners where appropriate to ensure the best use of the health and local authority financial resources.

We will keep under continuous review the internal processes we use to ensure that we streamline our business processes to remove bureaucracy and waste wherever possible.

Section Seven – How we will use this framework

The framework will be used by all our member practices to determine the strategic priorities and areas we will focus on for improvement.

Our member practices will be supported to review local data based on needs, evidence and resources, analyse the information taking into account the national, regional and local drivers, within the context of patient, user, family member, carer and staff feedback.

The list of areas for improvement will be assessed against the clinical commissioning strategic framework of the four overarching themes;

- Reducing unwarranted clinical variation
- Improving patient outcomes, health and wellbeing
- Improving patients' experiences
- Reducing unnecessary expenditure

Against the following six criteria;

- Patient Involvement
- Quality
- Evidence Base
- Best Value
- Integrated Care
- System Impact

The framework will enable the CCG to systematically prioritise areas for improvement. This list of CCG strategic priorities will be used to create and inform the annual plans (locality plans, QIPP, Commissioning Intentions, Communication and Engagement).

Section Eight – Our Clinical Commissioning Framework on a page