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Ref:
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Members of the Shadow Health and Wellbeing Board

Dear Member

Shadow Health and Wellbeing Board

Please attend the meeting of the **Shadow Health and Wellbeing Board** to be held on **Thursday 26 January 2012** commencing at **10.00am** in **Committee Room No 1, County Hall, Matlock**

The agenda is set out below.

Yours faithfully

John McElvaney.

John McElvaney
Director of Legal Services

A G E N D A

1. Introductions and Apologies for Absence

2. To confirm the minutes of the meeting held on 24 November 2011

3. Joint Strategic Needs Assessment

4. Health and Wellbeing Strategy – High Level Priorities

5. Obesity Services in Derbyshire

6. Cluster Local Integrated Plan

7. Derbyshire Clinical Commissioning Groups Update

8. NHS Derbyshire and CCGs Commissioning Intentions for 2012/13 and the National Operating Framework

9. Public Health Transition Update

10. NHS 111 Urgent (non-emergency) Health Care Roll Out

11. Health and Wellbeing Round-up Report

12. Any Other Business

MINUTES of a meeting of the **SHADOW HEALTH AND WELLBEING BOARD** held on 24 November 2011 at County Hall, Matlock

PRESENT

Councillor A I Lewer (in the Chair)

H Bowen	Chesterfield Borough Council
D Briggs	Derbyshire LINK
Councillor J Burrows	Chesterfield Borough Council
Dr D Collins	North Derbyshire Clinical Commissioning Group
Dr A Dow	Tameside & Glossop Clinical Commissioning Group
Councillor Mrs C Hart	Derbyshire County Council
Councillor C W Jones	Derbyshire County Council
Dr S King	High Peak Clinical Commissioning Group
B Laurence	Derbyshire County Council/NHS Derbyshire
Councillor B Lewis	Derbyshire County Council
Dr S Lloyd	Hardwick Health Clinical Commissioning Group
D Lowe	Derbyshire County Council
Dr R Marwaha	Erewash Clinical Commissioning Group
E Michel	NHS Tameside and Glossop
Councillor C R Moesby	Derbyshire County Council
Dr A Mott	Southern Derbyshire Clinical Commissioning Group
B Robertson	Derbyshire County Council
I Thomas	Derbyshire County Council
Councillor R J Wheeler	South Derbyshire District Council

Also in Attendance – J Collins (Derbyshire County Council), J Cox (Derbyshire County Council), Councillor S J Ellis (Derbyshire County Council), Councillor G Farrington (Derbyshire County Council), A Pritchard (NHS Derbyshire), S Savage (Derbyshire County Council/NHS Derbyshire), L Syson-Nibbs (NHS Derbyshire), and D Timcke

23/11 **MINUTES** **RESOLVED** that the minutes of the meeting of the Board held on 22 September 2011 be confirmed as a correct record.

24/11 **POPULATION SCREENING AND IMMUNISATION PROGRAMME** Details were given of the Primary Care Trust Cluster's current screening and immunisations responsibilities, along with information regarding the future commissioning and management arrangements.

It was stated that the NHS Constitution set out in statute the responsibilities of PCTs to commission all National Screening Committee recommended screening programmes. Screening programmes needed to do more good than harm, and the PCT was responsible for the coordination, performance management and quality assurance of all the programmes it

commissioned. The work was led by public health in partnership with Regional Quality Assurance teams and PCT employed coordinators, secondary care providers and primary care clinicians. The screening pathways were often complex and involved multiple providers, and were supported by a range of different clinical and non clinical data management systems.

Vaccination and immunisation programmes were one of the most important ways of preventing childhood and adult morbidity and mortality. Primary Care Trusts had overall responsibility for the implementation of the national immunisation programme, and the right to immunisation was now part of the NHS constitution. The PCT commissioned immunisation programmes from general practices and other providers, and health professionals all had a role to play in promoting uptake and providing 'one off' immunisation services. In Derbyshire County, the best uptake rates had been achieved through an integrated primary care team approach to immunisation delivery. However, it was felt that there could be further improvements by extending integration to the local Multi Agency Teams.

Following the publication of Healthy Lives, Healthy People, it was apparent that screening would be a core responsibility of Public Health England, but the commissioning of programmes would be mandated to the National Commissioning Board. It was stated that there would be a need to recognise that screening services were interdependent with other NHS services. Public Health England would provide public health advice and quality assurance of screening and possibly immunisation programmes, but the details of how this would be delivered at a local level were yet to be shared.

The role of the Director of Public Health in screening programmes had not yet been fully defined, but it was thought that the need to work in partnership with the National Commissioning Board would be integral to ensuring that screening programmes were based on and delivered population needs. Health and Wellbeing Boards had a responsibility to determine local priorities and strategies, and the draft Public Health Outcomes Framework had identified indicators for both immunisation and screening.

Further detail regarding the interrelationships between Public Health England, National Commissioning Board and Clinical Commissioning Groups was expected, and details were presented to the Board on the likely role and responsibilities of local authorities, the Health and Wellbeing Board, Clinical Commissioning Group, Public Health England and NHS Commissioning Board.

The NHS reform and transition arrangements presented risks and opportunities for immunisation and screening programme commissioning and

management. Although public health led the commissioning and coordination of national screening and immunisation programmes, it depended at PCT cluster level on support from other departments. As commissioning and other directorate functions were devolved to Clinical Commissioning Groups, it was important that interdependencies were not overlooked. There were a number of potential vulnerabilities, and these were highlighted.

The PCT cluster remained accountable for commissioning and performance management of screening and immunisation programmes. Overall, these programmes performed well, and in some instances were amongst the best in England and East Midlands. There would continue to be areas that required continued monitoring to ensure that the quality and effectiveness of the programmes was not compromised during the transition period. The Health and Wellbeing Board would take this into account when developing its strategic intentions to improve health and address health inequalities.

25/11 SEXUAL HEALTH SERVICES: FUNDING AND COMMISSIONING ISSUES An overview was given of sexual health needs and services in Derbyshire, along with a summary of key issues relating to the transfer of responsibility for commissioning most sexual health services to the County Council in April 2013.

Due to a ten year programme to improve sexual health in Derbyshire, there had been a marked improvement in a number of key sexual health outcome indicators. In general, Derbyshire had better sexual health than the population of England, but maintaining progress required further service development to secure effective pathways of care, and commissioning a comprehensive range of sexual health treatment, care and prevention needed to respond to a variety of needs across different populations. The current budget for sexual health services was £7.3million, and details were given of the range of sexual health provision currently commissioned in Derbyshire.

The Public Health white paper proposed that Tier 1 local authorities would take on responsibility for commissioning most sexual health services from April 2013. The NHS Commissioning Board would have responsibility for commissioning some sexual health services, but commissioning responsibility for some other services had not yet been finalised. Further details were expected in spring 2012. The Health and Wellbeing Board had overall responsibility for determining local priorities through the Joint Strategic Needs Assessment, and also for developing the strategic framework to ensure delivery against the priorities.

The ongoing NHS and public health system reforms presented a number of challenges and opportunities, which would need to be addressed to ensure successful transition to the new arrangements. A challenge was to

maintain sufficient capacity and infrastructure to support effective sexual health commissioning, contracting, procurement, performance management and governance. This would be facilitated by clear prioritisation of the sexual health commissioning work programme, developing links with the Clinical Commissioning Groups, and working with Derby City. Another key challenge was the need to maintain costs within available resources. The Public Health ring-fenced budget would be calculated based on actual public health spend in 2010/11, but this had not yet been confirmed.

RESOLVED to (1) note the significant changes to sexual health commissioning responsibilities proposed in the public health system reforms; and

(2) support the proposed measures for managing the transition to the new commissioning arrangements.

26/11 SCHOOL LUNCH TAKE-UP 2010/2011 'KEEPING CHILDREN HEALTHY' REPORT The results of the 2010/11 national school lunch take up survey had been published in July 2011. A summary was provided on the progress made with increasing the take up of paid and free meals in Derbyshire schools for 2010/11.

At a national level, school lunch take up continued to increase, and on average, 44.1% of primary school pupils and 37.6% of secondary school pupils had had a school lunch each day between April 2010 – March 2011. Since 2008/09, there had been a total rise in take up of 4.8% in the Primary sector and 2.6% in the Secondary sector. In Derbyshire, school lunch take up had also continued to rise. In 2010/11, there had been an increase of 2.8% in Primary school pupils and 2.3% in Secondary school pupils. Since 2008/09, there had been a total rise in take up of 4% in both the Primary and Secondary sector.

Since 2008, in Derbyshire over 1200 more children had been eating a school lunch each day. Some of the initiatives to increase take up had been improved choice on menus, acting on pupils and parent feedback, Food for Life Partnership project, a marketing campaign in Secondary Schools, the introduction of Deli bars in Secondary schools, intensive staff training, and a quality assurance training programme with increased targets.

The provision of healthy foods in schools was popular with some pupils. However, many schools and caterers still had problems with engaging pupils and parents to increase the take up of healthy meals at lunchtime. Take up of school lunches was still below 50%, which meant that over half of pupils in Derbyshire were either taking packed lunches to school or were eating off school premises. Lots needed to be done to ensure that the percentage of pupils having school lunches continued to increase.

The County Council would continue to improve school meal take up by working with schools to deliver low cost, practical solutions to increase the number of pupils eating lunches. Work would continue to improve kitchens and dining spaces to increase free school meal take up and introduce new marketing campaigns.

RESOLVED to note the continued increase in the take up of healthy and nutritious meals in Derbyshire schools.

27/11 CHILDREN'S SERVICES INTEGRATED COMMISSIONING TASK GROUP The Shadow Health and Wellbeing Board had previously endorsed the establishment of a time limited group to make recommendations regarding the future model for integrated commissioning of Children's Services. Details were given of the progress of this group.

It was proposed that the existing joint arrangements be retained and strengthened to ensure co-ordination across the county. Governance would be through the Children's Trust Board, and it was felt that effective links with the Clinical Commissioning Groups throughout the county would need to be developed.

A single integrated Children's Commissioning Team would commission services through a range of joint arrangements, and these were highlighted. The team would continue to include input from public health colleagues, and joint work with Derby City would take place where it was felt relevant. The ongoing development of the model would need to take account of any changes in policy/direction at a national/regional level, and progress would be formally reviewed in April 2012.

RESOLVED (1) to agree the proposed approach; and

(2) to endorse the further work required to develop this approach.

28/11 PROGRESS WITH IMPLEMENTING SELF-DIRECTED SUPPORT Progress made with the development and implementation of the assessment, support planning and service access arrangements introduced fully from 1 April 2011 to deliver Self-Directed Support (SDS) was reported.

The approach developed for Derbyshire was based on national policy and extensive local development work completed through the Making Care Personal Programme. The reorganisation of Adult Care, previously approved by Cabinet, had established a structure relevant and capable of delivering a sustainable system of personalised adult social care.

Following the completion of development work, coinciding with the conclusion of the Making Care Personal programme, and the reorganisation of the department, principal responsibility for the implementation and development of SDS had transferred to the Fieldwork Division. All new referrals were now received and dealt with using the new assessment approach, tools and systems, including the Resource Allocation System (RAS), that had been developed as part of a national consortia of local authorities.

Details were given of the growth of clients in receipt of a personal budget or a direct payment within each financial year since April 2008, and a projected outturn for 2011/12 and 2012/13 was also stated. Exponential trend analysis of national returns for all local authorities suggested that the forecast for 7983 in 2011/12 would be within the top 25 of local authorities in terms of the volume of clients. However, it was anticipated that a range of work currently being undertaken would increase the number of clients reviewed and assessed over the period, and as a result, the final position could vary.

The progress and performance of the Department with the implementation and further development of SDS had been reviewed by the SDS performance and strategy group. This had taken into account the data available, the evidence obtained from file audits, and the examination of 45 cases involving people with high support and complex needs as part of work completed to assist the further refinement of the RAS. The conclusions reached from this exercise were presented.

Overall, the Department had established a strong position, and it was felt that most people were being advised of their Indicative Budget before work to develop a support plan commenced. This was a key element of NI130. The introduction of the automated calculation system for the Indicative Budget into Framework-I had significantly improved the speed of response. There had been a reduction in the number of cases where the Indicative Budget appeared to be significantly in error or was disputed.

The development of the RAS was expected to further improve the accuracy and consistency of the calculation of the Indicative Budget, particularly for those people with high support needs and complex difficulties. There was strong evidence that the reliability of the Indicative Budget derived from the RAS was as a result of the steady improvement in the quality of assessments. The quality of descriptions of the personal circumstances of people had significantly improved.

The quality of person centred assessment work was reflected in the low level of complaints or referral to the review process established to deal with cases where clients had disputed the outcome of their assessment. There had been a positive response from care/support providers, which needed to

be matched by a further improvement in the quality of outcome descriptions developed for people.

Brokerage had developed well, and was widely used to secure quick access to care/support services provided by the independent sector and Direct Care domiciliary care services. The use of the Brokerage service for access to other personal care/support services provided by Direct Care needed to be developed. The Brokerage Team had secured flexible responses to an increasing number of support plans, and it was expected that this would expand the diversity of solutions used. The Brokerage Team invested a proportion of time to publicising the outcomes being achieved and the experience derived from work to establish cost effective support plans for individuals. Independent brokerage and support planning provided by the Disability Derbyshire Coalition for Inclusive Living through the service level agreement still needed to be more widely promoted.

Costing for Direct Care services needed further development and this had now been addressed by the Adult Care Senior Management Team. The inclusion of transport as an integral part of support planning was still limited, and the structure and budget for transport needed to be addressed. The Prevention Strategy 2011-2014 had been formally approved by Cabinet, and the investment proposed in the development of a Trusted Befriending Scheme was progressing well.

The priorities for development identified by the performance and strategy group were stated, along with the range of other matters that would be looked at in more detail over the next six months. This included Safeguarding and SDS, positive person centred risk management, equalities, advocacy, User Led Organisation brokerage and support planning, managed bank accounts and financial management, and leaner approaches to operating systems.

RESOLVED that (1) the progress made with the implementation of Self-Directed Support for Adult Care and priorities for further work be noted; and

(2) consideration be given by the Adult Care Board to the involvement of Clinical Commissioning Groups in Self-Directed Support.

29/11 DEVELOPING A HEALTH AND WELLBEING STRATEGY FOR DERBYSHIRE The process of developing the Derbyshire Health and Wellbeing Strategy by describing current plans and priorities which the Health and Wellbeing Board would need to consider was stated. Previous reports to the Board had highlighted the key elements of the Strategy.

To be effective the Strategy would need to be a means to drive local change, tackle public health challenges, achieve the better use of resources

through integrated commissioning, link Health and Wellbeing Boards to wider public services, and develop productive relationships with Clinical Commissioning Groups.

In order to develop the Strategy, the Board would need to agree a small number of high level priorities around which the strategy could be framed, and the development of these priorities would be undertaken over the coming months. It was the intention to have developed these by January 2012 so that the Board could consider them at the next meeting It was suggested that the prioritisation process adopted by the Board should be guided by an agreed set of principles, incorporating clear criteria. The Derbyshire Joint Strategic Needs Assessment had summarised key health and wellbeing priorities for the county, based on population health need. Views on priority issues had also been gathered via the Health and Wellbeing Board Stakeholder Engagement event. As well as taking these views into account, the priorities would also need to consider existing priorities for partner organisations along with national and other local priorities. A number of other key current or emerging strategies were highlighted.

A task and finish group would be convened, comprising representatives from public health and the County Council, to manage the day to day process of writing the strategy, and this group would be supported by a wider reference group.

RESOLVED that (1) a small number of high level priorities should be agreed by the Board, in line with agreed prioritisation principles, around which the strategy can be developed;

(2) these priorities should be those with clear benefits from joint action by the different agencies represented;

(3) the selected priorities will need to be linked with clear outcome indicators in order to ensure progress can be monitored;

(4) the Board approves the convening of a task and finish group to undertake the day to day management of the strategy development; and

(5) proposed priorities be put to the next Board meeting in January for consideration.

30/11 **SHAPING DERBYSHIRE HEALTHWATCH** HealthWatch would be the new consumer champion for health and social care in England, and it would exist in two forms – local HealthWatch organisations at a local level, and HealthWatch England, which would operate at a national level.

The County Council had the responsibility to facilitate the development of an effective local Derbyshire HealthWatch service to commence in October 2012. Derbyshire HealthWatch would provide a range of services, and these were detailed. It would take on all current LINk statutory roles and functions, build on what was already working well, and have a specific focus on the need to be representative of diverse communities.

As part of the initial considerations for HealthWatch development, it was generally felt that local LINks lacked visibility. Local HealthWatch would need to be more visible and better able to evidence its activity to ensure the greatest representation for local people. To promote a wider pool of stakeholders, it was suggested that a clause be written into contracts that providers needed to encourage membership of the local HealthWatch.

The local HealthWatch service would need to effectively manage relationships with the Clinical Commissioning Groups in Derbyshire, and up to 17 external acute hospitals that provided services to Derbyshire residents. The South Derbyshire Clinical Commissioning Group represented both the City and County, and consequently would require Derbyshire HealthWatch and Derby City HealthWatch to work closely together. Liaison between Derbyshire and Derby City commissioners had already taken place to ensure that both HealthWatch would be visible to the public across the council boundaries.

It was the intention to have procurement documentation, including the service specification, ready for February 2012, and adverts to tender the service would follow shortly after. A small project was being set up to oversee the development of a vision for HealthWatch in Derbyshire, and this group would take on the responsibility for shaping the specification in partnership with local stakeholders. The group would include representation from a range of organisations, and it was also felt that a member of the Derbyshire Youth Council should join.

RESOLVED that work continues on developing a vision for Derbyshire HealthWatch to include:-

- To continue drafting the service specification, taking account of any further Department of Health guidance about the expectations of HealthWatch and funding available
- Identifying with colleagues in Derby City potential ways of ensuring that each HealthWatch organisation provides clear advice across Health boundaries and to consider how infrastructure costs might be shared to promote Best Value
- To promote within the tender the expectation that a Host provider will work with the HealthWatch membership to develop a distinct/high profile organisation that has its own corporate identity

- To ensure that all new contracts set by Derbyshire Adult Care and the local NHS requires providers to take responsibility to promote to people HealthWatch when it is operational; and
- That further reports be submitted to the next meeting of the Board updating it on progress in establishing Derbyshire HealthWatch.

31/11 TAMESIDE AND GLOSSOP TRANSITION OF PUBLIC HEALTH INTO LOCAL AUTHORITIES An update was given on progress of the transition thus far, and proposed the process to manage the transition and facilitate the alignment of PCT Public Health staff to Tameside MBC. Local authorities had begun preparations for the change in responsibilities from April 2011 onwards, and by April 2012, shadow arrangements for discharging the public health responsibilities within upper tier local authorities should be in place.

Indicative budgets would be issued for April 2012 onwards, and ring fenced budgets based on the funding currently devolved to public health activity in the NHS would be given to local authorities from 2013. The current proposals were that public health commissioning would be subject to oversight by the Tameside Health and Wellbeing Board to ensure it reflected the priorities identified in the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. Derbyshire Health and Wellbeing Board would provide the oversight for the Glossopdale area, although responsibility for the health and wellbeing of Glossopdale residents would remain the responsibility of NHS Tameside and Glossop until the transfer of responsibility to Derbyshire County Council in April 2013. The roles and responsibilities of the Director of Public Health and supporting team were detailed.

In driving the transition agenda forward, a fundamental aim was to sustain and review existing programmes, maintain the resilience of local public health functions, and minimise risks from the transition. There were a number of issues, and much uncertainty was due to a lack of clarity in aspects of the role and function of the NHS Commissioning Board, Public Health England and the scope of local authority Public Health responsibility.

In order to support the transition of the function to Tameside MBC, a joint transition group was planned, which would focus on key areas, including public health role and functions, finance, human resources, IT and Information, commissioning public health services, and Glossopdale – work would need to be undertaken with the County Council and Derbyshire County PCT to determine a safe transition of responsibilities and commissioned services. All issues would be translated into the action plans, the implementation of which would enable the formal establishment of public health within local authorities. The Director of Public Health recruitment process had commenced, and the post would continue as a shared post with Tameside MBC and have responsibilities for the Tameside and Glossop

locality until 2013. Guidance was expected shortly regarding the content of the Public Health Transition Plan, which would have to be submitted to the Strategic Health Authority by March 2012.

The local authority was driving forward a comprehensive change agenda, and this would incorporate a vision for public health across all functions of the local authority that delivered health and wellbeing. Leadership for health, wellbeing and inequalities should be a corporate responsibility, and as such, the Director of Public Health had to be placed accordingly within the local authority to retain the independence that was essential to fulfil the role. In the transition period, the Interim Director of Public Health would undertake a variety of roles, and these were stated. It was expected that certain functions within the structure would transfer to other parts of the new NHS system, and this would be determined by further policy guidance.

During the transition period, the arrangements would be overseen by the Health and Wellbeing Board in Tameside to ensure engagement across all partners. The link to Derbyshire would be maintained through the Health and Wellbeing Board, and the other collaborative arrangements in the county.

It was stated that, for Tameside and Glossop, the prospect of an early move towards informal alignment would be possible due to the strength of the existing relationship between the local authorities and the PCT. As a result, it was proposed that arrangements were put in place to facilitate the transition of public health in Tameside MBC by March 2012.

In terms of next steps, it was the intention to set up a transition planning group, to ensure the transition plan was submitted to the Strategic Health Authority in March 2012, to develop a Memorandum of Understanding to clarify and underpin the terms of agreement for the early transfer of staff, and that the process of transition should be accountable to the Chief Executive of Tameside MBC, the Locality Board, Tameside Health and Wellbeing Board, and inform Derbyshire Health and Wellbeing Board.

It was noted that a Transition Steering Group for Derbyshire had already been established, and was undertaking a similar change process to that in Tameside.

RESOLVED to support and endorse the proposals to enable transition planning to continue.

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

26th January 2012

JSNA

Purpose of the report

The purpose of this report is to update the Board on the process and timetable for the development of the Joint Strategic Needs Assessment in Derbyshire.

Background

The Joint Strategic Needs Assessment (JSNA) has been a statutory requirement for upper-tier Local Authorities and Primary Care Trusts since 2008. Going forward, the Government expects the JSNA to have a strengthened role, and alongside Health and Wellbeing Strategies will be, "…the pillars of local decision-making, focussing leaders on the priorities for action and providing the evidence base for decisions about local services" (Department of Health, 2011, p.7).

When Health and Wellbeing Boards become statutory in April 2013 (subject to the successful passage of the Health and Social Care Bill through Parliament) they will take on the statutory responsibility for undertaking the JSNA and Health and Wellbeing Strategy.

Recent Guidance, "*Joint Strategic Needs Assessment and joint health and wellbeing strategies explained – Commissioning for populations"* has identified the following key aspects for the Health and Wellbeing Board in shaping an approach to the JSNA:

- An expectation that Health and Wellbeing Boards should take action now on refreshing their JSNA and developing Health and Wellbeing Strategies whilst statutory guidance is developed.
- Emphasising the role of the Health and Wellbeing Board in local leadership, integration and engagement of key stakeholders. Focussing on integration and alignment at both strategic and delivery levels and on "collective action" particularly in relation to the wider determinants of health and wellbeing and issues that need to be jointly tackled.
- Proposing that the Health and Wellbeing Board adopts an „outcomes-based approach". The Health and Wellbeing Board is suggested as the place where the national outcomes frameworks come together.
- Local Authorities, NHS Commissioning Board and Clinical Commissioning Groups (CCGs) will need to take due regard of the JSNA and Health and Wellbeing Strategy when drawing up their commissioning plans to ensure

alignment. This will also be a feature of the authorisation process for Clinical Commissioning Groups.

- The Director of Public Health will act as the “lynchpin“ between local health and local authority services.
- A clear shift in focus of the JSNA from not only identifying need but also as a tool to analyse available assets and resources.
- Draft guidance on the JSNA and Health and Wellbeing Strategies will be released in January 2012. The guidance will, however, „…not specify form or detailed content“ which is to be determined locally.
- Indicative timescales are suggested, proposing a JSNA refresh is underway by January 2012, priorities identified in April 2012 and strategy to be developed in May 2012.

JSNA – Our Approach in Derbyshire

Refresh of data sets

The current core data set underpinning the JSNA is being refreshed and cross checked with the indicators in the three national outcome frameworks, as they become available, to ensure the relevant measures are incorporated.

Presenting the story of health in an accessible and meaningful way to communities, stakeholder representatives and organisations

The H&WB strategy is adopting the life career approach reflected in the national strategy, *Healthy Lives, Healthy People*. It is important to enable an understanding of the health and wellbeing challenges predominant in Derbyshire to all stakeholders in an accessible form not solely dependent on IT and computer literacy. The ambition is also to draw as broad an audience as possible into exploring health and wellbeing matters further through the Derbyshire Observatory.

The JSNA steering Group is currently consulting on and developing a narrative template that will tell the story of health and wellbeing in Derbyshire at key life transition points, throughout the life career. The following examples would be used to highlight the variation across Derbyshire at a level the data allows. We would be able to focus on the predominant issues facing the particular population group across the factors that influence health and wellbeing - socioeconomic, behavioural, service use, social inclusion, public opinion etc.

Starting well – e.g. the experience of having a child, health in the first year

Developing well – e.g. starting in reception, starting in secondary school

Living and working well – e.g. Becoming an adult, “empty nesters”, living with specific needs

Ageing well – e.g. Retirement age, frail older age with dignity, dying with dignity

These snapshots of what it like in Derbyshire will be developed using key expert input and weave analysis of inequalities and vulnerability in the narrative as relevant. The number of narratives that we can produce using an agreed template will be determined by relevant stakeholders considering capacity and timescale.

This approach will also be complemented by summary geographical or local district spine profiles, for both adults and children, a task already completed for children's health.

Enable use of the Derbyshire Observatory and self-directed analysis utilising Instant Atlas and other profiling tools.

The aspiration is to make the Observatory a one stop portal to all information on health and wellbeing. The development of Instant Atlas is an important tool to enable people to explore the different aspects of health and well-being and make comparisons.

In doing so, it will be important to develop relevant geographies within Instant atlas that facilitate use by different organisations and communities, e.g. Adult Care, CAYA, and CCGs.

Also we will develop a "where I live" feature that will enable users to bring together information from different component geographies to develop a snapshot of health and wellbeing.

Identifying the priority health needs for Derbyshire and its localities to inform the H&WB strategy

The primary aim of the JSNA in telling the story of health and wellbeing in Derbyshire is to inform and influence the priorities for action and allocation of resources.

The JSNA will identify the most pressing health and wellbeing needs for different populations and local areas across the county. These can then be prioritised by the Health and Wellbeing Board taking into account other influencing factors and reflecting agreed principles such as equity, fairness, value for money and effectiveness.

The actions we can take on prioritised areas once identified can be based on further information on what works and the available evidence, as well as the resources currently targeted at the priorities. (See assets section)

Identifying gaps in intelligence and where appropriate incorporating these into a work programme.

Each refresh of the JSNA should be a mix of core data sets and filling gaps identified in our knowledge. The core data set will evolve over time but initially should cover the three outcomes framework indicators where possible. The JSNA Steering Group will identify the gaps and develop a prioritised work programme.

It may also, where appropriate, be possible to develop joint working arrangements with colleagues in Derby City for certain health issues to be looked at pan Derbyshire.

Asset mapping is a new expectation of the JSNA process.
The national guidance suggests an asset could be anything that can be used to improve outcomes. Others refer to asset mapping as identifying the skills strengths, social capital, capacity and knowledge of communities.

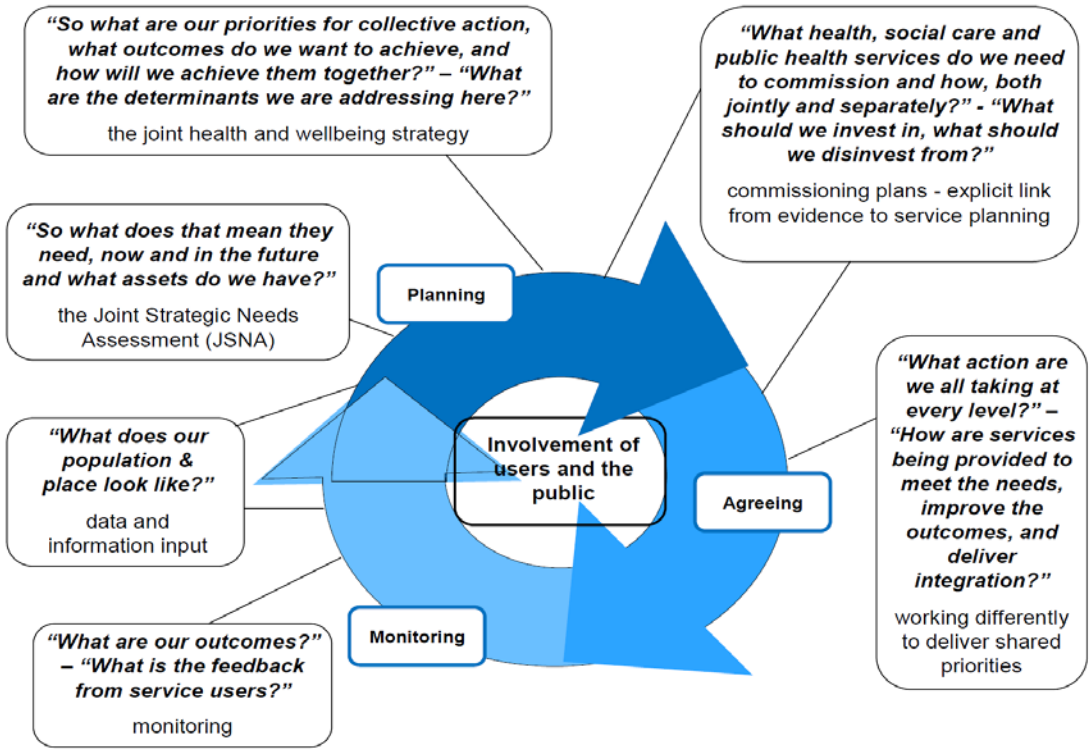
A piece of work was carried out in in North East Derbyshire engaging local people and locally elected representatives. This asked people what assets (people, skills, places, organisations) they valued in their local community that contributed to health. The results identified a range of important resources. This approach could be carried out over a period of time across the whole county.

Initially asset mapping could focus on the priorities identified by the Health and Wellbeing Board. This could be a summation of the resources and assets currently engaged in tackling the priorities

Engaging the public in the JSNA and Health and Wellbeing Strategy
The focus on assets and resources may offer an opportunity to shift the emphasis when engaging with the public and asking about health and wellbeing. Rather than asking what the needs are, it may be possible to present local communities with the identified health and wellbeing needs and ask people about solutions and what the positive things there are going on in their community that can be built on in response to the problems identified.

This should supplement the existing work that seeks the public's views about services provided, their accessibility, quality, etc.

Summary of process



'Joint strategic needs assessment and joint health and wellbeing strategies explained' (DH 2011)

Next Steps/Way Forward

April 2012	Refresh of data sets and predominant health issues identified for prioritisation by H&WB Board
May	Instant atlas searchable by different geographies for core data sets and life career profiles available
June/July	Further work on evidence and resources completed for identified priority areas
September	Approach to asset based assessment developed for agreement by Board

Recommendations

The Health & Wellbeing Board endorses this approach to the JSNA and mandates the JSNA Steering Group to develop and implement the proposed action plan for the JSNA.

Steve Pintus
Associate Director of Public Health
NHS Derbyshire County

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

26 January 2012

DERBYSHIRE HEALTH AND WELLBEING STRATEGY DEVELOPMENT: PROPOSED HIGH-LEVEL PRIORITIES

Purpose of the report

To update the Board on progress towards developing the HWB Strategy and to seek the Board's approval on the proposed high-level priorities.

Background

At the HWB Board in November the HWB Strategy Group were tasked with developing a small number of high level priorities around which the full strategy can be developed. The priorities should be those with clear benefits from joint action by the different agencies represented and would need to be linked with clear outcome indicators in order to ensure progress can be monitored.

Information and Analysis

To take this process forward the Strategy Task group reviewed existing plans and priorities (including the JSNA, views from the recent stakeholder engagement event, LSP plans, Adult Care, Children's Trust, and the NHS Operating Framework 2012/13). The evidence base for effectiveness and cost-effectiveness was taken into account. Views of the Strategy Reference Group were sought. From this the proposed list of high-level priorities was developed. These are detailed in the appendix, along with the relevant indicators from each of the three outcome frameworks.

Next Steps/Way Forward

Once agreed, the high-level priorities will form the framework around which the full HWB Strategy will develop. The Strategy Task and Reference Groups will continue to work with the Health and Well Being Board in developing the strategy by June 2012. Feedback will be sought throughout the process in line with existing consultation routes and the HWB Board's emerging stakeholder engagement plan.

This work will be closely linked with the on-going development/refresh of the Derbyshire JSNA and with emerging commissioning plans of partner organisations in the 2012/13 financial year.

The publication of the final strategy in June 2012 will ensure it can be a core part of partner's planning cycles for the 2013/14 year and onwards.

Recommendation
That the Board approve the proposed high-level priorities and note the plans for developing the strategy.

Alison Pritchard
Consultant in Public Health
NHS Derbyshire

Derbyshire Health and Wellbeing Strategy development: proposed high-level priorities

Key strategic aims across all priority areas will be to improve health and wellbeing by **reducing health inequalities,** to **strengthen investment in evidence-based prevention and early intervention** and for all partners to deliver **high quality care that promotes privacy and dignity along with robust safeguarding processes**:

- Improve health and wellbeing in early years. Every child fit to learn and attain the highest levels of literacy. **Focus on early identification and intervention of vulnerable children and families (including children with disabilities)**

- Develop lifestyle services to prevent and reduce harmful alcohol consumption, obesity, physical inactivity, smoking and sexual ill-health. **Focus on preventing and reducing alcohol misuse, obesity and physical inactivity**

- Promote the independence of all people living with long term conditions and their carers. **Focus on providing community based support and care close to home including increased use of evidence-based telehealth and telecare**

- Improve emotional and mental ill-health and provide increased access to mental health services. **Focus on improving access to the full range of evidence-based psychological therapies (services that offer treatments for depression and anxiety disorders and other complex mental health problems)**

- Improve health and wellbeing of older people and promote independence into old age. **Focus on strengthening integrated working (pathways/referral mechanisms etc) between health and social care providers and housing-related support services (LAs/registered social landlords/voluntary sector)**

High level priority	Focus on	NHS outcomes/indicators	Adult Care/Children's outcomes/indicators	Draft Public Health outcomes/indicators
START WELL DEVELOP WELL Improve health and wellbeing in early years. Every child fit to learn and attain the highest levels of literacy.	**Focus on early identification and intervention of vulnerable children and families (including children with disabilities)** Rationale: • JSNA priority • Stakeholder priority • Breastfeeding initiation and smoking in pregnancy outliers in Derbyshire Health profile • Graham Allen report 'Early Intervention: Smart Investment, Massive Savings'; focus on evidence-based policy and cost-effective programmes for first three years of children's lives, as well as older children, to promote social and emotional development, significantly improve mental and physical health, educational attainment and employment opportunities, prevent criminal behaviour, drug and alcohol misuse and teenage pregnancy, reduced child abuse incidences, reduced first-time offending rates and increased numbers of parents participating in training or employment • The benefits of literacy start at very young age and it is at this early stage that cognitive and social skills are developing. • Low literacy is associated with poorer health outcomes. Children with poor literacy are more likely, when adults, to live on benefits in a non-working overcrowded household. Poor literacy is associated with higher rates of smoking and alcohol.	• Reducing deaths in babies and young children	CAYA outcomes to be added	• Children in poverty • School readiness: foundation stage profile attainment for starting Key Stage 1 • Rates of adolescents not in education, employment/training • Percentage of healthy weight 4-5 /10-11 yrs • Breastfeeding initiation/ prevalence 6-8 weeks • Incidence of low birth-weight of term babies • Hospital admissions from unintentional and deliberate injuries (1-5 years) • Infant mortality • Child development at 2-2.5 years • Reduced rates of teenage pregnancy

LIVE WELL WORK WELL Develop lifestyle services to reduce harmful alcohol consumption, obesity, physical inactivity, smoking and sexual ill-health	**Reducing alcohol misuse;** **Reducing obesity and physical inactivity** Rationale: • Alcohol harm and adult obesity are outliers in Derbyshire Health profile • JSNA priority • Stakeholder priority • New national alcohol strategy expected in early 2012 • Alcohol, obesity and physical inactivity are risk factors for cancer, hypertension, diabetes, dementia, CHD, stroke and other long term conditions; alcohol also linked with mental health problems • Good evidence for effectiveness and cost-effectiveness e.g. screening and brief intervention for alcohol misuse in primary care	• Life expectancy at 75 • Under 75 mortality rates from liver disease, cardiovascular disease and cancer	• Effectiveness of prevention/ preventive services - everyone has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs. • CAYA outcomes to be added	• Prevalence of healthy weight in adults • Rate of hospital admissions per 100,000 for alcohol-related harm • % of adults meeting recommended guidelines on physical activity 5X30min/wk • Under 75 mortality rates from liver disease, cardiovascular disease and cancer • Differences in life expectancy and health life expectancy between communities
LIVE WELL WORK WELL Promote the independence of all people living with long term conditions and their carers.	**Providing community based support and care close to home including increased use of evidence-based telehealth and telecare** Rationale: • JSNA priority • Stakeholder priority • Derbyshire Health profile outlier (diabetes) • NHS Operating Framework priorities: the enhancement of quality of life in long term conditions and support for carers. Specific focus on development of telecare/telehealth services to benefit people with social care needs and/or with LTCs such as diabetes, heart failure and COPD. • Emerging and promising evidence from DH report Whole Systems Demonstrator Programme: early indications show if used correctly telehealth can deliver 15% reduction in A&E visits, 20% reduction emergency	• Health related quality of life for people with LTC • Reducing time spent in hospital by people with LTC • Enhancing quality of life for carers • Enhancing quality of life for people with dementia • Emergency readmissions within 30 days of discharge	• Proportion of people with LTC feeling supported to be independent and manage their condition • Carer reported quality of life • The proportion of carers who report they have been included or consulted in discussions about the person they care for • Improving recovery from fragility fractures	• Employment of people with LTC • Prevalence of recorded diabetes • Work sickness absence rate • Emergency readmissions within 28 days of discharge

	admissions, 14% reduction elective admissions, 14% reduction in bed days, 8% reduction in tariff costs; 45% reduction in early mortality rates.		• Emergency readmissions within 28 days of discharge.	
LIVE WELL WORK WELL Improve emotional and mental ill-health and provide increased access to mental health services	**Improving access to the full range of evidence-based psychological therapies (services that offer treatments for depression and anxiety disorders and other complex mental health problems)** Rationale: • Derbyshire health profile outlier for admission due to self-harm • Stakeholder priority • NHS operating framework focus on mental health services including access to psychological therapies • National Mental Health Outcomes Strategy; No Health Without Mental Health. Good mental health and wellbeing, and not simply the absence of mental illness, results in health, social and economic benefits for individuals, communities and populations e.g. better physical health, reductions in health-damaging behaviour, greater educational achievement, less crime, more participation in community life, reduced mortality. • Good evidence base for effectiveness: National Institute for Health and Clinical Excellence (NICE) and DH 'Talking therapies: A four-year plan of action' (supporting document to 'No health without mental health')	• Reducing premature death in people with serious mental illness • Enhancing quality of life for people with mental illness • Improving experience of healthcare for people with mental illness	• Effectiveness of prevention/ preventive services - everyone has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs. • Effectiveness of early diagnosis, intervention and reablement: avoiding hospital admissions	• Rate of hospital admission as a result of self-harm • Self-reported well-being • Suicide rate • Mortality rate of people with mental illness
AGE WELL Improve health and wellbeing of older people and promote independence into old age.	**Strengthening integrated working (pathways/referral mechanisms etc) between health and social care providers and housing-related support services (LAs/registered social landlords/voluntary sector)** Rationale:	• Helping older people to recover their independence after illness or injury (i. still at home 91 days after	• Earlier diagnosis, intervention and reablement - helping older people to recover their independence after	• Fuel poverty • Health related quality of life for older people • Healthy life expectancy • Excess seasonal

	• Stakeholder priority; JSNA priority • NHS Operating Framework priorities include care of older people and dementia • Housing has a central role to play in enabling older people to remain involved and live their lives to the full. Key issues include insulation and energy saving; home security and safety, practical help around the home and garden; more independent living opportunities; less waiting times for adaptations; more flexibility of housing, care and support options, clearer information and advice on what is available. • WHO report; Environmental burden of disease associated with inadequate housing • The Real Cost of Poor Housing BRE 2010: Estimates cost to NHS of poor housing as being £600m a year and evidences the cost-effectiveness of simple home improvements • Living Well at Home All parliamentary enquiry 2011 and Chartered Institute of Housing report June 2011: advocate joined-up approach in health, social care and housing as means of effective prevention and reducing care costs. • Interim report on the fuel poverty review: quantifies health and social effects of living at low temperatures	discharge; ii. offered rehab following discharge) • Improving recovery from stroke • Improving recovery from fragility fractures	illness/injury (i. still at home 91 days after discharge; ii. offered rehab following discharge) • Admissions to residential homes per 1,000 population • Delayed transfers of care from hospital, and those which are attributable to adult social care • Effectiveness of early diagnosis, intervention and reablement: avoiding hospital admissions	mortality • Acute hospital admissions as a result of falls or falls injuries for over 65s

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

26th January 2012

OBESITY SERVICES IN DERBYSHIRE: COMMISSIONED SERVICES AND FUTURE STRATEGY ISSUES

Purpose of the report

To give an overview of obesity needs and services in Derbyshire linked to the transfer of responsibility for commissioning to Derbyshire County Council in April 2013 and to suggest future strategic direction for the provision of appropriate support.

Background

Obesity has been described as a modern epidemic, with its impact on health considered by many to be as significant as that of smoking. The rates of those who are overweight and obese is increasing rapidly, a trend which is matched by the rate of increase in co-morbidity, as well as the rate at which resources are being consumed in order to address it.

Obesity is a significant risk factor for many diseases that result in long-term ill health and disability, with subsequent resource impact upon health and social care.

Obesity provides a key causal link between disease and lifestyle topics, such as nutrition and physical activity. For these reasons, obesity is now emerging as the key health improvement priority for the 21st century in its own right.

Obesity and overweight pose a major risk for serious preventable chronic diseases with some becoming more evident in children as well as adults. These include; type 2 diabetes, cardiovascular disease, hypertension, stroke, and certain forms of cancer, such as large-bowel cancers, and those which are hormonally related. Health consequences range from increased risk of premature death, to serious chronic conditions that reduce the overall quality of life, cause disability and place more demand on care services.

The tendency to be obese varies significantly with age, with the likelihood of being overweight or obese increasing with age. The pattern of obesity and overweight differs between the genders. There are differences in obesity through social class in professional groups, education level, ethnicity and level of deprivation.

This information is further expanded upon along with greater detail on obesity data in Derbyshire within the Derby and Derbyshire Strategic Framework: Obesity 2007-10.

The national strategy A Call to Action on Obesity in England (November 2011) and the preceding Public Health white paper Healthy Lives Healthy People

(November 2010) propose that Tier 1 Local Authorities will take on responsibility for commissioning weight management services from April 2013. Prescribing and Bariatric Surgery will not be part of the budgetary responsibility that accompanies Public Health into Tier 1 Local Authorities.

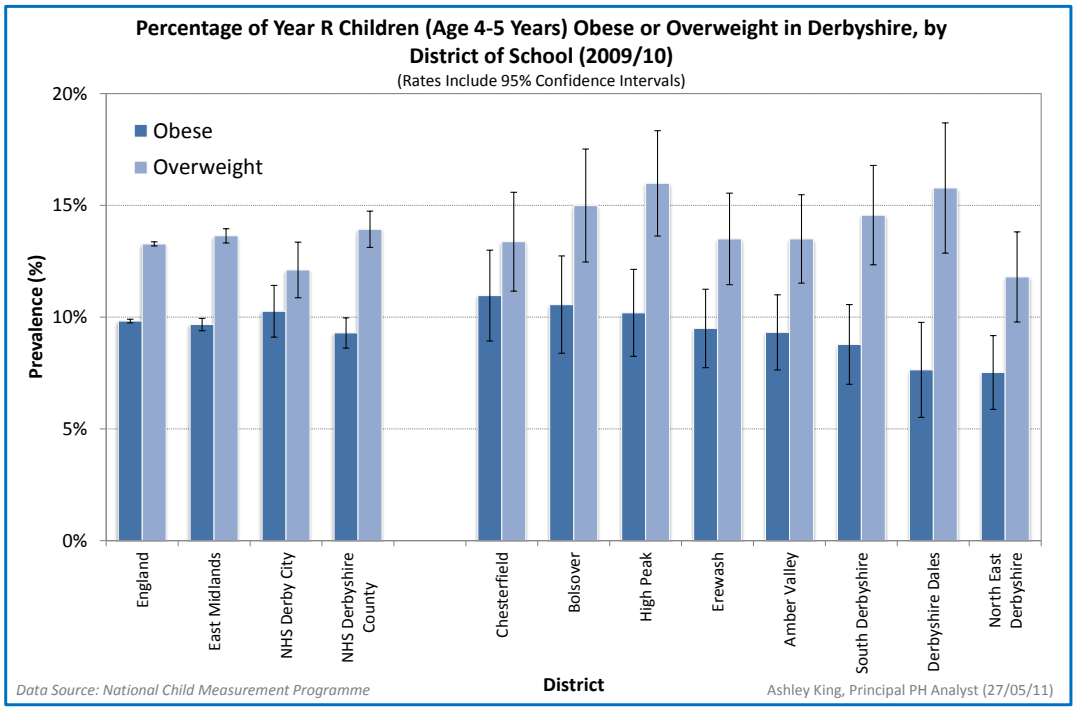
A Call to Action on Obesity in England announced a rallying cry with two national ambitions; a sustained downward trend in the level of excess weight in children by 2020 and a downward trend in the level of excess weight averaged across all adults by 2020. Key features of the national strategy include a continuation of the Change4Life campaign and the Responsibility Deal, which includes networks on Physical Activity and Food. The best evidence and evaluation will be used in supporting innovative approaches to behaviour change.

Information and Analysis: Obesity in Derbyshire

Obesity Prevalence

Charts show the overweight and obesity rates as measured in Derbyshire in 2009/10 for Reception (3.1) and Year 6 (3.2) children. Obesity rates almost double between Reception Year and Year 6, reflecting the national trend.

3.1



3.2

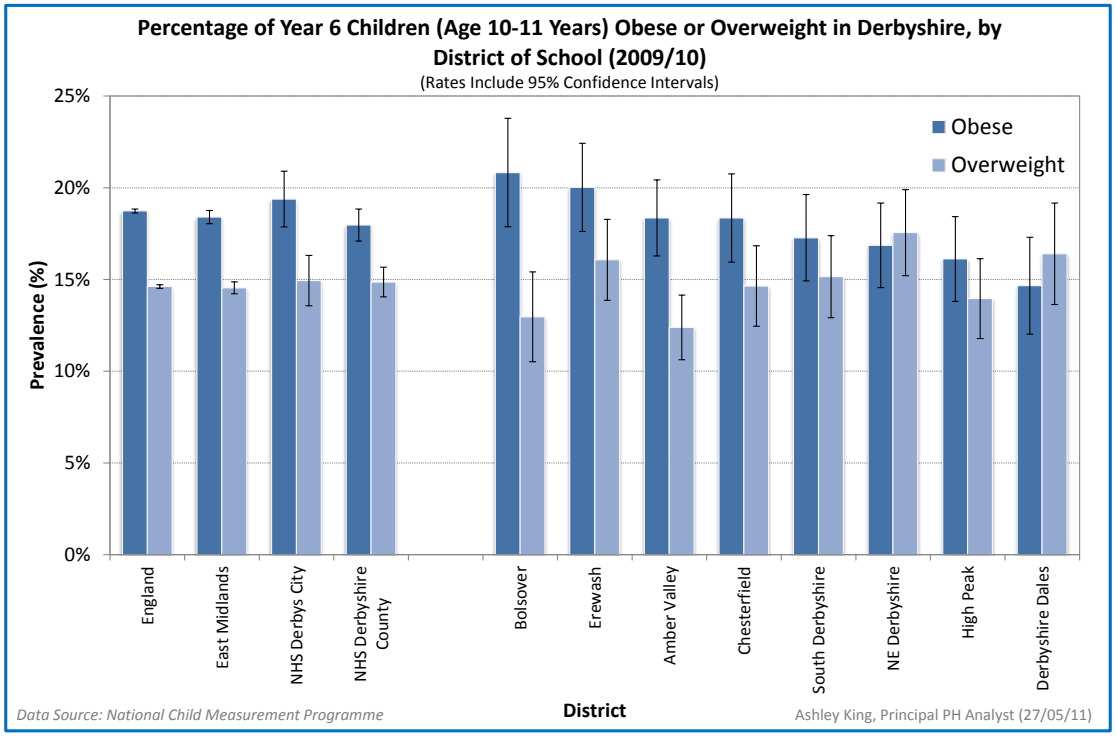
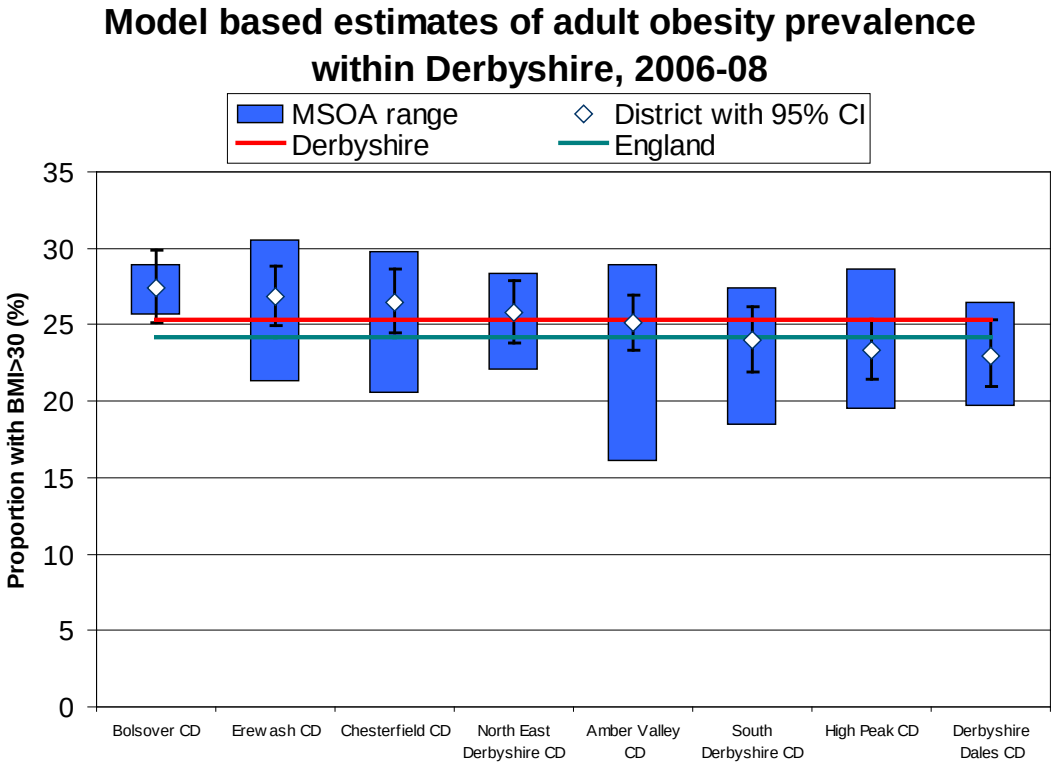


Chart 3.3, below, demonstrates the variation of obesity prevalence in the county. The estimated level of prevalence nearly doubles between the lowest and highest area.

3.3



NB: Health Survey for England (HSE) and other data are used to create a model based estimate of obesity prevalence. Local prevalence is not currently collected.

Modelling

Based on these national estimates approximately 190,000 adults in Derbyshire are overweight or obese.
Service modelling indicates that, based on the East Midlands Specialised Commissioning Group (EMSCG) uptake prediction of 4%, in Derbyshire:

- approximately 6000 people per year will access the Healthy Lifestyle Hub for obesity
- approximately 130 people per year will access the Tier 3 Service.
- it is estimated that 3,350 new cases of obesity will be identified in Practice each year.

One of the challenges is that obesity is generally not perceived by the public as a problem, as supported by the uptake formula.

In the continuing battle against rising global obesity levels local services have been introduced and amended based on a gradually growing evidence base as to the most effective methods of prevention and treatment (see NICE Guidance CG43).
Under the current strategy Derbyshire now has consistent provision of service and a robust clinical care pathway.

Current Approach

NHS Derbyshire County has taken a bold and innovative approach to commissioning weight management interventions:

- Universal breastfeeding training for health workers and Children's Centre staff to acquire UNICEF Baby Friendly best practice compliance and skills
- Investment in a targeted peer breastfeeding support service for the most disadvantaged wards
- Investment in the universal prevention programme Five60 for all primary school children in Derbyshire
- Integration of the specialist weight reduction service Waistwise into the sustainable Healthy Lifestyle Hub model
- Development of the psychology led Tier 3 weight management programme for the morbidly obese

NHS Derbyshire County is one of the few primary care trusts to consistently use the Standard Evaluation Framework (SEF) to ensure quality and to measure outcomes.
The East Midlands Public Health Observatory (EMPHO) recently performed an evaluation on the Family Lifestyle Intervention Programme (FLIP) pilot to confirm that the approach holds value.
In 2010 the East Midlands NHS Internal Audit Services audited the Derbyshire Obesity programme. The strengths of the programme were identified within

the delivery and the only recommendations were with regard to improving monitoring processes, which has subsequently been achieved.

Early Years and Childhood Obesity

Derbyshire wide levels of childhood obesity are lower than the population of England as a whole (England 18.7; Derbyshire 17.9 - based on Year 6 measurements, *Derbyshire Health Profile 2011*). However we recognise that within Derbyshire there are pockets of childhood obesity that are higher than the national average. In line with national trends childhood obesity is increasing. This suggests the need to strengthen the interagency approach, particularly within school settings. NHS Derbyshire County 2009/10 obesity prevalence rates in Year 6 increased by 0.2% points on previous year, 0.3% points less than the assumed 0.5% point national annual increase in obesity. The current trajectory for Derbyshire shows Year 6 obesity trends stabilising (2008/09 17.8% to 18.0% in 2009/10). Participation rates for the same year show significant Year 6 uptake of 94.1% against the 87% target set. Participation targets are based upon an annual 1% point improvement from 2007/08 85% target.

Prevention and Weight Management

Breastfeeding is well evidenced for its positive effect on reducing health inequalities, improving the health of the mother and child and contributing to the reduction of early childhood obesity. The evidence shows that where breastfeeding rates are lower, there is a higher prevalence of obesity in children. However, the culture of many communities within Derbyshire is not to breastfeed, and much can be done through schools, libraries and other means to influence this.

Maternity Services are commissioned and have the lead responsibility to improve the prevalence of breastfeeding initiation and reduce the drop off rates at 10 days at which point responsibility is transferred to Health Visiting Services. Both hospitals within Derbyshire are UNICEF Baby Friendly accredited.

Paid Peer Support through DCHS and in partnership with Maternity Services to provide targeted support to mothers in disadvantaged areas, who are least likely to breastfeed.

Health Visiting Services are commissioned to have the lead responsibility to maintain the breastfeeding rates from 10 days onwards. Increasingly, the relationship between Health Visiting and Children's Centres, where breastfeeding groups are held, helps to strengthen and provide valuable support to local communities.

Healthy Start is a statutory government initiative promoted through Maternity Services and Health Visiting Services targeting low income pregnant women, children and families. Vitamins are distributed in partnership with Children's Centres and Health Centres.

HENRY (Health Exercise Nutrition for the Really Young) is an evidence based parenting programme which adopts the Family Nurse Partnership model. Health professionals and childcare practitioners are trained in the knowledge and practical skills to influence parents to provide a home environment that will most benefit the children. Health Visitors and the pre-school workforce identify families of the under 5's who may be vulnerable to obesity and can refer them to a programme.
It is expected that 10-15 courses will be delivered each year, prioritising areas of high need. Children's Centres host most courses. HENRY training has been delivered to Health Visitors, Children's Centre Staff, Social Care, foster parents and carers to ensure a consistent approach to infant feeding and lifestyle.

National Child Measurement Programme (NCMP) records BMI at Reception Year and Year 6. School Nursing teams are commissioned to measure pupils and collate the data. A letter offering support is sent to the parents' of the child of an unhealthy weight. Participation rates in Derbyshire are above the national average.

Five60 is a preventative universal programme supporting the Key Stage 2 curriculum delivered to all Derbyshire pupils in Years 3-5. The programme consists of physical activity and nutritional information to facilitate a healthy lifestyle. This early intervention aims to improve a child's understanding of a healthy lifestyle and also contributes to reducing the prevalence of childhood obesity.

The ***Family Weight Management Programme*** is a pilot that will target children and young people, who are documented as obese, and their parents/primary carers. Development of this programme will explore methods of support. Evidence indicates parental participation as key to facilitate change in family lifestyle choices, as the majority of obese children have at least one obese parent.

There is exploration for development of a ***Pregnancy Lifestyle Programme*** for first time mothers, utilising existing resource. The programme will target primigravida and provide advice, access to services and support regarding lifestyle and health.

Adult Obesity

Derbyshire has significantly worse levels of adult obesity than the population of England as a whole (England 24.2; Derbyshire 25.3, *Derbyshire Health Profile 2011*) based on the Health Survey for England. The Derbyshire Obesity Pathway outlines the services within the county commissioned to combat obesity.

Prevention

In response to public consultation Derbyshire is developing one of the most extensive ***Walking for Health*** networks in the country with many accredited, organised walks in each district. Volunteer walk leaders are trained to run walks in their local area.

There are over 75 scheduled walks countywide with 1672 registered participants amassing 28197 walk hours from December 2010 to November 2011 (up over 100% since 2008).

The ***Active Derbyshire Partnership*** is operated by Derbyshire Sport and is marketed as a recognisable brand. The Active Derbyshire Plan 2009-13 sets out 8 overarching goals to increase levels of physical activity in Derbyshire. A physical activity website, which is regarded as a trusted source of information containing no commercial influence, is available to the public. The site provides access to activity logs for self-management, information on local activity and mechanisms of support.

The ***Derbyshire 2012 Olympic Legacy*** will work to strengthen the infrastructure and increase participation in physical activity, sport and active recreation within Derbyshire through '*2012 and Beyond; 2010-2015'.*

Derbyshire Food and Health Group is a multi-partner alliance that produced the June 2011 Derbyshire Food and Health Framework. The framework aims to create and promote Derbyshire guidance on cooking skills, healthy eating, portion sizes, food labels & food safety information so to provide a consistent approach across the county. A partnership between Derbyshire County Council, the Food Standards Agency and the Child and Family Nutrition Lead developed guidance for pre-school and nursery settings on healthy eating and food standards for pre-school children.

Derbyshire has gained a national reputation for the development of its ***health trainer and health champion programme***, aiming to support people from disadvantaged and vulnerable communities achieve personal health plan goals and changes in behaviour. A number of different delivery models operate in the county, which will be the subject of a separate briefing paper and much of the focus of the work of the health trainers supports people in the area of physical activity, nutrition and weight management.

Weight Management

Launched in April 2011 the ***Healthy Lifestyle Hub*** is an ambitious, client-centred model, placing lifestyle change support outside of NHS settings. It is a partnership between NHS Derbyshire County and the 8 local authorities within Derbyshire. The philosophy of the Hub is to link people into local services to increase the likelihood of sustained lifestyle change and to contribute to the viability of services regarded as assets in the community. In addition to

obesity, the Hub serves patients referred with other health issues such as CVD risk and mental health issues.

In recognition that not everyone would like to access traditional leisure services, providers have been commissioned to offer 6 available activities, some of which will be non-centre based. These include walking and other activities suitable for and accessible to older people. The ***Health Referral Scheme*** enables subsidised access to professionally supported, individualised exercise. The DCHS operated weight reduction service, ***Waistwise***, has been incorporated to deliver in the Hub with the potential for additional services to be integrated. The Hub also includes a specialist Central Administration Team (CAT) which administers referrals and collates an outcomes database, and a workforce development programme to strengthen appropriate staff knowledge and skills.
Based on modelling from the current year, over 3100 clients will successfully complete the Healthy Lifestyle Hub programmes, with approximately 2200 (70%) of them referred for weight management.
The Hub model is designed to drive efficiency and to maximise utilisation of the skillset available.

The ***Tier 3 Specialist Weight Management Service*** is an innovative psychology led service for the morbidly obese. A multidisciplinary team provide an intense family support model with key support workers assigned to each client. An aim of Tier 3 is to reduce the number of clients progressing to bariatric surgery by providing an alternative successful weight loss method. A pre-requisite for undergoing bariatric surgery is successful completion of Tier 3, which also provides post-surgery support. In response to evaluation and reflecting emerging evidence on supporting morbidly obese clients, the service was adapted during the second year of existence to treat the client over a longer period of time to achieve the target weight loss goal of 5% and embed sustainable lifestyle behaviour change. Over 70% of clients now achieve 5% weight loss and over 75% have increased quality of life by 10 points or more.

Clinical Treatment
The following two interventions are included for completeness but fall outside of the responsibility being transferred to the local authority.

Prescribing
Currently the main drug prescribed by primary care practitioners to assist weightloss is Orlistat. From 2009/10 to 2010/11 there was a countywide reduction in prescribing of £181,472 through greater adherence to the clinical pathway and access to weight management services. The total prescribing cost for 2010/11 was £446,316. Prescribing is funded from the NHS budget. One aim of the obesity treatment services is to reduce the number of prescription items and therefore the cost.

Bariatric Surgery
The two commissioned providers for Derbyshire are Royal Derby Hospital and Sheffield Teaching Hospital. The number of bariatric surgeries performed decreased by 5 cases between 2009/10 to 2010/11. Bariatric Surgery is funded through the East Midlands Specialised Commissioning Group (EMSCG).

Maintaining progress requires constant service development to secure the most effective and efficient pathways of care.
Commissioning a comprehensive range of obesity prevention, care and treatment, with an ever evolving evidence base, across several providers and with a responsibility to respond to inequalities across the population of the county, is complex. After an anticipated stall the Healthy Lifestyle Hub and the Tier 3 service have evolved to provide a quality service with achievable outcomes.

Appendix 1: Table 3 provides an overview of the services currently operating within Derbyshire.

The Way Forward: Developing a Strategic Framework 2012-15
The challenge is to break the intergenerational cycle of obesity targeting appropriately at the earliest point of intervention. This also recognises the influence of the wider environment and the family's socio-economic status, resources available, lifestyle choices and behaviour.
The available evidence of effectiveness and the national strategy inform the approach to refreshing the strategic framework in Derbyshire. It also indicates the need to engage stakeholders from across organisations in Derbyshire to identify what more can be done locally to stem the growth in obesity and ameliorate its impact on health, social and other public services.

A number of principles underpin the strategic approach:

- To highlight and challenge the public perception of obesity to combat its normalisation. This not only applies to the public, but also to our workforce
- To intervene early and at points of intervention when people are most susceptible to change
- Parents who are obese shape the environment in which their children grow up therefore interventions to support obese children need to start with the parents
- Messages about food and physical activity need to be consistent throughout the county e.g. portion size
- Services commissioned in Derbyshire focus on lifestyle change as measured at one and two years, in contrast to weight cycling (yo-yo dieting)
- Responsibility lies not just with individuals and families, but permeates through all service provision. The 'every contact counts' moniker

supports this ideology and should help to facilitate engagement. Strong and clear preventative action must be taken through school activities, school curriculum, workplaces and communities.

Is an Equality Impact Assessment required? Yes
If yes, has one been carried out? No

Recommendations

The Health and Wellbeing Board is asked to:

- Endorse the importance of the early years, including; the key roles of health visitors; the importance of antenatal intervention; strengthening the links between maternity services and the Healthy Lifestyle Hub model
- Support development of obesity programmes to explore further support for weight management through intense family support models.
- Consider the possibility of a Commission or similar approach within Derbyshire to gather views and evidence to determine what can be done locally and to help engage wider stakeholders to encourage acknowledgement of responsibility towards obesity

STEVE PINTUS
ASSOCIATE DIRECTOR OF PUBLIC HEALTH
NHS DERBY CITY AND NHS DERBYSHIRE COUNTY

JAMES CREAGHAN
PUBLIC HEALTH LEAD FOR ADULT OBESITY AND PHYSICAL ACTIVITY
NHS DERBY CITY AND NHS DERBYSHIRE COUNTY

Appendix 1 - Table 3: Overview of Current Obesity Services in Derbyshire

Starting Well:		
Maternity and Early Years	• Obesity in pregnancy incorporated into Health Referral • Healthy Start • Breastfeeding Peer Support • Health Visiting • HENRY programme	• Pilot at Staveley HLC • Vitamins distributed via Children's Centres and Health Centres • Countywide network • BMI measure at 2.5years; Support for those identified as unhealthy weight • Evidence based holistic family aproach to a healthy lifestyle; Relevant staff trained in HENRY
Developing Well:		
Children	• National Child Measurement Programme • School Nursing • Five60 • Nursery Nutrition: Food for the under 5's booklet • Children and Young Peoples Health Promotion Service • Family Weight Management Programme	• Measures BMI in Reception and Year 6. Letters sent to those of an unhealthy weight • Provide support, make referrals • Universal programme for all primary aged children in Derbyshire promoting physical activity and healthy eating • Distributed to all pre-schools and nurseries in Derbyshire. Made accesible to all pre-school age workforce • Promote physical activity and healthy eating through delivery and training • Pilot emphasising a family approach
NHS Derbyshire County: Total annual investment in childhood obesity **£485,500**		

Live and Work Well and Aging Well		
Adults	• Active Derbyshire Partnership and website • Derbyshire Food and Health Group • Healthy Lifestyle HUB, which includes: - Walking for Health - Health Referral Scheme - DCHS Waistwise - Central Administration Team (CAT) - DCHS Workforce Development • Jog Derbyshire • Tier 3 Specialist Weight Management Service • Prescribing • Bariatric Surgery	• Support for self management and mass participation • Developing guidance regarding cooking skills, healthy eating, portion size, food labels and food safety. • Ambitious model of client-centred support - Countywide accredited, accessible network of walking groups - Leisure Centre based physical activity offer - Weight reduction services integrated into leisure facilities; - Link referrers, patients and providers; Collate outcome data - Training of Primary Care and provider staff • Countywide accredited jogging groups • Psychology led, multidisciplinary intensive support for the morbidily obese • Orlistat prescriptions through Primary Care • Commisioned through EMSCG
NHS Derbyshire County: Total annual investment in adult obesity **£1,450,283**		
NHS Derbyshire County: Total annual investment in obesity **£1,935,783**		

DERBYSHIRE COUNTY COUNCIL

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

26 January 2012

CLUSTER LOCAL INTEGRATED PLAN

Purpose of the Report

To inform the Board of the process and assurance in respect of planning for 2012/13.

Background

Following the annual publication of the Operating Framework, which essentially is the key document which sets out all the requirements of Commissioners all PCT Clusters are required to develop and submit to Department of Health (via SHAs), a single system-wide Integrated Plan which includes PCT Cluster Plans, CCG plans, Public Health transitional plans, Provider activity planning and Quality Outcomes and Measures.

In particular this will reflect:

- National requirements of the 2012/13 Operating Framework.
- National requirements within the DH planning guidance.
- Regional requirements articulated in the commissioning framework.
- Current performance challenges in the Derbyshire system.
- Innovation Health and Wealth.
- Feedback from the 8th December SHA / Derbyshire system review.
- Impact of QIPP initiatives on activity and implications for workforce and physical capacity.
- Feedback from colleagues in relation to the initial submission

Next Steps/Way Forward

The timeline is shown overleaf for information and the plan will be developed with local authorities prior to final sign off.

Figure 2: Planning timeline

Is an Equality Impact Assessment required?

This will be carried out at service change level

Recommendations

The Board are asked to note the report and to receive a copy of the Derbyshire Local Integrated Plan at a future meeting.

Trish Thompson
Director External Relations
NHS Derby City and Derbyshire County

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

26 January 2012

Derbyshire Clinical Commissioning Groups Update

Purpose of the report

To provide an update to the Board on progress in establishing Clinical Commissioning Groups (CCGs) in Derbyshire.

Background

Members of the shadow Health and Wellbeing Board will already be aware of the emerging pattern of six CCGs within Derbyshire created using a fully bottom up approach from GP practices. At a previous meeting an update on individual progress was given and this report is intended to build on this rather than replicate information already imparted. The required pace of development of CCGs has increased significantly with an expectation that each will enter a full "shadow" year carrying out all functions from April 2012 ready for authorisation from September/October 2012 through to March 2013.

The Cluster Strategic Health Authorities (SHA) are carrying out a series of Gateway Reviews of CCGs to ensure they meet the necessary competence levels and requirements. These are currently scheduled to look at:

- Configuration and capacity to perform all functions – initial assessment complete and all issues to be resolved by the end of January 2012.
- Governance
- Leadership

It should be noted that the process in the Midlands and East SHA may be slightly different to that adopted in the North of England SHA for Tameside and Glossop CCG but we are trying to keep these as aligned as possible for ease of working with the Shadow H&WB in Derbyshire.

Information and Analysis

At the first Gateway each CCG in the Midlands and East SHA was given a rating and High Peak CCG was asked to consider their future as it was considered that it would be very difficult to fulfil all the statutory functions expected with a small population and resultant management cost available to pay for GP time and staff etc. The group has discussed this over the last few weeks and now agreed that they will not pursue authorisation as a standalone CCG but look to join an existing CCG as a locality. The preferred option is

North Derbyshire CCG and it is helped that this will be confirmed by the end of January.

There is an expectation by both SHAs that all configuration issues will be resolved by the end of January so that CCGs can be confident on which geographical basis they are moving forward.

It should be noted that CCGs are membership organisations made up of the GP practice building blocks within their catchment areas and that the practice unit connects the care pathways and organisations together for the benefit of patients and people.

Draft guidance has been issued on the make up of CCG governing bodies and how the three key roles of Chair, Accountable Officer and Chief Financial Officer will be identified and appointed. This is very new to the NHS with clinicians seriously considering the roles of Chair and Accountable Officer and it is unlikely that a post entitled Chief Executive will exist in the new commissioning structures.

Next Steps/Way Forward

The authorisation process is expected to be a combination of the following elements:

- Pre application submission e.g. the current scheduled Gateways
- Application form with documented evidence of track record
- 360 degree feedback from key partners and stakeholders
- Site visit

Authorisation is currently expected to be in a series of “waves” on a monthly basis from July (with a decision in October) through to October submission (decision in January).

Is an Equality Impact Assessment required?

No.

Recommendations

The Shadow Health and Wellbeing Board is asked to NOTE the ongoing development of CCGs within Derbyshire and the expectations around the authorisation process.

Jackie Pendleton
Chief Operating Officer – North Derbyshire CCG
on behalf of all Derbyshire CCGs.

More information from: Jackie.Pendleton@derbyshirecountypct.nhs.uk

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

26 January 2012

DERBYSHIRE CLINICAL COMMISSIONING GROUPS' COMMISSIONING INTENTIONS FOR 2012/13

Purpose of the report

To inform the Board of the NHS Operating Framework for 2012/13 and of the collective and individual commissioning intentions of the Derbyshire Clinical Commissioning Groups (CCGs).

Background

Every year around Christmas, the NHS is issued with a set of expectations and requirements for the following financial year (April to March) called the NHS Operating Framework. A summary of this is attached and a link to the full document is below:
http://www.dh.gov.uk/health/2011/11/operating-framework/

These cover both commissioners and providers although the commissioners are expected to enact all of the requirements and will be held to account for delivery.

The commissioners are also required to issue a set of commissioning intentions (attached) to the main providers of NHS services by the end of September each year. These can never cover everything within the Operating Framework as they are issued in advance of the Framework being received but capture the local intentions for large service changes. They will also not cover work going on with adult and children's services within local authorities or the voluntary sector.

Information and Analysis

This year the situation is more complex as the commissioners are larger in number as each CCG is a commissioner, the PCT Cluster itself in respect of primary care, prison health, specialised services in lieu of the NHS Commissioning Board and public health services ahead of the transfer to local authorities. In Derbyshire the CCGs are working together to ensure a degree of consistency in the application of policies whilst ensuring that local issues for local people, clinicians and communities are addressed.

Next Steps/Way Forward

During the next six weeks contracts will be negotiated with all providers of NHS services which will commit to activity levels and funding from April 2012 to 2013. Most contracts then require at least a six month notice period before major changes can be enacted.

The PCT Cluster will also be coordinating a submission to the Cluster Strategic Health Authority which details how all the targets and requirements of the Operating Framework will be met as well as a financial plan to show how a balanced budget will be achieved through a Quality, Innovation, Productivity and Prevention (QIPP) savings programme.

Is an Equality Impact Assessment required?
No, this will be carried out at individual service change level.

Recommendations
The Shadow Health and Wellbeing Board is asked to NOTE the national expectations of the local health system for the coming financial year as well as the emerging plans for the individual CCGs.

Jackie Pendleton
Chief Operating Officer – North Derbyshire CCG
on behalf of all Derbyshire CCGs.

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2012-13 JOINT DERBYSHIRE COMMISSIONING INTENTIONS

Background

2012/13 will be a year of transition with the influence of Clinical Commissioning Groups increasing as they begin to take on responsibilities from the primary care Trust. As such these commissioning intentions have been developed jointly between the 5 Derbyshire Clinical Commissioning Groups and NHS Derbyshire cluster outlining some of the key challenges to be faced during the 2012/13 contracting year.

This document is intended to supplement CCG local commissioning intentions and highlight areas which the CCG's intend to collaboratively commission or remain under the responsibility of the cluster to commission.

Context

Specific requirements will be detailed within the Operating Framework for the NHS in England 2012/12 (due to be published in November 2011). It is expected that the Operating Framework will reflect the NHS existing priorities and the latest evidence based guidance.

2012/13 will see a continuation and heightening of the challenge to maintain or improve quality whilst increasing productivity and encouraging innovation and prevention strategies (QIPP). As such a common underlying priority across the health community is the realisation of the financial savings associated with QIPP delivery programmes as established in previous years and those due to be implemented in 2012/13.

The financial assumptions of the CCG's is that there will be zero growth in funding allocation set against a backdrop of continuing growth in activity and resource requirements and as such the financial outlook is challenging across the health community.

The required level of savings/QIPP targets to be delivered by the CCG's during 2012/13 has been identified as follows:

- Erewash CCG - £6m
- Hardwick Health CCG - £6m
- High Peak CCG - £2m
- North Derbyshire CCG - £10m
- South Derbyshire CCG - £41m

There will be further amendments as financial allocations become clearer.

Commissioning Priorities

The following areas have been identified as areas of commissioning that are county wide and as such will affect all five Clinical Commissioning Groups. It should be noted that CCGs may have additional commissioning intentions under these headings so reference should also be made to individual plans.

Urgent Care: we will be working towards a full roll out of the 111 pilot by 2013. During 2012 a procurement exercise will take place to identify a future provider for the 111 service. The tender will also cover out of hours clinical service and we will look to see what other innovative service improvements can be delivered.

Cancer Services: we will look to comply with the Operating Framework Guidance for 2012/13.

Children and young people: the following areas have been identified as priorities for the commissioning of children and young people's services:

- Increase in Health Visitor capacity and implementation of Family Health Partnerships
- Revised specification for children's occupational and physiotherapy, school nursing and children's speech and language therapy within existing resources/ QIPP requirements
- Review of community paediatrics service
- A review of provision of antenatal parenting courses within existing resources/ QIPP requirements

East Midlands Specialised Commissioning Group: EMSCG has released detailed commissioning intentions. A summary of some of the key areas affecting local providers are included below:

- There will be a national "pick-list" of CQUIN schemes for Specialised Services for 2012/13 and beyond and CQUIN payments will be targeted at a range of tangible, high impact quality improvements
- National QIPP plans will focus on the biggest areas of Specialised Commissioning spend including cardiac care, neurological conditions, and renal provision. There will also be a set of local QIPP plans to address specific issues across the new SCG cluster
- Key Performance Measures to measure outcome and quality of services
- Major Trauma Centre to be commissioned at Nottingham University Hospitals

Medicines Management: all Providers are expected to use medicines effectively and efficiently to avoid medicine related harm and admissions and ensure wastage is minimised. Providers must abide by Joint Area Prescribing Committee decisions, guidelines and policies as per the medicines management website. Black status drugs must not be prescribed. Pharmacy

Advisors working with practices will continue to promote effective prescribing in primary care.

Mental Health: the following areas have been identified as a priority for the commissioning of mental health services;

- Deliver IAPT services across all practices and develop psychological therapy services to address the gaps in integration and current provision of therapies and support.
- Support the development of PbR for mental health
- With local authorities to re-commission carer support services for mental health within less or existing resources
- With local authorities review and consider re-commissioning Out of hours support line for mental health
- Work to bring as many people in placements out of county back to services as near to home and in the least level of security clinically appropriate
- In partnership with the local authorities and voluntary sector infrastructure organisations develop outcome based monitoring arrangements for the voluntary sector.
- In partnership with the voluntary sector deliver primary care mental health training programme
- Working with local authorities support the move to personalised services
- Support recovery based approaches to service delivery.

Learning Disabilities: the following areas have been identified as a priority for the commissioning of learning disabilities services;

- Together with Derby City and Derbyshire County Council, work towards transferring the lead commissioner role for Learning Disability services
- Together with Derbyshire County Council undertake a review of short break services
- Together with Derbyshire County Council develop the autism pathway consistent with the Autism Act and subsequent guidance
- On LD for Derby City we are looking at accelerating the placement in the community from out of area of people with LD and exploring the possibility of personal health budgets.

Community Services: the following areas have been identified as a priority for the commissioning of community services

- A review of the frail elderly pathway and current services to support the provision of care
  at home or close to home as possible. This will include a review of the provision of assessment and treatment services for the frail elderly including establishment of rapid referral and access routes into the appropriate care setting. Work will be undertaken to further develop integrated working with health and social care to maximise utilisation of current resources and ensure appropriate access to available services with both health and social care

- A review of consultant led planned care services provided within the community will be undertaken to review demand for services and ensure best value in relation to use of resources is obtained across the whole health economy
- Further roll out of the changes agreed through the introduction of the district nursing specification during 2011/12
- The implementation of any qualified provider for the contracting of the following community services:
    - Community podiatry
    - Musculo-skeletal services for back and neck pain
    - Primary care psychological therapies (adults)
- The requirement for the provision of information to meet the community minimum dataset

Ambulance Services: East Midlands Procurement and Commissioning and Transformation (EMPACT) have developed a draft 'Commissioning Intentions Working Paper' which sets out seven areas of development for ambulance services. Please refer directly to this paper for more information.

Dental

- The PCT is looking to establish a Local Professional Network (LPN) pilot scheme in line with the National Commissioning Board's (NCB) developments for Primary Care, so that outcomes and processes can be developed ahead of the NCB introduction in 2013
- We will continue to ensure access to dental services across the region urgent care/ new patient sessional contracts have been renewed for a further period of time to 2013
- The PCT will continue to support the dental pilot scheme introduced in 2011 for practices in the region

Pharmacy

- The New Medicines services will be introduced by pharmacies and patients will be able to obtain advice and assurance about the medicines they are prescribed
- New Market entry regulations for Pharmacies are currently out to the public for consultation and it is expected that these regulations will be introduced some time during 2012, and PCTs will follow the new guidance

Optometry

- It is anticipated that if possible the Glaucoma Referral Refinement scheme will be introduced across all locations for the region during 2012

PLCV**:** procedures of limited clinical value will continue to be incorporated into the Derbyshire PLCV Policy to ensure the effective use of resources. The Department of Health has made it clear that a referral is not an authority to treat where policies setting out procedures which have not been

commissioned are included in contracts. CCGs will be responsible for implementing and monitoring the PLCV policy within the contracts they lead on.

Quality

CQUIN: schemes will be required to meet national requirements. Local CQUIN schemes must support QIPP.

Strategic Health Authority Priorities: CCGs are committed to delivering the 5 priorities identified by NHS Midlands and East. They are:

1. Elimination of pressure ulcers
2. Ensuring 'every patient contact counts' through systematic Public Health advice delivered by front line professionals
3. Significantly improving quality and safety in primary care
4. Ensuring radically strengthened partnerships between the NHS and local government
5. Delivering a revolution in patient and customer experience

Clinical Variation: the CCGs are also committed to reducing clinical variation to improve quality and increase value. The Atlas of Variation, Summary Hospital-level Mortality Indicator (SHMI) and other indicators will support this work across both primary and secondary care.

Outcomes: the CCGs will continue to work on commissioning outcomes as and when they are released.

Contracting Intentions

The following sets out the contracting requirements common across all CCG's and contracts.

- For each contract a lead CCG has been identified to act as co-ordinating commissioner across all CCG's and associate PCT/CCG's where appropriate. This lead CCG will have the responsibility for representing all CCG's in that PCT during contract negotiations.
- As CCG's are not statutory bodies they will not have organisation codes however it is expectation that all 2012/13 activity plans will be agreed and monitored at CCG level.

The following timeline sets out the expected deadlines in relation to the contract agreement process:

Nov	Dec	Jan	Feb	Mar	April
★ Operating framework published		★ 2012/13 PbR tariff published	★ Contract agreement reached	★ Final contract sign off	

NHS Erewash Clinical Commissioning Group

Commissioning Intentions 2012-13

1.0 Introduction

This document outlines the draft commissioning intentions for 2012-13 for NHS Erewash Clinical Commissioning Group (ECCG).

This reflects the initial commissioning intentions to deliver local and national priorities. This document should be read in conjunction with the 2012-13 Joint Derbyshire Commissioning Intentions which have been developed jointly by the five Clinical Commissioning Groups in Derbyshire. The Joint Derbyshire Commissioning Intentions supplement these local commissioning intentions and highlight areas which the CCG's intend to collaboratively commission or remain under the responsibility of the cluster to commission. Both sets of commissioning intentions signal to providers any significant commissioning and service changes as part of a wider engagement process with providers ahead of the contract negotiations for 2012-13. This will allow providers the opportunity to take account of commissioner requirements and review their own service plans.

In addition, both this document and the Joint Derbyshire Commissioning Intentions are supplemented by the East Midlands 2012-13 Collaborative Commissioning Intentions Framework which highlights the areas where East Midlands' commissioners have signalled an intention to work collaboratively on common issues during the 2012-13 contract negation round.

Erewash CCG is composed of 13 practices serving around 100,000 population. The CCG has a requirement to commission health services for its population and to do so whilst staying within financial balance. With expectations of nil growth in finances in 2012-13, ECCG faces a significant challenge to improve quality and deliver efficiencies and at the same time meet the increasing population health needs. To meet the QIPP challenge the CCG will need to use its resources more effectively and to increase productivity in every area of work we undertake and in all services commissioned. Providers will be required to play their part in working collaboratively with commissioners to realise the required efficiencies.

We have put in place measures to involve clinicians in our commissioning cycle and contracting for 2012-13 including involvement of GPs directly in contract discussions and service review. This will be underpinned through on-going dialogue between clinicians within primary and secondary care throughout the year.

1.1 Financial Assumptions

The expectation for 2012-13 is that there will be nil growth in funding. The CCG will be required to continue to meet the health needs of the population within the overall resource limit. To make up for the shortfall in growth, the CCG will need to deliver significant improvements in Quality, Innovation, Productivity and Prevention (QIPP). An indication of the QIPP requirement for 2012-13 for Derbyshire County is that almost £27 million of savings will be needed which equates to 3.47% of the budget. QIPP targets for 2012-13 are still indicative and are dependant on several variables such as actual levels of growth received in 2012-12 and the successful delivery of QIPP efficiency and actual activity outturn in 2011-12.

2.0 Principles

The mission statement for NHS Erewash CCG is to deliver "Better Care. Better Health. Better Value." The aim is to deliver improved outcomes and quality for patients, to deliver the necessary QIPP requirements by improving efficiency and quality; deliver integrated partnership working to improve the delivery of services on the ground to patients and strengthening clinician and public involvement in our commissioning role.

The guiding principles that inform the commissioning intentions and subsequent contracting dialogue with providers are as follows and it is expected that all main providers will agree to these.

a) The shared objective of ECCG and providers in facing the current financial challenge is to transform the services we offer patients that further improves the quality and clinical and cost effectiveness.
b) All organisations will be required to deliver their required part in service changes to improve quality and effectiveness in order to secure added value in services within existing resource constraints. We will use incentives within contracts to support delivery the required service change.
c) National and local priorities to be delivered within available resources.
d) We will work with the public, local authority and partner organisations to understand the need for service changes and to commission services which are of high quality but also deliver improved efficiency and value for money.
e) We are working with Primary Care to reduce unwarranted clinical and operational variation. It is expected that clinicians in Secondary Care and community services will also work to deliver reductions in clinical variation.
f) We will support the greater integration of services through use of appropriate contract levers and incentives.
g) We will work with providers and partner organisations to tackle any long standing health community issues even if these cannot be resolved in the normal annual contracting round.
h) The CCG will commission services in accordance with the Operating Framework for 2012-13 and other national guidance.
i) Where no specific mention is made of a service or area within this document the Derbyshire County PCT's Contracting Intentions for 2011/12 will continue to be relevant.

3.0 Areas of potential change

This section flags up to providers areas of service change within ECCG which will impact on activity to be commissioned in 2012-13.

3.1 Unwarranted Clinical Variation

Please also refer to s.4.3 of the 2012-12 Joint Derbyshire Commissioning Intentions.
The CCG has identified specific clinical pathways to be included in the Quality and Productivity Indicators for primary care and has established an additional local CQUIN scheme proposal to tackle unwarranted clinical variation.

The aim of the Quality and Productivity Indicators is to seek to improve the quality of care provided to patients and deliver productivity gains by identifying and in turn providing alternative care options to avoid inappropriate referrals and emergency admissions. The focus is on:

- Prescribing
- Outpatient Referrals
- Emergency Admissions

The purpose of the indicators is to contribute to the productivity savings by undertaking reviews (internal and external) of current practice by GPs. This will be facilitated by analysis of specific data that looks to understand the reasons and, if appropriate, ways to address outlier performance in the areas set out above. The indicators also aim to support Practices to deliver care in line with pathways to reduce unnecessary secondary care activity.

Practices will be undertaking internal review and external peer review of emergency admissions and development of action plan and identification of specific actions which can be put into place to reduce avoidable A&E attendances and admissions such as Right Care Plans (see below), improved management of patients in nursing homes and proactive management of patients.

By 31st March 2012, 2% of the patient population with Rightcare plans in place with priority given to the following patient groups (extending to 5% in 2012/13):-

- Patients with 3 or more admissions, A&E attendances, or Out of Hours attendances in the previous year (adults only)
- Severe COPD patients
- End of Life patients
- New nursing home patients

In addition, practices will be focussing on implementing the pathway for COPD patients with key interventions aimed at reducing A&E attendance and hospital admission:

- Self management plans and standby medication for appropriate patients
- Review of patients following discharge from hospital with referral on to other services where appropriate
- Annual influenza and pneumococcal vaccinations

In relation to first outpatient referrals, practices will be undertaking an internal peer review of all referrals to the top 6 specialties within their practice and subsequent post review of the outcomes of referrals. The main specialties within Erewash CCG are:

- Dermatology
- Trauma & Orthopaedics
- Gynaecology
- ENT
- Ophthalmology
- General Medicine

In addition practices are required to make:

- Use of the Integrated Diabetes Service Pathway as replacement to all appropriate Diabetes hospital referrals
- Full use of the Procedures of Limited Clinical Value policy

It is expected that this will deliver:

- 10% reduction in GP referrals
- 15% reduction in emergency admissions.

These assumptions will be fed into activity plans for 2012-13.

3.2 Community services

To enable patients to be treated in the most appropriate setting, there is a requirement to review existing community services provided by health and social care. The utilisation review of acute hospital and community hospital beds in Derbyshire and Nottinghamshire shows that there is scope to make more effective use of existing beds by providing alternative levels of care in the community. We will work with acute providers and Derbyshire Community Health Services (DCHS) to identify gaps in services and commission appropriate alternative services in the community to deliver care in settings aligned to the patient's clinical needs.

ECCG plans to work with DCHS and Social Services to develop a new model for the proactive management of patients at risk of hospital admission. This will build on general practice as the locus of integration, with community matrons and district nurses and GP practice staff and social care, working to support proactive management of the practice population. This will also enhance integrated services through the involvement of social care. Work to develop the new model of care is being undertaken through the Department of Health QIPP for LTC Programme taking place in East Midlands.

ECCG will explore development of community services within Nottingham to consider if any of these developments should be offered within Erewash and will use existing contract links to consider early adoption of new developments.

3.3 Ophthalmology

ECCG will explore the possibility of establishing a primary care assessment service for eye conditions delivered by local opticians with the aim of providing a local assessment and treatment service for patients with minor eye conditions.

3.4 Right Care Pathways

ECCG will explore the adoption of the right care pathways developed through the East Midlands Right Care Workstream for Urology and General Surgery which had secondary and primary care clinician involvement in the development of the pathways. We will consider the adoption of these evidence based pathways and seek to commission local arrangements to deliver the best value pathways. This incorporates LUTS, scrotal swelling, hernia repair and rectal bleeding. This will also explore the development of patient decision making aids.

Linked to the work by GP practices on outpatient referrals, the CCG will review pathways and services around Trauma & Orthopaedics, Dermatology and Ophthalmology.

3.5 DVT

ECCG will explore the possibility of introducing a DVT screening test in primary care to reduce avoidable referrals to hospital.

3.6 Phlebotomy

ECCG will review the phlebotomy service following changes in the Primary Care funding arrangements.

3.7 Diabetes

ECCG intends to commission an integrated intermediate level 2 diabetes service through a competitive tender process. The service will commence in 2012/13. This service will move secondary care activity into community settings bring care closer to home for Erewash patients.

3.8 Urgent Care
We are currently reviewing the urgent care pathway at Ilkeston Minor Injuries Unit (MIU). We wish to change the operating hours to 8am-8pm, 7 days a week, with cover over night from Out Of Hours provider. We wish to extend the X-ray hours so that they run concurrently to the daytime MIU and also ensure that children under 5 can be x rayed. We are exploring the possibility of blood analysis at Ilkeston MIU which would help us to pilot the diversion of Category C calls away from acute care providers to the MIU.

3.9 Trauma and Orthopaedics
We will be reviewing the T&O pathway to understand reasons for higher then average activity. ECCG will be exploring opportunities to reduce activity and commission at the national average.

3.10 Frail elderly including Dementia
ECCG will be working closely with the Southern Derbyshire CCG who is leading on a project to improve the care of frail elderly including those people suffering from dementia. This will include learning from the evaluation of the Older Peoples Mental Health Liaison Service currently being piloted at RDHFT.

4.0 Contract
NHS Erewash CCG leads on the following contracts for the Derbyshire Cluster:

- Nottingham University Hospital NHS Trust
- University Hospital Leicester
- Birmingham Children's Hospital NHS Foundation Trust
- Voluntary Sector Contracts
- Private Hospitals for patient choice –ISTC, BMI and Ramsey

The following reviews/ developments will be undertaken throughout 2012/13:

4.1 Elective surgical intervention: will be commissioned in the least clinically intensive setting for treatment in line with British Association of Day Surgery rates and regional best practice.

4.2 Maternity: any new pathway tariffs developed for maternity services within the PBR system in 2012/13 will be used by ECCG as the currency to fund maternity services.

4.3 111: ECCG will introduce the 111 national initiative to the Erewash area. We are currently exploring the options of working with the Derbyshire or Nottinghamshire to ensure the best out of hours care for our population.

4.4 Consultant to consultant ratios: we will expect providers to improve their consultant to consultant referral ratios in order to move into upper quartile national performance.

4.5 Coding review: we will work with Nottinghamshire PCT as lead commissioner to implement the coding review commissioned through EMPACT.

4.6 Re-admissions: funding for readmissions will be paid in line with national guidance.

4.7 Independent Treatment Centre: we will be working with the lead commissioner Nottingham City PCT on a decision about retendering/or other for the contract for the provision of services at Nottingham Treatment Centre. Work will take place locally to identify services which would benefit from being delivered in the Treatment Centre and where services can be moved out into community locations.

4.8 Waiting times: we will commission no further reductions in waiting times for routine elective admissions, agreeing where clinically appropriate and necessary, and minimum waiting time standards for routine outpatients and operations across the CCG.

4.9 New to follow up ratio: We will expect upper quartile/ decile national performance on this area. We will work with trusts to reduce the first to follow up appointments to those of the most efficient providers nationally. We expect provider to develop improved standards of communication between primary and secondary care. Opportunities to move away from routine follow up outpatients following surgery in favour of patient directed open follow ups will be promoted.

We will continue to be represented on the NUH Clinical Contract Group which is exploring ways of reducing new to follow up appointments.

4.10 Information from providers: ECCG requires all providers to provide the CCG and constituent practices with electronic information on a daily basis of A&E attendances, admissions, discharges, outpatients, pathology, radiology and other hospital services. This is required to assist GP practices in the identification of patients who may require additional support from primary care in order to facilitate early discharge from hospital, ensure a safe discharge back home and provide proactive care to help avoid readmission to hospital. This data will be fed into an Urgent Care Clinical Dashboard for use by practices to support proactive management of patients.

An improved Schedule 5 is being developed in Nottingham and Derby for this year's contract round.

4.11 Excess treatment costs: excess treatment costs have to be considered within the cost envelope of the commissioners. Researchers should discuss excess treatment costs with the provider trust where the costs will be incurred. The provider trust should be able to cover these costs through existing commissioning arrangements and are expected to do so as part of the NHS tariff. Exceptionally, where the provider trust feels they are not able to cover the costs, it is the trust (not the researcher) who should present a business case to the commissioners for additional funding.

Martin Cassidy, Programme Lead, Strategy & QIPP
Ciara Scarff, Contracts and Performance Improvement Manager

HARDWICK CLINICAL COMMISSIONING GROUP

COMMISSIONING INTENTIONS 2012/2013

1. INTRODUCTION

Hardwick Clinical Commissioning Group (HCCG) comprises 16 practices with a registered population of 103k. HHCCG aims to meet the challenge of commissioning healthcare services care for an area with high levels of deprivation and health need, as well as providing consistently high quality primary care.

HCCG is the lead commissioner for the following contracts; Barlborough NHS Treatment Centre, Derbyshire Healthcare Foundation Trust (DHcFT), Improving Access to Psychological Therapy contracts and Care Homes. The CCG are also lead Associate Commissioner for mental health services for Nottinghamshire, Staffordshire, Leicestershire, Sheffield, Pennine and regional lead on a number of Rehabilitation contracts. The CCG is also lead associate for Derbyshire for the Sheffield Teaching Hospitals NHS FT, Sherwood Forest FT, Sheffield Children's NHSFT, Doncaster & Bassetlaw NHS FT, The Rotherham FT, Leeds Teaching Hospitals, The Claremont and Thornbury contracts. Also the CCG is associate commissioner for Chesterfield Royal FT (CRH), Derbyshire Community Health Service (DCHS) and Derbyshire Health United (DHU). The CGC is the lead associate for Mental health NHS provider contracts on the Derbyshire borders and also for some key regional mental health and LD independent hospitals.

The purpose of this document is to outline the commissioning intentions of HCCG for 2012/13 as an early message of intent to give providers an opportunity to inform and engage with the development process.

2. VALUES AND VISION

The values and vision of HCCG are as follows:

- **To deliver personalised patient-centred care to the CCG population**
- **To support patient-centred care through effective commissioning**
- **To support equitable distribution of health resources**
- **To be financially viable**
- **To support and sustain a model of general practice which is cost-effective and value-for-money**

Hardwick CCG Strategic Objectives:

- **High quality patient care** in commissioned and provided services is paramount to the development of the organisation.
- **Patient choice and engagement** is at the heart of the organisation.
- An organisation which is **responsive and accountable** to its population and the wider healthcare system.
- A **national leader in both the provision and commissioning** of services in response to population need.
- An **organisation of collaborators** across all boundaries whether these are geographical, organisational or cultural boundaries.
- **Extensive and embedded clinical engagement** to underpin robust decision-making process.
- **Financial stability** across all areas of the organisation.

3. COMMISSIONING INTENTIONS:

As for 2011/12, a common underlying theme for commissioning in 2012/13 remains the delivering of recurrent NHS financial savings and to achieve the delivery of the QIPP programme through a clinically led approach.

Also Hardwick CCG would expect providers to deliver the Department of Health requirements for the implementation of Payment by Results, by adopting an approach with minimum financial risk to CCGs and Derbyshire Cluster.

3.1. PRIMARY AND COMMUNITY CARE

- Develop and shape the proposed service design changes for community services including changing bed models, increasing intermediate care provision, and implementation of the SPA.
- Implement robust case management embedded in every practice.
- Increase the level of appropriate use of RightCare for patients at risk of emergency admission particularly for patients nearing the end of life and patients with long term conditions.
- Implement the Basket of Services in each practice within the CCG.
- Together with DCC, develop and help shape a sustainable model for integrated health and social care for people with complex long term conditions and to implement it.
- Review the support offered to Care Homes to increase quality of care and reduce emergency admission including pharmacy and nutrition support. Develop and coordinate the level of

primary care provided to patients in care homes across the CCG to reduce emergency admissions to secondary care.

- Review the provision of generalist and specialist palliative care bed levels available in the community.

- Develop solutions for patients who frequently attend services, this may include community based health promotion services.

- Develop a research and development cell or 'skunk works' to formulate commissioning solutions in the areas of timely visit management to reduce A+E attendance and pain management in the community.

3.2. ACUTE CARE & URGENT CARE

- Ensure implementation of the Operating Framework guidance on payment for readmissions; to include ensuring appropriate acute and community services are in place to reduce avoidable readmissions.

- The CCG will commission services in accordance with the Operating Framework for 2012/13 and will take account of the 2012/13 Payment by Results Guidance and any other national directives.

- Consolidate the pathway out of acute care and back into the community through timely and quality discharges including transforming current teams working across the interface.

- Work with Chesterfield Royal Hospital FT (CRH) to further develop the Ambulatory Care pathway at CRH to embed sustainable change which enables increased access to senior decision makers and reduced delays to the patients and costs to system of treating ambulatory patients.

- Develop improved standards of communication and understanding between primary and secondary care.

- Ensure T&O referrals have been appropriately screened on or before referral to ensure the relevant criteria is adhered to.

- Continue to work with providers and clinical commissioners to ensure compliance with the Procedures of Limited Clinical Value Policy. If a patient is treated for a procedure/condition within the Policy and approval is not granted for exceptional circumstances, then HCCG will not pay for the treatment. The policy will also include surgical thresholds criteria for referrals. The policy will also include procedures and treatments for low volume high cost procedures requiring prior approval. Any such individual patient level approvals must be approved by HCCG or via the IFR route.

- Ensure emergency ambulances are utilised efficiently and effectively in the community and alternative to conveyance to acute hospital are widely understood and implemented. Develop clinical advice pathways for urgent care providers to access primary care clinicians and information.

- New drugs and treatments should not be introduced into practice without the knowledge and consent of HHCCG. All new technologies should be anticipated in advance and their introduction should be commissioned through negotiated contractual changes during the annual contracting round. There should be no in year cost pressures for commissioners caused by the unanticipated introduction of new drugs and treatments. Any digression will be reported to MMT as agreed.

- The Individual Funding Request (IFR) route should not be used for the introduction of new technologies or to fund treatment either covered within current contracts or of limited clinical effectiveness. Prior approval will be required for a number of high cost and low volume procedures to ensure that national and local policies are being followed.

- Where no specific mention is made of a service or topic within this document, then Derbyshire County PCT's Contracting Intentions for 2011/12 will continue to be the relevant statement of HCCG's position unless superseded by changes to Payment by Results.

3.3. MENTAL HEALTH AND LEARNING DISABILITY

Mental Health Commissioning Intentions specific to HCCG:

- The CCG will pilot integrated care pathway for people with dementia across primary, community, and secondary care to address inequalities and to explore where the costs fall in the new arrangements. The CCG will also explore training in dementia for home care staff in all localities where it isn't currently available with the aim of reducing avoidable emergency admissions.

- The CCG will commission the refreshing of the MH needs assessment for Derbyshire.

- Review clinical care pathways and make recommendations where appropriate regarding changes to contracts or services.

Mental Health Commissioning Intentions across all CCGs:

- The MH services available to Derbyshire patients who live in Nottinghamshire will be reviewed.

- The CCG will ensure improved provision of information by LD providers to fulfil SHA requirements and all practices are to be providing health checks to fulfil SHA requirements.

- Together with Derby City and Derbyshire County Councils, the CCG will work, towards transferring the lead commissioner role for Learning Disability services.

- Together with High Peak CCG review the service provision for the adult care pathway in the High Peak.

- Deliver IAPT services across all practices and develop primary care mental health services to address the gaps in current provision of therapies and support.

- Work with secondary health care providers to have primary care facing mental health services and as and when resources allow embedded CPN roles within practices

- Support the development of PbR for mental health.

- Together with Derbyshire County Council develop the autism pathway consistent with the autism act and subsequent guidance.

- Work with East Midland Specialist commissioning group to ensure the transition of all minimum take services to the Midlands and East Cluster.

- With local authorities to re-commission carer support services for mental health.

- With local authorities review and consider re-commissioning Out of hours support line for mental health.

- Work to bring as many people in placements out of county back to services as near to home and in the least level of security clinically appropriate.

- In partnership with the local authorities and voluntary sector infrastructure organisations develop outcome based monitoring arrangements for the voluntary sector.

- In partnership with the voluntary sector deliver primary care mental health training programme.

- Working with local authorities support the move to personalised services.

- Support recovery based approaches to service delivery.

3.4. CHILDRENS SERVICES

- The CCG intends to work with DCC and the Derbyshire Children and Young People's Trust to implement an integrated pathway for children aged 5 to 19 in primary care.

4. PATHWAY DEVELOPMENTS

- **111**
  Some of the member practices in HCCG will be part of the first wave pilot for introducing 111 in Derbyshire and the remainder will be included in the second wave pilot.

- **Ophthalmology**
  Options for a community pathway to reduce referrals to secondary care ophthalmology services will be explored and implemented in 2012/13; this may include a community glaucoma follow up service.

- **Neurology**
  Specific clinical guidelines for neurology pathways will be revised and implemented, possibly including Headache Management.

- **DVT**
  A community pathway for providing D-Dimer testing across the CCG will be implemented fully in 2012/13.

- **Alcohol**
  The CCG will identify lead contacts within CCGs and the DAAT and understand existing pathways of care.

- **Carpal Tunnel**
  Review the carpal tunnel pathway, with a view to utilising Nerve Conduction Study testing at Barlborough NHS Treatment Centre.

- **Heavy Menstrual Bleeding**
  All practices will implement the HMB pathway in primary care if not already done so. Further work will be done to explore options for the secondary care element of the pathway.

- **Obstetrics**
  The audit of hospital emergency admissions during pregnancy will be reviewed with a view to identifying areas for pathway development and possible future commissioning

HIGH PEAK CLINICAL COMMISSIONING GROUP

A SUB – COMMITTEE OF NHS DERBYSHIRE

7th October 2011

High Peak Clinical Commissioning Group

Statement of Commissioning Intentions 2012/13

Introduction

The High Peak Clinical Commissioning Group (HPCCG) is composed of 8 practices whose GPs and staff between them have a long history of providing primary care services to this geographically distinct area and are well acquainted with the health needs of its population. The HPCCG faces an unprecedented challenge – to reduce expenditure to its equity share of the former Derbyshire Primary Care Trust's budget as determined by a national funding formula. This means improving the quality of services while reducing costs by in the region of £4.5m. This can only be achieved by significantly changing the way health services are delivered and working practices. The HPCCG welcomes the opportunities which this challenge will bring to work with provider organisations and other partners in new and innovative ways.

Principles

- Engage local people and listen to local views – the HPCCG will involve local communities and consider local interests in the design and provision of services, as far as it is practicable to do so.

- Accessible services – services which do not need to be provided in an acute hospital setting should be located as close to home as possible, whilst accepting that in a predominantly rural area some travel will be a necessity

- Tackling inequalities – resources will be targeted at areas of known deprivation and highest need informed by local Health Needs Assessments and the Joint Strategic Needs Assessment.

- Challenging historical provision – the HPCCG will work with the public, local authority and partner organisations to understand the need for change and to commission services which are of high quality but also adaptable, efficient and economical. All provider organisations will be required to deliver their part in service changes, and partnership working will be vital to developing new ways of delivery.

- Following due process – where services are commissioned or re-commissioned, the HPCCG will follow the required 'Any Qualified Provider' or other relevant procurement guidance.

- The CCG will commission services in accordance with the Operating Framework for 2012/13 to be published later in the Autumn and with other national directives.

- Where no specific mention is made of a service or topic within this document then the Derbyshire County PCT's Contracting Intentions for 2011/12 will continue to be the relevant statement of the HPCCG's position unless superseded by changes to Payment by Results.

Areas of Potential Change

The HPCCG commissions either directly or through the lead of a neighbouring CCG an extensive range of services for its population. It is not possible or desirable to seek to change all of these services in a short space of time. Outlined below are the areas of service which the CCG will be concentrating upon in the first instance.

Acute Hospital Care

Out patients
The full range of outpatient specialties will continue to be commissioned and a range of providers will be involved in order to enable patients to have choice at the point of referral. However, a review of outpatient services is ongoing and the HPCCG hereby gives notice that some decommissioning of services may be the outcome. The volume and nature of the decommissioning is not yet determined but the intention is that outpatient services delivered in locations in the High Peak should reduce, not duplicate or supplement, those provided in acute hospitals and where possible local access will be increased.

Follow Up Outpatient Appointments
It is the intention to reduce the ratio of first to follow up appointments to those of the most efficient acute providers nationally. One way of doing this will be to work with providers to identify patients in a number of specialties who are referred to secondary care for an opinion. The patient can be discharged to the care of the GP with a management plan after the first outpatient appointment and will not require a follow up at a hospital. Many patients currently are followed up by GPs and acute providers thereby duplicating effort.

Elective procedures, Day Case and Outpatient Procedures
The British Association of Day Surgery (BADS) sets out a list of procedures and for each the ratio of procedures that can be carried out as an outpatient procedure rather than as a day case. The HPCCG will not pay day case rates for procedures which can be carried out in an outpatient setting because of inefficiency in the service delivery of acute providers.

Procedures of limited clinical value (PLCV)
The aim of the HPCCG is to commission evidence based procedures and the current PLCV policy is the result of a careful assessment and review of the published evidence. It is likely that policies which set out the circumstances in which commissioners will, or will not, fund certain procedures will continue to evolve. Where procedures are not commissioned or are commissioned against certain criteria only, the HPCCG will not pay for procedures which do not comply with the PLCV policy even though a referral may have been made to an acute provider. The

DoH has made it clear that a referral is not the authority to treat where policies setting out procedures which are not commissioned are included in contracts.

Urgent Care

Clinical Commissioners will work with acute providers to limit the continued expansion of demand for urgent care. This may involve greater scrutiny of the reasons why people attend at Emergency Departments and the reasons for admission from the Emergency Department.

Length of Stay

The HPCCG will commission efficient services which reduce unnecessarily long lengths of stay usually associated with transfers between wards and handovers between clinicians. In so doing it is expected that the number of excess bed days will reduce and associated costs will be removed from contracts with acute providers.

Readmissions

It is anticipated that there will be changes to the Payment by Results regime for readmissions in 2012/13, acute providers becoming responsible for patient care for 30 days following discharge and tariffs being amended to reflect this additional responsibility. The HPCCG will abide by the PbR payment mechanism for readmissions for 2012/13.

Maternity Services

It has been suggested that a pathway cost for maternity services will be introduced into Payment by Results including all outpatient midwifery and consultant led contacts, non-delivery events and a delivery event. Should such a pathway cost be introduced in 2012/13 this will be the currency by which the HPCCG will fund maternity services.

Review of Pathways

A number of sources of information are available to the HPCCG against which to benchmark its use of services. These include data toolkits, the national Right Care data and locally commissioned reviews. From these sources a number of areas have been identified for further work to ensure that pathways are efficient as possible and operate in the best interests of patients. Through the work of the CCG's Clinical Reference Group it is intended that the following pathways will be considered as a priority in 2011/12 with a potential for impact upon contracts in 2012/13:-

- Cardiovascular disease, in particular palpitations
- Trauma & Orthopaedics and in particular musculoskeletal pathways and hip replacements
- Deep Vein Thrombosis (DVT) identification and treatment
- Dermatology
- Ophthalmology, in particular raised intraocular pressure

Targets

Sufficient activity will be commissioned to meet the HPCCG's commitment to achieve patients' rights under the NHS Constitution and particularly with regard to 18 week

wait pathways, cancer referral to diagnosis and referral to treatment targets, A&E waiting times and stroke pathways.

Older People with Complex Health Needs

As life expectancy increases so does the number of people who live with multiple co-morbidities and long term conditions. The HPCCG will work with all NHS, Social Care and Independent Sector Providers to improve packages of care for older people with complex health needs, targeting resources at those with the greatest needs. Provision should be as local to home as possible. The re-commissioning of a supported care bed in the High Peak is under consideration in order to prevent avoidable admissions to an acute setting.

NHS funded nursing care and complex packages of care will continue to be commissioned by the Continuing Care team responsible to the Derbyshire PCT Cluster until the National Commissioning Board is established.

End of Life

It is the intention of the HPCCG to enable patients to die at home where they choose to do so. The Gold Standards Framework and the Liverpool Care Pathway will be instrumental in allowing this to happen.

Specialised commissioning

Currently the HPCCG commissions specialised services as the East Midlands Specialised Commissioning Group (EMSCG) do not commission from providers in the North West and the North West SCG does not commission for the population of Derbyshire. The arrangement will change with the establishment of the National Commissioning Board (NCB) and the transfer of specialised commissioning for a defined number of services to the NCB. It is not anticipated that flows of patients into Manchester hospitals for cardiac surgery and cancer treatments, for example, will change but it is anticipated that the NCB will introduce policies which are nationally consistent.

The introduction of new technology

New drugs and treatments should not be introduced into practice without the knowledge and consent of the HPCCG. All new technologies should be anticipated in advance and their introduction should be commissioned through negotiated contractual changes during the annual contracting round. There should be no in year cost pressures for commissioners caused by the unanticipated introduction of new drugs and treatments.

Individual Funding Requests (IFRs)

The IFR route should not be used for the introduction of new technologies. Prior approval will be required for a number of high cost and low volume procedures to ensure that national and local policies are being followed.

Primary Care
The commissioning of Primary Care Medical, Dental, Pharmaceutical and Ophthalmology services will continue to be the responsibility of the PCT Cluster until such time as the National Commissioning Board is established. The HPCCG will seek to influence the commissioning of primary care services where it can be demonstrated that efficiency and outcomes for patients can be improved.

Medicines Management
All providers are expected to use medicines effectively and efficiently to ensure that wastage is minimised. Pharmacy advisors working with practices will continue to promote effective prescribing in primary care.

Community Services
A range of community services to meet the needs of local people will be commissioned in locations that avoid the need to travel excessive distances. It is anticipated that the HPCCG will review the business case setting out proposals for the future of community hospitals and will take into account the health needs of the local community in doing so. Greater scrutiny will be made of the reasons for admission to community hospitals, though it is accepted that bed days in community hospitals will continue to be required. Better information to support the use of community services by practices will be essential.

111 – new NHS telephone number to provide a single point of access to all non-emergency NHS services
The HPCCG will work with the PCT Cluster to introduce the 111 national initiative to the High Peak. Out of Hours services will continue as at present until the point at which it is necessary to retender the service.

Mental Health
Work has commenced with providers and stakeholders in order to evolve current delivery arrangements to an integrated model that offers the required service improvements, demonstrates full and effective use of the High Peak allocation of the mental health budget and demonstrates the full and effective engagement of all providers in this health care system. A phased timetable for action has been produced.

Notice is hereby given that it may be necessary to tender for a single provider to ensure the effectiveness of an integrated model of care if such a model cannot be achieved through joint working between providers.

Quality, Innovation, Productivity and Prevention (QIPP)
A major event has been arranged for the 19th October when the CCG Board and key partners will be meeting to determine how best to meet the considerable financial challenges facing the Clinical Commissioning Group. The outcomes from this event will inevitably impact on most if not all providers and more details will be forthcoming at a later date if not already covered in this Statement of Commissioning Intentions.

North Derbyshire Clinical Commissioning Group

Commissioning Intentions 2012/2013

1 Background

The North Derbyshire Clinical Commissioning Group (NDCCG) is composed of 30 practices with a registered population of 227,915. The GPs and staff between them have a long history of providing services to this urban and rural population which contains a wide spectrum of social deprivation.

NDCCG is the lead commissioner for Chesterfield Royal Hospital Foundation Trust (CRHFT), Derbyshire Community Health Services (DCHS), Home Oxygen Services for the East Midlands and Ashgate Hospice. The CCG is also an associate commissioner for a number of other local contracts. The CCG is responsible for supporting the Cluster PCT (and future National Commissioning Board) in providing assurances around quality of primary care provision across North Derbyshire CCG constituent General Practices.

The purpose of the document is to outline the commissioning intentions for NDCCG for 2012/13, highlighting NDCCG initial key priorities and the agenda for service change across providers. This document should be read in conjunction with the Derbyshire wide commissioning intentions document as this details all of the county wide commissioning priorities.

Whilst these commissioning intentions will give providers an initial view of the priority areas for the ND, the CCG, with all key partner organisations, are developing integrated working agreements which will endeavour to deliver an integrated vision and commissioning plan.

NDCCG is committed to a clinically led evidence based approach to service commissioning involving patients, the public, carers and collaborative working with providers and other partners.

2 Values and Visions

- To improve health outcomes for individuals and communities
- To improve the quality of care for patients registered with CCG member practices and those unregistered but living within the geographical area of the CCG through effective partnerships with other organisations and with local people.
- To conduct all business in a fully inclusive and clinically led way engaging with member practices, patients and the public and key partners.
- To work jointly with Derbyshire County Council to develop the Joint Strategic Needs Assessment (JSNA) using available health data but also bottom up intelligence from primary care on very local needs.
- To encourage innovation and strive to find new and better ways of commissioning services
- To support improvements in productivity and deliver cost reduction and value for money by commissioning quality services.
- To bring more health services closer to local people by improving primary and community based services to improve outcomes.

- To improve the experience of local patients by complying with Statutory duties to ensure health services are provided promptly, safely and effectively by:
    - Promoting continuous quality improvement
    - Assuring that services commissioned are of appropriate quality
    - Intervening where adequate quality and safety standards are not being met and early warning signs are being raised
    - Observing the duty to consult and involve patients and communities in the planning and delivery of services
- To renew the focus on prevention to improve wellness and avoid patients having to go into hospital unnecessarily
- To improve the provision of urgent care in primary care and the community and develop more responsive urgent care services.
- To undertake all preparatory and development work necessary to achieve Authorisation by April 2013.

3 Commissioning Priorities

3.1 Integrated Working

CCGs are fundamentally different to previous NHS commissioning organisations. They are clinically led and their approach to service redesign will be different. The key priorities for NDCCG include:-

- Living within the recurrent allocation given to the CCG by the Department of Health
- Ensuring investment is shifted away from less clinically effective services to enable the CCG to meet the needs of the ageing population.
- Believing that the best way to achieve the above 2 points is to ensure collaborative and close working relationships with all health and social care partners leading to less waste and more integrated services.
- Reducing unwarranted clinical variation.

A meeting of all Health and Social Care partner organisations was held in October 2011 at which agreement was gained to work in a truly integrated manner across Health and Social Care in North Derbyshire. This new way of integrated working should result in delivery of the following:-

- A shared vision on the future of health and social care for North Derbyshire
- Integrated commissioning plans
- Investigation of options around financial models and risk sharing.
- Integrated service provision to limit the continued expansion of demand for urgent care.
- Ongoing identification of programmes of work e.g. diabetes care, shared assessments.

A number of priority areas where integrated programmes of work are already underway are summarised below.

Frail and Elderly

Delivery of a review of the current problems with regard to the care of the frail and elderly, followed by integrated pathway development and implementation. Including a focus on dementia services, rehab, end of life care and quality discharges.

Shared Records
Work stream to focus on IT solution opportunities available to the CCG and partner organisations to enable better access to shared patients records across North Derbyshire.

Baseline Review of Existing Change of Work
A review to identify all existing change and development work which is underway across Health and Social Care in North Derbyshire.

Respiratory Care
Undertake a review of the respiratory care pathway which is currently in place across Health and Social Care in North Derbyshire, and loot at opportunities for a collaborative provider model or joint venture.

Access to Senior Decision Makers in Secondary Care
The CCG will work with Chesterfield Royal Hospital FT (CRHFT) to further develop the Ambulatory Care pathway at CRHFT to embed sustainable change which enables increased access to senior decision makers, reduced delays to the patient and reduced costs to the system.

Developing Community Services to Provide Care Closer to Home
North Derbyshire CCG will work closely with our community service provider (DCHS) to develop and determine the service redesign changes required to support patients to receive high quality care at home or as close to home as possible, including health and maintaining independent living and quality of life..

This may include changing the community bed provision both in terms of clinical and capacity requirements, increasing intermediate care and community nursing provision both in relation to capacity and breadth of service provision and increasing ease of access for professionals to community services, potentially through the use of a single point of access and clinical navigation service. A pilot Single Point of Access will be evaluated and if benefits are not demonstrated this will be decommissioned.

The CCG as the lead commissioner for DCHS is continuing to support them in the development of their integrated business plan to support them with their application for authorisation as a foundation trust.

3.2 Ensuring Value for Money

The CCG is committed to working on the following work areas to help ensure value for money from the available CCG funding whilst being clinically led.

Pathway Development
The North Derbyshire CCG's Clinical Reference Group has identified the following pathways to be developed as a priority in 2011/2012 with a potential for impact upon contracts in 2012/13.

- Hip and knee pathways
- COPD pathway
- Optometry pathway
- DVT pathway

- Avoidable admissions – The CCG will work with primary care and all other health care providers to increase the level of appropriate use of RightCare for patients at risk. of emergency admission particularly for patients nearing the end of life and patients with long term conditions.
- Dermatology
- Heavy Menstrual Bleeding

Further areas of focus continue to be identified through these locally, clinically led pathway development groups, which include representatives from across primary and secondary care.

Maternity Services

The CCG will implement the decision of the Cluster Board in relation to the review of maternity services provided from the Darley Dale Birthing Centre, and will be fully involved in specifying a new community based model should the unit close.

Reducing Unwarranted Clinical Variation

The North Derbyshire CCG is focusing on reducing clinical variation across the CCG through the use of regular monthly performance reports and locality budget management clinical discussions. These include the use of data toolkits, the national Right Care data and local commissioned reviews. Through review of these data sources a number of areas have been identified for the further work to ensure that pathways are efficient as possible and operate in the best interest of patients.

Referral and Medicines Management Team

The CCG has established a referrals and medicines management team (RMMT) which will build on the success of the medicines management teams, to share good practice and reduce clinical variation. This team will target outlier practices first for a robust GP peer to peer discussion supported by medicines management team colleagues and locality managers. Action plans will be agreed and these will be monitored monthly and repeat visits agreed to review performance.

Southern Derbyshire Clinical Commissioning Group

Commissioning Intentions 2012/13 (additional to the Derbyshire Joint Commissioning Intentions)

Southern Derbyshire Clinical Commissioning group (SDCCG) is a sub-committee of NHS Derbyshire and Derby City (previously the PCTs for Derbyshire County and Derby City). SDCCG has delegated responsibility for the commissioning of the majority of NHS services for all patients registered with its constituent GP practices. The CCG also commissions services for unregistered and temporary patients residing within its geographical boundary. The total registered population is estimated to be 523,000 and covers the whole of Derby City as well as Amber Valley, South Derbyshire and the southern part of Derbyshire Dales.

SDCCG is the lead commissioner for Derby Hospitals Foundation Trust (DHFT) and Queens Hospital, Burton.

A separate letter has already been sent to DHFT setting out the financial envelope within which SDCCG proposes to negotiate this year's contract.

SDCCG's commissioning priorities are described in two different ways:

- **Locality priorities**. SDCCG works through four localities:

    - Amber Valley & South Derbyshire Dales
    - Derby Advanced Commissioning
    - Derby Commissioning Network
    - South Derbyshire

    Each of the localities has started to identify local issues affecting their local populations. There is still more work to be done but the CCG is committed to ensuring that these priorities are taken forward. These priorities will be negotiated with providers as they become further developed.

- **Priorities which the CCG wishes to take forward** across the whole of the SDCCG area. Some of these may be determined nationally; others are based on local information and intelligence

SDCCG-wide priorities

1. Dementia care
   The CCG aims to:
   - Improve the care of dementia patients in acute hospitals
     - Move towards more community based diagnosis and care
     - Greater support for carers
2. Integrated Care
   The CCG aims to:
     - Focus on meeting the needs of frail and elderly people
     - Start initial work in Derby City to develop a single point of access to services
     - Consider the implications for community services
3. Health inequalities
   The CCG aims to:
     - Agree which inequalities to prioritise and link to the Equality Delivery Scheme
     - Move towards greater consistency in what is commissioned from primary care.
     - Reduce inequalities in the provision of Health Visitors
4. Planned care
   The CCG aims to:
     - Develop care pathways based on the work of the joint clinical groups
     - Commission Any Qualified Provider services in Podiatry, Physiotherapy, and Psychological therapies
     - Pilot shared decision-making between patients and clinicians
5. Mental Health
   The CCG aims to:
     - Work with clinicians to identify the key issues in southern Derbyshire, – particularly in the City
     - Critically examine the costs and outcomes of services in southern Derbyshire
     - Reduce the number of out-of-county placements
6. Support for carers
   The CCG aims to:
     - Facilitate greater provision of short breaks and other respite care
     - Move towards pooled budgets and lead commissioning with local authorities

Collaborative Commissioning Intentions for EMAS 2012/13

1 Introduction

1.1 This paper outlines the 2012/13 commissioning intentions for EMAS including commissioner's key priorities and agenda for change for the year ahead.

2 Background

2.1 These intentions have been developed in conjunction with the Associate Commissioners to the EMAS contract and on-going dialogue between the EMPACT clinical lead and Clinical Commissioning Groups (CCGs).

2.2 The intentions have been informed by the Operating Framework 2012/13 and the East Midlands 2012/13 Collaborative Commissioning Intentions Framework.

3 Local Engagement

3.1 The need for greater local engagement has been a key message from CCGs to increase transparency / understanding and facilitate locally sensitive and flexible service model variations.

3.2 Commissioners would welcome an EMAS representative to attend the lead CCG Board in each division on a quarterly basis to report on performance and developments.

3.3 Quarterly divisional planning meetings between CCGs and EMAS are also recommended with clear links into established local urgent care planning arrangements.

3.4 The agreed feedback loops for local concerns raised through CCGs will also be established in 2012/13.

3.5 These actions will build on the growing local engagement already seen across the EMAS patch.

4 Performance Recovery

4.1 The recovery of A19 performance and the sustainment of A8 performance to deliver the nationally required minimum target levels is the key priority for 2012/13.

4.2 The implementation of the performance recovery plan will be closely monitored and supported by commissioners on an on-going basis.

4.3 Commissioners will also be working closely with EMAS throughout 2012/13 to establish robust baselines and improvement goals as required across the full range of the 23 new national quality and systems indicators.

5 Quality, Innovation, Productivity and Prevention (QIPP)

5.1 The QIPP agenda is the central theme of both CCG and the East Midlands commissioning intentions, and the 2012/13 Operating Framework.

5.2 Commissioners see the proactive and innovative matching of capacity / capability to demand as the key QIPP opportunity for EMAS and are keen to collaborate both at the corporate EMAS and divisional levels. Full integration into urgent care planning should maximise the QIPP potential for both EMAS and the system as a whole.

5.3 To support this commissioners wish to discuss the appointment of a jointly agreed third party advisor for both parties on operational improvements.

6 Priority Areas for Service Improvement

6.1 Commissioners are keen to work with EMAS on:

- Reducing unnecessary conveyance
- Improving the system for inter-hospital transfers
- Maximising the impact of dispatches / multiple dispatches and avoiding unnecessary dispatches
- Improving turnaround performance
- Implementing NHS Pathways

7 Improved Information for Commissioners and Patients

7.1 In line with the Operating Framework, the East Midlands Commissioning Intentions and the national Information Strategy commissioners will be significantly strengthening the Reporting & Information Schedule (formally schedule 5).

7.2 Commissioners' will be working with EMAS to develop an information improvement plan to enable CCGs to effectively contract collaboratively at the divisional level and EMAS to report at CCG level, over an agreed time period.

8 Common Financial Approach

8.1 Commissioners' recognise the practical benefits to EMAS of a single and consistent financial planning approach.

8.2 To this end there is an agreement to use the nationally directed position in the operating framework and David Flory's covering letter to the PbR road test guidance as the baseline i.e.

"The national efficiency requirement is -4% and pay and price inflation is assessed at +2.2%. This gives an adjustment of -1.8% which should be the starting point for discussions on price for non-tariff services."

8.3 Commissioners', will in line with national direction, implement the mandatory currencies for ambulance services. The outputs from the jointly instigated finance sub-group will inform the agreement of local prices for these currencies.

8.4 In view of EMAS's reference costs being 98 against a national average of 100 for 2010/11 and Commissioner's understanding of the relatively positive settlement for 2011/12, we believe there will be no need for any specific local arrangements to manage the transition to a national tariff in 2013/14.

8.5 In line with current local practice and national guidance we will have a single tariff structure (as opposed to differential pricing) for all commissioners.

8.6 Additional commissioner investment for 2012/13 will be channelled through the additional 1% CQUIN payment. The 2012/13 scheme will be collaboratively developed through the Quality sub group and agreed at the negotiation meeting.

9 Common Activity Requirement Planning Approaches

7.1 EMPACT will be producing baseline activity requirements for each Associate using a single and consistent forecasting model for dispatch activity.

7.2 Changes to the baseline requirement will need to be justified and agreed between each commissioner, EMPACT and EMAS.

7.3 The translation of current activity data into the 4 new currencies will be collaboratively progressed through the established Finance Sub-group.

7.4 Although the current activity projection for dispatches (the current currency) in 2012/13 is downwards, commissioners will assess the impact of this on the overall financial baseline in the context of projected requirements across the 4 new currencies.

10 Planning for Foundation Trust Status

10.1 Commissioners' are committed to the strategic development of EMAS as a high performing and efficient Foundation Trust.

10.2 As EMAS strategically focuses solely on emergency and urgent care we believe the Trust is now better placed to proactively engage and meet commissioners' requirement across the whole urgent care system.

10.4 We look forward to embedding the actions and processes from the validation of the Tripartite Formal Agreement in the contract as appropriate.

Michael Whitworth
Draft 1.1 January 2012

East Midlands Specialised Commissioning Group

Commissioning Intentions for 2012/13

Editor / Owner(s)	
Version No.	
Approval Date	
Distributed	30 September 2012

1. PURPOSE

This document aims to set out Commissioning Intentions for 2012/13 and beyond for Specialised Services.

The role of Specialised Commissioning Groups is to commission specialised services for their populations and this document sets out how the SCG will commission services during 2012/13, whilst ensuring financial control and driving improved service quality and care pathway management. Changes to the specialised portfolio, associated contractual changes for 2012/13, strategic commissioning developments impacting on future arrangements, and where applicable, specific terms of business are also covered.

As the NHS is facing a period of unprecedented change and financial challenge for all organisations, this increases the need for both improved productivity and performance around our agreements with providers. This will ensure that all of our resources are targeted effectively to maximise patient treatment and care and to ensure parity of charging and coding between our providers.

The SCG will commission consistently within the requirements set out in the National Operating Framework for 2012/13; the 2012/13 Payment by Results (PbR) tariff, and the national contract terms and associated guidance. The SCG will incorporate key requirements of all national documents, and any guidance issued by the cluster Strategic Health Authority, into our contracts with our providers when published.

These intentions are designed to be distributed to a number of organisations and stakeholders. As a result, not all of the paragraphs will relate to services relevant to each particular organisation.

Providers should take this document as formal notice of our intentions in all of the areas set out below.

2. NATIONAL STRATEGIC DIRECTION

This document is being published at a time of unprecedented change within the NHS with a significant piece of legislation that sets out reform to the structure of the Health Service currently passing through parliamentary processes. This document is therefore written in a way to be cognisant of the proposed changes however needs to be read with this context in mind and with a recognition that any amendment to the current Health Bill as it passes through the parliamentary process may result in changes with regard to these Commissioning Intentions.

On 3rd August, Bob Ricketts wrote to all Providers (Gateway Ref 16467) outlining the transition for specialised services to the new commissioning arrangements, as part of the passage of the Health and social Care Bill. The overall aim is to have national convergence of commissioning specialised services from April 2012, with full responsibility transferring to the NHS Commissioning Board from April 2013.

For 2012/13, the overriding planning principles will be to maximise progress to national working whilst minimising clinical, financial and reputational risk through transition. Where possible and beneficial, there should be convergence for ‘early implementer’ services, incorporating nationally consistent service specifications, quality standards and policies into all contracts, as

long as there is no significant service or financial risk identified. This is a national process, which will need to be implemented locally.
The phased approach to convergence will mean there will still be some national variation across SCGs through 2012/13 however; every attempt will be made to achieve standardisation across SCG clusters, where this can be achieved without unacceptable risks to PCT clusters.

3. KEY CHANGES IN 2012/13

In order to achieve national convergence the following key changes will be implemented:

3.1 Clustering

From October 2011 the 10 SCGs across the country will be clustering into the SHA footprints. This is an interim stage in the transition process to establish four SCG clusters prior to the establishment of a single function within the NHS Commissioning Board. The four SCG cluster footprints are:

North SCG Cluster	North West, Yorkshire & Humber and North East SCGs.
Midlands & East SCG Cluster	West and East Midlands and East of England SCGs.
South SCG Cluster	South West, South Central and South East Coast SCGs.
London SCG Cluster	London.

3.1 Single Contracts

There will be one contract per Provider, with one SCG commissioning the totality of specialised services on behalf of the rest of the country. In 2012/13 this will be achieved through all SCGs becoming Associates to one SCG's contract with each Provider. Contracts will continue to be held by the SCG's Host PCT, with the duties and responsibilities of the Coordinating Commissioner delegated to the SCG. There will be clearly defined roles and responsibilities for the Host SCG and Associates. Associates will continue to pay Providers directly for their activity.

There will be a need for separate contract documentation from that used by the Coordinating Commissioner for non-specialised services. The SCG intends to use the NHS Standard Contract for 2012/13 with all Mental Health, Acute Hospital and Community Service Providers. This will ensure consistent contractual terms and conditions with all of our providers, in line with nationally set expectations. The contract will be managed in accordance with the obligations of the NHS Standard Contract.

Governance to support the new arrangements will need to be reviewed and revised. Department of Health guidance is expected in November to nationally address establishment and consortium agreement issues and the clustering of boards.

3.2 Separation of Specialised and Non-specialised Activity

As outlined in DH Gateway Letter 16467 and in the Shared Operating Model for PCT Clusters, the direction of travel with regard to contracting is that Specialised Services will be separately contracted for from other NHS services. Work is underway to disaggregate Specialised Services from other services within contracts held by the NHS with Acute and Mental Health Providers.

Providers of Health Services will be expected to work with Specialised Commissioning Teams; Primary Care Trusts; and Commissioning Support Agencies in the disaggregation of specialised activity from other healthcare services. This will be undertaken in two phases, with some activity novated from existing agreements for the 2012/13 contracting year, and the remainder novated for 1 April 2013.

SCGs that currently commission non-specialised services will also make arrangements to transfer commissioning arrangements to the relevant PCT.

This disaggregation and transfer of services will be undertaken as part of the national Contract Transition Controls Process that all commissioners will be asked to undertake during 2011/12. Further guidance relating to this will be published shortly by the DH.

3.4 "Minimum Take" Services

To support a nationally consistent approach towards the commissioning of specialised services by the NHS, it is proposed that all SCGs will commission a consistent sub-set of the Specialised Services National Definitions Set ("minimum take services") from April 2012, with the remainder being commissioned from April 2013. A summary list of these services is attached as Appendix 1 (further details on specific service issues will be confirmed by your SCG shortly).

Those services, or parts of services not included in this list (but included within the Specialised Services National Definition Set (SSNDS)) would be subject to development work during 2012/13 to enable direct commissioning of these from 2013. Where SCGs currently commission these services from Providers, they will however continue to do so.
Consistent commissioning of "minimum take" services by SCGs will require any service on the agreed list that is currently commissioned by PCT clusters, to be migrated into SCGs for commissioning from April 2012 through the Transition Controls process. The precise contracting definitions for "minimum take" services and associated SUS/SLAM algorithms, to facilitate the formation of the 2012/13 contracts are currently being finalised. It is expected these will be shared with you during October. You will then be requested to test your data using the information provided to produce an output that may form the basis for 2012/13 contract baselines.

4. PLANNING ASSUMPTIONS

The SCG will seek, where appropriate and there is evidenced need, to contract at validated 2011/12 outturn levels, subject to ensuring that outturn reflects the recurrent nature of work. The SCG will undertake a continuous programme of efficiency benchmarking to ensure value for money and cost effectiveness. Key assumptions will include:

- In the event that non-recurrent or extraordinary patterns of activity are noted, these will be considered for exclusion from the baseline.
- Impact of repatriations of care, to ensure care pathways closer to home where appropriate, will inform contract activity.
- The impact of new technologies and service developments, introduced by agreement with the SCG Board.
- Evidence-based practice and national guidelines.
- Impact of any specific PCT/SCG initiatives or changes, including demand management initiatives.

5. FINANCIAL ASSUMPTIONS

We expect a minimum of 1.5% reduction on tariff, matched by 1.5% reduction on local prices for non-tariff services for all providers (NHS, FT and Independent sector).
This will be the planning assumption until the operating framework is issued for 2012/2013 by the Department of Health. Any growth assumptions agreed will be in line with the National Operational Plan. It is anticipated that, excluding changes to tariff, a 'flat cash' position will be maintained for 2012/13.

5.1 Mitigating Financial Risk

Financial control will remain our highest priority for 2012/13 and we will seek continued improvements in efficiency from all our Providers and agreement of Contract Terms that mitigate financial risk to all parties, including marginal rates and 'floors and ceilings' where appropriate.

Transfers of activity between providers i.e. result of grouper and care pathway changes will be cost neutral.

Transfers of activity between commissioners i.e. result of disaggregation of specialised and non-specialised activity will be cost neutral and all parties including the SCG and PCT clusters will require an understanding of the total financial impact and work towards contract agreement that is achievable and contained within the existing financial resources.

5.2 Prices

5.2.1 Tariff Changes

We will follow PbR guidance in respect of tariff changes and it is our intention to work with providers to establish the impact from the 2012/13 Operating Framework.
Where new mandatory tariffs are set by the national PbR team, all providers will move to that currency and value in 2012/13.

5.2.2 Non-Tariff Changes

For non-tariff services, we will uphold rigorously the requirements of Clause 7 of the National Contract, ensuring that prices paid are transparent, fair and representative of actual costs incurred, reviewing all non-PbR price issues for specialised services, as part of the commissioning process prior to contracts being signed off for 2012/13, in accordance with clause 7.3 of the standard contract.

Non tariff pricing issues relating to specialised services should be notified to the SCG no later than **30 October 2011** to allow sufficient time for negotiation. In the event of non compliance, the default shall be in accordance with national guidance or national average cost, whichever is the lower.

Devices will only be paid for where they are provided within agreed protocols, such as NICE TAGs. Where devices have been utilised outside of agreed protocols, payment will be withheld. All excluded devices shall be paid for at actual cost on a pass through basis with no on-cost payable. The information provided will be audited and payment withheld if usage is outside of agreed protocols and/or if the minimum data set is unavailable to validate attribution
Drugs should only be issued to patients in line with agreed protocols, Patient-based information will be available for all drugs excluded from tariff. A minimum data set is required which includes strength, indication, dose and frequency; patient and GP practice identifier and activity code. All excluded drugs will be paid for at actual cost on a pass through basis with no on-cost

payable. The information provided will be audited and payment withheld if usage is outside of agreed protocols and/or if the minimum data set is unavailable to validate attribution.

CQUIN payments and generic inflation/deflation will not be applicable to pass through payments relating to high cost drugs/devices that have been subject to a national/pan-Sector tender & which Trusts are unable to achieve further price efficiencies. The two principle examples of this are ARV drugs and clotting factor products. CQUINs payment on all other pass through payments will be subject to review of appropriateness.

6. SERVICE SPECIFICATIONS & POLICIES

In line with the policy direction articulated in Sir David Carter's review of Specialised Services, consistent national service specifications (and where necessary consistent commissioning policies) are currently being developed to describe Specialised Services in such a way as to ensure that, in future, these can be provided equitably to patients across England. These consistent specifications will be introduced in a phased way, with wave 1 being implemented for 2012/13. Providers of Health Services will be expected to work with Specialised Commissioning Teams on the implementation of these changes and the further development of appropriate specifications.

Where a national policy has not yet been developed, existing local policies will still be included in 2012/13 contracts as for previous years. All Specialised Services policies that are introduced nationally during 2012/13 will supersede regional policies and will be implemented within contract as per contract guidance.

7. ACTIVITY PLAN & MANAGEMENT

In light of the current migration changes it is clear that there may be an increase in the volume of services and associated activity for SCG to review and manage. Currently there has been no guidance to suggest that existing tolerance and threshold arrangements introduced in 2011/12 contracts should change significantly. However, it is intended that they will be re-negotiated on the basis of risk management or negotiated into the contract where no such arrangement exists and Providers will continue to have share responsibility for managing performance in line with the overall plan, including withholding of payment for provider generated demand.

8. INFORMATION REQUIREMENTS

The intention for information and data flows for 2012/13 is that any information requirement for specialised care will be compatible with the existing central returns, however further local data provision will need to be documented where national returns do not adequately specify specialised care. Further guidance will be issued later.
The National Transition Team sub-group for Information and Data Flow is currently working on a new Schedule 5 to be incorporated into the national contract template. It is expected that this will be issued within the normal contracting development round for 2012/13.

SCGs are concerned that a number of providers consistently fail to provide complete, accurate and timely data to support contracts and patient level clinical validation and require providers to examine their performance and put arrangements in place to ensure that they comply with the data and information sharing clauses of the contract and the best practice behaviour set out within the Code of Conduct for Payment by Results.

SCGs have been monitoring this area closely during 2011/12 and will raise this as a significant performance issue, with full contractual financial penalties being imposed, where providers fail to provide data and information on a monthly basis, in line with the requirements of commissioners to effectively performance manage the contract.

In line with the national contract template, providers are expected to comply with the reporting requirements of Secondary Uses Service (SUS) and UNIFY. This includes compliance with the required format, schedules for delivery of data and definitions as set out in the Information Centre guidance and all Information Standards Notices (ISNs) where applicable to the services being provided. As a minimum, providers will be expected to flow admitted patient care, intensive care data extensions and outpatient data to SUS for all activity that can be evidenced in that manner even if the method for payment of the activity is outside the PbR tariff.

SCGs expect that the Provider shall meet the PbR monthly reporting requirements as set out in PbR Guidance. Where activity is outside national tariff scope, providers should make returns of equivalent data in CDS format through local monitoring direct to the SCG by the nationally agreed SUS inclusion dates. If any specialised activity is not submitted through to SUS, this should be identified via standard national templates which will be produced.

In accordance with the NHS Contract providers must ensure that, each dataset that they provide (Including the Mental health minimum data set) for monthly reporting requirements contains the ODS organisation code for the relevant specialised Commissioner. These codes may change in line with the new SCG clusters.

8.1 Changes to Coding

The principles underlying proposed counting and coding changes remain as:

- Improvements in data quality to support better patient care, demand and capacity, planning, resource utilisation and transformation
- Changes or corrections to counting and coding must be agreed with commissioners and comply with national data definitions and information standards
- Improved coding and counting is not intended to lead to activity and cost inflation (volume and case mix)

Providers should notify the SCG and Coordinating Commissioner of any specific planned changes to coding of specialised services observing the good practice behaviour set out within the Code of Conduct for Payment by Results. Providers should give notification of changes planned for 2012/13, to EMSCG, by no later than the 30 September 2011, in order to provide sufficient notice for pricing and other contractual adjustments to be made in good time for business to be completed by the expected 31 January 2012 deadline. Changes notified after this date will be accepted for consideration and implementation in 2012/13, at the discretion of the SCG. All other SCGs will notify the provider of their deadlines appropriately.

8.2 Acute Contracts

We will work to secure access to the information we need through SUS and SEND, but in addition we will continue to require local monitoring data. Patient details and names need to be reported with drugs and devices.

A document outlining the full business rules is required from the provider. By applying these rules to SUS data the commissioner should apply the same tariff as that used by the provider for invoicing purposes. Any differences will not be paid.

In order to validate data, we may also request more information regarding the clinical reasons for admission, outpatient attendances etc. We expect providers to comply with these requests.

To enable the SCG to plan for 2012/13 the following needs to be agreed and action given by the given dates:

- Period used to set 2012/13 activity. The default position is year to date actual financial and activity position at M6 rolled back into a full year effect.

- Providers to send through activity proposals and profiles by the end of November 2011

8.3 Critical Care

Commissioners require providers to transition to national currencies where these are stipulated and it is anticipated that providers will have implemented recording systems for new currencies from April 2012. In accordance with national mandatory data flow requirements all adult and neonatal critical care activities must also be substantiated with supporting data flows via SUS.

8.4 Neonatal Care

Trusts will be required to produce activity to support the commissioning of this service using the neonatal HRG as detailed within the Neonatal Critical Care Minimum Dataset NCCMDS) which was introduced as a mandatory data flow in April 2007. Units currently provide data in a variety of ways. During 2012/13, Trusts need to continue to support the collection of data on a monthly basis.

The SCG will ensure Trust data collection improves and is billed on a monthly basis, and matches the validation within the clinical information system (Badger Net). In addition where babies are still admitted post 40+ 4 weeks (corrected) Trusts will be required to notify the lead commissioner and provide a transition plan for home or to paediatric care.

8.5 Cystic Fibrosis

During 2011/12 national work is being undertaken to determine the annual disease severity tariff and the services to be included. Information will be required during 2011/12 to assist with this work, and the PbR Guidance for 2012/13 will include the detail needed to manage this change.
Commissioners will look to implement, in partnership with providers arrangements under tariff for 2012/13, subject to identification of shared care arrangements and current Primary Care pharmacy expenditure; and with consideration to the current service costs of Providers.

8.6 Renal

Commissioners require that providers move to full tariff arrangements for 2012/13 and providers shall provide all activity information to support payment. There is also an expectation that providers shall implement systems to enable payment of actual daily sessions of Peritoneal Dialysis.

8.7 Mental health

Providers of specialised mental health services to the NHS are required to submit a Mental Health Minimum Data Set (MHMDS) quarterly to the Mental Health Bureau Service identifying

the appropriate commissioner of the service. From April 2012, providers of specialised mental health services must be fully conformant with MHMDS v4.0, including the capture and flow of any new data requirement.

8.8 Cancer Drugs Fund

It is expected that any cancer drug funded via the CDF will be reported separately from contract monitoring submissions.

8.9 KPIs

The current national model contract includes requirements for significant exchange of information between Providers and Commissioner. These data flows include both quantitative and qualitative evidence of performance, and include activity data on process as well as quality data in the form of patient satisfaction returns.

Historically the SCG has centred its attention on process and volume activity data, and has lacked focus on the softer quality areas. During 2012/13 it is expected that key performance indicators will move rapidly toward outcome and quality measures. From April 2012, the SCG will require a significant shift in the compliance with data returns on these neglected areas, while not losing any compliance on existing activity.

Providers are advised that for 2012/13 SCG will expect that all providers will make timely, complete and accurate returns of ALL data including CDS and supporting clinical MDS. Furthermore SCG's also expect providers to make regular and timely submissions of information to relevant clinical registries or clinical audit data bases to support the clinical management of patients. In addition areas of the provider Quality Account data will be used, as required, to demonstrate performance (including patient outcome and quality performance) on a regular basis. Information should be provided for CQUINs in order to meet the timescales and requirements of reporting defined by the indicators in the contract.

9. QUALITY & COST EFFECTIVENESS

We will ensure that the services we commission reflect what is known about best practice, clinical effectiveness and cost-effectiveness. To achieve this objective we expect providers to share information on clinical outcomes, audits and the evidence-base of the services they provide. We would also expect to obtain a breakdown of costs for non-PbR activity where requested.

9.1 CQUINs

There will be a national "pick-list" of CQUIN schemes for Specialised Services for 2012/13 and beyond and CQUIN payments will be targeted at a range of tangible, high impact quality improvements. There will be provision for a very limited number of local CQUIN indicators to be developed to allow local issues to be addressed.

The Specialised CQUIN scheme will operate separately from that in the provider's main agreement with their host commissioner for non-specialised services and will be specific to the specialised services that are included in that agreement.

The SCG expect CQUINs to be agreed within contracting timescales and before 31 March 2012 at the latest. Progress towards CQUIN goals will be regularly monitored and discussed with providers in Contract Review meetings and payment made in line with separate invoice and evidence submitted.

CQUIN payments are worth 1.5% of total contract value in 2011/12 and this is likely to apply in 2012/13. The Department of Health (DH) will set out the requirements underpinning 2012/13 CQUIN schemes as part of the 2012/13 Operating Framework which is due to be released in late 2011. The arrangements set out by DH must be applied to specialised services CQUIN schemes.

CQUIN levels of achievement may be set differentially by provider (for example requiring a higher percentage of achievement of a particular target), or be given differential financial weightings, to ensure that local circumstances and levels of achievement are taken into account, and that targets set are achievable but also sufficiently stretching.

It is envisaged that each CQUIN scheme will have between 3 and 6 CQUIN indicators to both operate effectively and to provide a sufficient degree of financial incentive.

9.2. QIPP

A suite of national QIPP plans will focus on the biggest areas of Specialised Commissioning Spend including cardiac care, neurological conditions, and renal provision. There will also be a set of local QIPP plans to address specific issues across the new SCG cluster.

One key area of national convergence will be around specialist neonatal care working together to define a national QIPP programme for neonatal care nationally; a national specification, quality dashboard and work on the national currency and national price for neonatal care. The focus of the QIPP recommendations relates to using the current resources available more efficiently to improve productivity and quality of care. The results being reductions in length of stay; a focus on outcomes and quality of care provided, through innovation across the networks.

We will develop ways to horizon scan for new and expensive technologies so that we can undertake comprehensive planning for their introduction. This will need to be considered as part of our QIPP programme of work and take account of the financial environment. We expect providers to inform us in advance of new technologies that are likely to impact on the services they provide.

9.3 Quality Dashboards

Quality Dashboards are currently being developed for all Specialised Services and we will seek that Providers populate information into and participate in the usage of these as and when they are rolled out.

9.4 NHS Outcomes Framework

The SCG will expect providers to report against the agreed outcomes in the NHS Outcomes Framework and take remedial action where intelligence indicates a level of performance below the national expected level.

In accordance with this framework we will be seeking more information from providers regarding clinical outcomes and results of audits. We will consistently monitor the performance of our providers with regard to the quality of patient outcomes and services, and we will challenge and investigate poor performance in these areas.

9.5 Quality Monitoring

Although the SCG contract will be separate, as a transition year it is expected that SCGs will still work with the Co-ordinating PCT to manage corporate KPIs and processes and national quality performance targets (e.g. SUI reporting, MRSA, CDiff, waiting times etc).

10 PERFORMANCE INDICATORS

The SCG will seek to agree a range of performance measures, linked to the following areas:-

- We require Providers to eliminate duplication of diagnostic testing and may ask them to produce linked activity reporting that provides access to results. This will demonstrate integrated management across direct access activities, outpatient and inpatient settings. This will reduce unnecessary testing and lead to improved patient care.
- We will not commission or fund HRG WA14Z 'planned procedures not carried out' unless there is a clinically viable reason for doing so.
- We will not pay for service developments, new technology and/or associated cost pressures unless approved in advance during the commissioning cycle.
- We will agree to unbundling of tariff only where patient level MDS data can be made available, value for money can be demonstrated and the change is part of a clearly defined, agreed and documented pathway.
- Unless otherwise stated explicitly for 2012/13, we believe that the tariff structure for 2012/13 will include the requirement for a Provider to deliver all of the NICE Quality Standards within the tariff costs.
- Where new mandatory tariffs are set by the national PBR team, all providers will move to that currency and value in 2012/13.
- Prior approval will be required for elective NCAs over £10k and notification will be required for all activity over £50k.
- We will work with Providers to manage excess bed days and delayed transfers of care. We will require evidence of improvement in the effective use of estimated date of discharge and the planning of discharge from the day of admission, for acute and mental health services.

  Commissioners will monitor the use of HRGs 'with complications' to better understand the clinical condition of patients. Commissioner also expect that any complications are fully auditable within patient records and that there is clear evidence that the complication or co-morbidity has interfered with/inhibited the patient's treatment.

  EMSCG will only pay for an HRG 'with complications' where there is a full and auditable reason in the discharge letter for the complication being evidenced.

Appendix 1: Minimum Take Services

SSNDS	Service
1	Radiotherapy Pet Scanning
2	BMT
3	Haemophilia
6	Spinal Cord Injury Complex Spinal Surgery
8	Neurosurgery
9	Burns
10	Cystic Fibrosis
11	Renal Replacement Therapy Kidney Transplantation
13	Cardiology and Cardiac Surgery Electrophysiology Inherited heart disorder Congenital heart disease Pericardial lesions and pathology Pulmonary Hypertension Cardiovascular MR
15	Cleft Lip and Palate
16	Specialised Immunology (IViG only)
18	Infectious diseases Paediatrics Paediatrics HIV Specialised Infectious diseases
20	Genetics
22	Eating disorders Forensic/Secure MH Specialised MH for Deaf Gender Identity Perinatal MH Tier 4 CAMHS
23	Paediatric Cardiology and Cardiac Surgery PIC NIC Paediatric Neurosciences Paediatric Oral & Maxillo- facial Surgery Paediatric Renal
28	Hyperbaric Oxygen
29	Respiratory intensive care Pulmonary vascular Complex thoracic surgery
30	Vascular disease radiology Vascular disease surgical procedures
32	Cochlear Implants
34	Major Trauma (At Major Trauma Centres only using specific VA Chapter codes for Major Trauma)
38	Haemoglobinopathies

SSNDS	Service
	Sickle cell Beta thalassaemia major Thalassaemia intermedia

TAMESIDE AND GLOSSOP CLINICAL COMMISSIONING GROUP - EARLY WORKING DRAFT OF THE 'PLAN ON A PAGE' 2012-16

About us	We represent a population of 238,000 people registered with 43 Practices working across 5-localities. We co-commission services with local authority colleagues of the Tameside Metropolitan Borough, Derbyshire County and High Peak Borough Councils, to meet jointly prioritised needs highlighted in and prioritised by the Joint Strategic Needs Assessments and Health and Wellbeing Boards respectovely, of both Tameside, and Derbyshire. We operate with a revenue budget of £265m of which £225m is currently deployed across our practices using a national 'fair shares' allocation formula. We are host commissioner for services provided by Tameside and Glossop Foundation Trust (£115m); Tameside and Glossop Community Healthcare Division of Stockport Foundation Trust (£30m); and are Associate Commisisoners of mental health services of the Pennine Care Trust (£23m) and 8 acute hopsitals (£48m). Our spend on medicines management is approximately £50m.
Our vision	Your CCG is led by local GPs. By Inspiring all NHS colleagues, and working closely with partners, we will ensure the development and delivery of excellent compassionate, cost effective care, leading to longer, healthier lives
Our principles	Our priorities are: listening to patients; developing innovative services closer to home Increasing taxpayer value for money, and improving health indicators
Health prioties	The locality PCT health priorities to 2014 were reducing preventable mortality/increasing life expectancy, prioritising prevention and a healthy start in life; CVD; mental health and reducing alcohol related harm. Recent clinical conversations indicate the need to improve services for the frail elderly, end of life care and COPD
Outcomes	We will work to develop an appropriate range of key indicators against our key goals drawing on the national Commissioning Board and Public Heralth outcomes Frameworks.

		Our transformation programmes			
		Transforming public services All public services working together and being ambitious on behalf of our public	**Transforming systems** Taking shared and equal responsibility of system priorities	**Transforming services** Making every contact count and avoiding duplication	**Transforming lives** Helping every live lionger healthier happier lives
Our Goals	1. There is a year on year differential improvement in health outcomes in comparison with our peers	Supporting the establishment and effective evolutionof our Health and Wellbeing Boards setting clear and strong directio; enabling and working with the transfer of public health services to Local Auhtorities	Set and work to a range of outcomes indicators thriough a clear performance framework using the National Public health outcomes measures	**SS: LTC -** Primary care management and prevention of long term conditions: Targeted support for NHS health checks, primary care registers, and QOF performance	Focus on reducing avoidable and premature mortality including SHMI: end of life, CVD, COPD, tobacco control, reduce harm from alcohol adn improve care for people with dementia.
	2. We challenge and reduce unwarranted variation in health and access to services	Ensuring all of the reformed parts of the health system meet their statutory equality and diversity duties.	Development of new incentives frameworks	Build equity audits into JSNA and commissioning models	Raising population aspirations about health and health care
		Benchmarking across organisations of delivery and outcomes		Focus on levelling up primary care.	
				Primary Care management of unmet health needs for people with a learning disability – increase access and uptake of annual health checks	
				Increase access to psychological therapies – targeting groups such as older people, BME and also to increase the range of therapeutic interventions. Efficiencies in primary/secondary care interface and development of pathways to support this	
	3. Our public feel supported and able to make informed appropriate choices about their health, self care, and the services they use	Development of new models of public and patient engagement ('once' models across public sector services	- Development of new models of public and patient engagement ('once' models across public sector services	- Development of new models of public and patient engagement ('once' models across public sector services	Focus on choice
		Focus on children's and mental health services integration; reablement urgent and planned care system reform, managed care	- Focus on children's and mental health services integration; reablement urgent and planned care system reform, managed care	- Focus on children's and mental health services integration; reablement urgent and planned care system reform, managed care	
		Develop optimum range of alternatives to hospital-based service delivery	- Develop optimum range of alternatives to hospital-based service delivery	- Develop optimum range of alternatives to hospital-based service delivery	
			SS: Planned care - delivery of "Any Qualified Provider" in audiology, physiotherapy and diagnostics goal 3	**SS: Urgent care -** Initiatives to prevent admission via A&E: ambulatory care pathways, primary care A&E pilot, primary care access	
			SS: LTC - Optimise use of technology: expansion of PCT wide telehealth programme	**SS: Urgent Care -** Support for patients in care homes to reduce hospital admissions	
				SS: - Intermediate care (urgent care): develop capacity and capability to support admission avoidance and reduce LOS, development of transition and short stay wards	
				SS: LTC - Pathway transformation: development of new models for cardiology, diabetes and respiratory medicine, with increased primary care based expertise, (e.g. GPwSI), diagnostics and supported self care	
	4. We ensure that all commissioned healthcare and wellbeing services are safe, sustainable, high quality and cost effective	Establishing the Clinical Commissioning Group	Roll out programmes for e-sharing and communications of clinical data where this is appropriate, and meets all relevant security and information governance requriements.	**SS: Planned care -** Increase activity in a community setting for specialties including ENT, oral surgery, urology, dermatology	Continue to build and deliver a quality improvement strategy which is in keeping with recommendations of the Francis Inquiry and prioritises harm free care.
				Children's and families - pathway review of asthma in U19's to reduce NEL admissions and expand options for delivery in the community	
				Children's and families - review the pathways into urgent care for children with a view to making best use of total resource	
				Children's and familites - review CAMHS pathways to ensure community based care is prioritised	
				SS: Urgent care - Initiatives to prevent admission via A&E: ambulatory care pathways, primary care A&E pilot, primary care access	
				SS: Urgent Care - Support for patients in care homes to reduce hospital admissions	
				SS: - Intermediate care (urgent care): develop capacity and capability to support admission avoidance and reduce LOS, development of transition and short stay wards	
	5. We deliver maximum benefit to our public with the resources available to us, working within our operating costs and delivering a surplus on our allocation every year	Focus on collaborative working: whole place and community budgets	Joint commissioning of services; sharing back office services	Cost effectiveness built into commissioning and decommissioning service plans	Ensuring effective engagement of the public and partners in prioritisation
			SS: Planned care - Efficiencies in secondary care: Reduce Consultant to Consultant referrals, deliver "enhanced recovery" approach, 1st to follow up ratios in line with national averages, optimise OP procedures and daycases		

NB: priorities preceded by the text SS: LTC, Planned, or Urgent Care indicate there is a corresponding submission in the financial QIPP template

The Operating Framework for the NHS 2012/13
November 2011

On 24 November 2011 the Department of Health (DH) published the Operating Framework for the NHS in England for 2012/13, the first full year of the transition to the proposed new structure for the NHS.

We believe its focus will help the NHS shift into implementation mode and away from the political debate, and we are pleased it does not contain lots of new initiatives.

This briefing outlines the key points from the Operating Framework and what we see as the challenges and opportunities for members.

Key announcements in the Operating Framework include:

- key areas for improvement of dementia and care of older people, carers support, and military and veterans health
- a range of outcome measures or proxies for them under the domains of the NHS Outcomes Framework
- new measure for referral to treatment so that 92 per cent of patients on an incomplete pathway should have been waiting no more than 18 weeks
- PCT clusters to ensure all patients are seen on the basis of clinical need with no justification for the use of minimum waits
- the running cost of clinical commissioning groups (CCGs) to be £25 per head
- all NHS trusts expected to achieve NHS foundation trust (FT) status by April 2014 other than by exceptional agreement
- PCT allocations to grow by at least 2.5 per cent
- tariff price adjuster will be a reduction of at least 1.5 per cent. This will also be applied to non-tariff services
- CQUIN (Commission for Quality and Innovation) to be increased to 2.5 per cent on top of actual 'outturn' value.

OPERATING FRAMEWORK OVERVIEW

Sir David Nicholson's introduction emphasises the importance of getting the basics right, in light of recent Care Quality Commission and Health Service Ombudsman reports, alongside the importance of maintaining a grip on performance, meeting the QIPP (Quality, Innovation, Productivity and Prevention) challenge and building the new system.

The Framework for 2012/13 is set out in four chapters that cover: quality; reform; finance and business rules; and planning and accountability.

Its stated goals are to improve services for patients by:

- putting patients at the centre of decision making
- successfully completing the last year of transition to the new system and building CCG capacity
- increasing the pace of delivery of the quality and productivity (QIPP) challenge
- maintaining strong control over service and financial performance.

QUALITY

Improving services and patient experiences

- the staff survey results should be monitored locally and nationally
- all NHS organisations must comply with the Equality Act 2010 and its associated Public Sector Equality Duty
- the NHS needs to be ready in 2012 with clinical governance arrangements for medical revalidation
- NHS bodies must ensure staff have knowledge of English necessary to perform their duties.

Dementia and care of older people

- the Operating Framework identifies a systemic set of areas that organisations need to work together on, including:
    - commissioners need to ensure providers comply with relevant NICE standards
    - commissioners should work with GPs to improve general practice and community services so that patients only go into hospital if that will secure the best clinical outcome.
    - organisations are to ensure information is published in providers' quality accounts including:
        - ensuring participation in and publication of national clinical audits for services for older people
        - reducing inappropriate prescribing of antipsychotic drugs for people with dementia
        - improving diagnosis rates
        - continuing to eliminate mixed-sex accommodation
        - use of inappropriate emergency admission rates as a performance measure
        - non-payment of emergency readmissions within 30 days of discharge following an elective admission.
- PCT clusters should ensure all providers have a systematic approach to improving dignity in care, staff training and incorporating learning from patients and carers.
- PCTs need to work with local authorities to set out progress on the national dementia strategy and local or national CQUIN goals should be included in 2012/13.

Carers

- PCT clusters to agree policies, plans and budgets with local authorities and voluntary groups to support carers where possible with personal budgets. Plans should be in line with the national carers strategy and published on PCT websites by 30 September 2012.

Military and veterans health

- SHAs to maintain and develop their armed forces networks to ensure principles of the Armed Forces Network Covenant are met.
- Implementation of the MoD/NHS Transition protocol for those seriously injured in the course of duty, as well as improving mental health services for veterans.

Health visitors and family nurse partnerships

- SHA and PCT clusters need to work together to increase the number of health visitors
- PCT clusters are to maintain existing delivery and expand family nurse partnerships to double capacity to 13,000 places by April 2015.

Outcomes across the domains of the framework

The Operating Framework makes significant reference to a range of measures in the NHS Outcomes Framework, which we have summarised below.

- NHS organisations are expected to prepare to use the NHS Outcomes Framework to hold the NHS Commissioning Board to account in 2013/14
- The Operating Framework identifies outcome measures or proxies for each of the domains of the Outcomes Framework which are set out below
- NHS organisations should continue to work to meet expectations in service specific outcomes strategies published for services such as mental health services, cancer and long-term conditions associated with premature mortality
- Each domain is to be underpinned by a suite of NICE quality standards.

Outcomes Framework Domain 1: preventing people from dying prematurely

- the NHS is to support clinical strategies aimed at reducing early mortality from cardiovascular disease, including heart disease, stroke, kidney disease and diabetes. Commissioners and providers need to work together to ensure earlier diagnosis and treatment
- all hospital trusts should examine and explain their Summary Hospital Mortality Indicator and identify and act where performance is falling short
- existing operational standards in ambulance services should continue to be met or exceeded
- all four of the 31 day operational standards and all three of the 62 day operational standards for early cancer treatment should continue to be met or exceeded.

Outcomes Framework Domain 2: enhancing quality of life for people with long-term conditions

- the NHS needs to track progress in improving quality of life for people with long-term conditions through indicators including the proportion of people feeling supported to manage their condition and unplanned hospitalisation for certain patients
- PCTs with local authorities and emerging CCGs should spread the benefits of telehealth and telecare
- PCTs should consider the *No Health Without Mental Health* strategy to support local commissioning, with a particular focus on: access to psychological therapies as part of the full roll-out by 2014/15 with an increase in access for black and minority ethnic groups, older people and people with severe mental illness and long term health problems; physical healthcare of those with mental illness; offender health; and targeted support for children and young people at particular risk, such as looked after children.
- NHS organisations need to meet the QIPP challenge with a continued focus on investment in high-quality mental health services, with national monitoring of:
    - number of new cases of psychosis served by early intervention teams
    - percentage of inpatient admissions gate-kept by crisis resolution/home treatment teams
    - proportion of people under adult mental illness specialities on the Care Programme Approach (CPA) who were followed up within seven days of discharge from inpatient care.

Outcomes Framework Domain 3: Helping people to recover from episodes of ill-health or following injury

- the Operating Framework makes clear that commissioners need not reimburse hospitals for admissions within 30 days of discharge following elective admission, but that savings are to be invested in clinically driven initiatives through reablement and post-discharge support. Commissioners are to work with partners to ensure initiatives are understood and used by patients
- the DH will monitor emergency admissions for acute conditions that do not normally require admission and seek confirmation on the deployment of savings.

Outcomes Framework Domain 4: Ensuring that people have a positive experience of care

- a Duty of Candour is being introduced – a new contractual requirement on providers to be open and transparent regarding mistakes
- commissioners are to ensure contracts allow for central returns on mistakes, 'never events', incidents and complaints, and use sanctions if providers are not compliant
- in addition to existing national surveys, each local organisation is expected to carry out more frequent patient surveys, including the use of real-time data, and to respond appropriately where needed
- commissioners need to identify local measures of integrated care that will support improved delivery such as patient-reported outcomes
- PCT clusters should publicise the NHS Constitution right for a maximum 18-week wait for treatment from referral for non-urgent conditions, as well as the options

available where there is a risk that treatment will not be provided within 18 weeks. It is the provider trust's responsibility to ensure patients have the information. Pilots focused on orthopaedics especially will be carried out in 2012/13 to indentify the best ways trusts can meet this responsibility
- the referral to treatment (RTT) operational standards of 90 per cent for admitted and 95 per cent for non-admitted completed waits remain. In order to sustain the delivery of these standards, trusts will need to ensure that 92 per cent of patients on an incomplete pathway should have been waiting no more than 18 weeks
- the RTT standards should be achieved in each speciality and will be monitored monthly. Less than 1 per cent of patients should wait longer than six weeks for a diagnostic test
- patients should have access to Choose and Book and commissioners should take all reasonable steps to offer the patient a quicker appointment at a range of alternative providers, if the patient makes such a request
- patients need to continue to be informed that the two week wait is standard from GP referral for urgent referrals where cancer is suspected and the standard for two week waits from GP referral for breast symptoms should be met
- PCT clusters must ensure all patients are seen on the basis of clinical need, which means there is no justification for the use of minimum waits
- all organisations must have reviewed planned waiting lists for all specialities and diagnostic services no later than December 2011. Patients should be added to planned waiting lists only if there are personal or clinical reasons
- The Operating Framework stipulates that there is no justification for the use of blanket bans for treatments that do not take account of healthcare needs of individual patients
- clinically led indicators for accident and emergency will remain in place during 2012/13 and information on this is to be published locally. The ability of local commissioners to impose fines will continue. Operational performance will be judged nationally using the current operational standard that 95 per cent of patients are seen within four hours
- SHAs are to complete the roll-out of NHS 111 by April 2013 using solutions such as: Any Qualified Provider (AQP) principles for procurement; establishing services initially through pilots; and an 'opt-in' model involving a consortium of NHS Direct, ambulance services and other providers
- CCGs need to lead the design of urgent care service provision through NHS 111. In any solution reached, there must be evidence of local clinical approval and compliance with national service specifications.
- breaches of mixed-sex sleeping accommodation will continue to attract contract sanctions through the NHS contract.

Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm

- providers and commissioners need to identify and agree plans for reducing MRSA bloodstream and CDiff infections
- there will be national monitoring for hospital-related venous thrombo-embolism

- PCTs need to ensure a sustained focus on safeguarding to ensure access to the expertise of designated professionals and to work with CCGs to ensure they are prepared
- PCTs need to work with local authorities on the transfer of public health commissioning, and PCT clusters must maintain appropriate investment in public health services throughout transition. The number of four week smoking quitters and NHS healthchecks will be monitored nationally
- accountability arrangements for emergency preparedness, resilience and response should be clear at all times through the transition. PCTs must ensure they maintain current capability and capacity of existing Hazardous Area Response Teams in ambulance trusts.

The Operating Framework highlights examples of good practice to support of the delivery of the QIPP challenge.

REFORM

The new commissioning landscape

- the Operating Framework reiterates that PCTs and SHAs will remain statutory organisations throughout 2012/13. They will be held to account on delivering ongoing performance and supporting development of new organisations and clinical leadership for commissioning
- further guidance will be published in 2012/13 on the transfer of responsibilities from PCTs to the NHS Commissioning Board
- PCTs must support the CCG authorisation processes, development of commissioning support offers, establish effective transition for services and staff, and demonstrate they are allocating both non-pay running costs and staff to support emerging CCGs. They will work with GP practices to review practice registered patient lists by March 2013
- SHAs and PCTs must support shadow health and well-being boards and encourage CCGs to take an active part in their formation
- specific guidance on the CCG authorisation process will be issued, but CCGs should be coterminous with a single health and wellbeing board as far as possible
- by 31 January 2012 SHAs should be confident that any CCG configuration issues can be solved by end of March 2012. SHA clusters are responsible for oversight of the readiness of CCGs for authorisation
- almost half of available budgets have already been delegated to emerging CCGs, and delegation is expected to increase. CCGs will need to:
    - manage budgets well and play active roles in 2012/13 planning
    - develop relationships with local partners including (social care, local community) and be active on the shadow health and wellbeing boards
    - deliver relevant share of QIPP agenda
    - address configuration issues by end of March 2012
    - prepare application for authorisation and identify how to secure commissioning support and plans to use running cost allowance

- commissioning support must be commercially viable and distinctly separate from the PCT cluster and may occupy different geographic service footprint to PCT clusters and their PCT constituents
- it is expected that clinical senates and networks will be established in 2012/13.

The new public health landscape

- Public Health England will operate in shadow form 2012/13 and as a statutory executive agency from April 2013
- the NHS will be accountable for delivering successful public health transition with local authorities. PCT and SHA clusters will need robust transition plans for public health
- PCTs will need to work with local authorities to develop the vision and strategy for the new public health role, prepare local systems for new commissioning arrangements, ensure new clinical governance arrangements are in place and test the new arrangements for emergency planning, resilience and response.

The new provider landscape

- the Operating Framework confirms that NHS trusts are expected to achieve FT status on their own or part of an existing NHS FT or in another organisational form by April 2014
- national support will be considered for a small number of NHS trusts where solutions cannot be found locally
- in 2012/13 PCTs should start to offer patients choice of AQP in at least three services. They should work with CCGs and patients to set outcomes-based specifications for providers to deliver high-quality services.

Choice and personal health budgets

- PCTs need to continue implementing choice of: named consultant team, diagnostic test provider, post-diagnosis treatment, treatment and provider in mental health, care for long-term conditions and maternity care
- from April 2012 providers will accept patients referred to a clinically appropriate named consultant-led team and list their services on Choose and Book
- PCTs are to work with GPs to establish new outer areas to enable patients to stay with their existing practice. Three pilots will take place looking at opening up choice beyond traditional practice boundaries. PCTs will need to ensure patients who register with a practice beyond their local area have an appropriate access to local urgent care services
- PCTs need to prepare for wider roll out of personal health budgets. Subject to programme evaluation this should include offers to all patients with NHS continuing care for relevant aspects of care by April 2014.

Information

- the NHS will need to prepare for the forthcoming information strategy to give patients better access to their records, provide information on outcomes to support choice, support integrated care through sharing of information, and allow for better use of aggregated information

- NHS organisations will ensure availability and quality of key NHS datasets published by Prime Minister David Cameron[1]
- patients written to about the summary care record should have one created by March 2013
- organisations are to use the NHS number consistently in 2012/13 and commissioners should link the use of the NHS number to contractual payments. There will be punitive contract sanctions for any organisations not compliant by 31 March 2013
- appropriate governance policies and guidelines for protecting information must be implemented. This is particularly important during transition.

Workforce

- NHS and partner organisations must sustain a talent pipeline for critical posts. Nationally the new NHS Leadership Academy will provide talent management for all those involved in leadership of healthcare
- the NHS should use the NHS staff survey to improve staff experience and services
- organisations should improve staff health and well-being, including ensuring occupational health services are accredited, following NICE public health guidance, making pledges through the Public Health Responsibility Deal and promoting flu vaccination for staff.

Education and training

- In 2012/13, SHAs remain accountable for education funding, commissioning decisions, medical recruitment and working with healthcare providers. SHAs are to set up provider-led partnerships to take on these responsibilities from April 2013 and work on education commissioning for 2012 to 2014, as well as medical recruitment in 2012
- SHAs need to ensure business continuity and plan for transfer of education and training contracts
- SHAs need to plan for implementation of revised education and training tariffs.

Pension and pay

- The NHS will be required to implement increased employee contributions from April 2012. A pensions charter will clarify roles and responsibilities.
- This is the second year of a two-year pay freeze for public sector workers and the Government recommends that staff earning £21,000 or less receive a flat rate increase of £250 from April 2012.

FINANCE AND BUSINESS RULES

Surplus strategy

- aggregate surpluses for 2011/12 among SHAs and PCTs will continue to be made available to these organisations during the following year. The 'drawdown' of surplus is projected at £150m

[1] http://www.number10.gov.uk/news/letter-to-cabinet-ministers-on-transparency-and-open-data/

- no PCT or SHA should be planning for an operational deficit in 2012/13 and PCTs carrying a legacy debt will be required to clear it. CCGs will not be responsible for PCT legacy debt arising prior to 2011/12 and are expected to work closely with PCTs and clusters to ensure no PCT ends 2012/13 in deficit. NHS trusts must plan for a surplus consistent with their pipeline plan and their tripartite formal agreement (TFA)
- PCTs will continue to set aside 2 per cent of recurrent funding for non-recurrent spending. SHAs will hold these funds, with PCTs required to submit business cases to access them. The non-recurrent cost of organisational and system change will need to be met from the 2 per cent.

PCT allocations

- PCT recurrent allocations will grow by at least 2.5 per cent. PCT 2012/13 revenue allocations will be announced in December 2011 and will be informed by the Office for Budget Responsibility's inflation forecast. Additional allocations for primary dental services, general ophthalmic services and pharmaceutical services will also be announced in December 2011
- transfers of funding between PCTs and local authorities included in the NHS Operating Framework 2011/12 will continue, including £622 million in 2012/13 for social care services to benefit health
- financial support from the health system for social care will continue in 2013/14 and 2014/15.

Running costs

- targets for running cost savings will be set at SHA cluster level, with the assumption that there will be no further savings at the SHA organisation level during 2012/13
- the running cost allowance for CCGs from 2013/14 is expected to be £25 per head of population per annum before any entitlement to a quality premium
- the running cost allowance for the core functions of the NHS Commissioning Board will be at least £492 million.

Capital

- NHS trusts must ensure they have a clean and safe environment by prioritising any urgent backlog maintenance and upgrading work. They should also evaluate the need for any single en-suite rooms that may be required to fulfil their obligations regarding mixed sex accommodation, patients' dignity and infection control
- capital expenditure plans for NHS trusts and PCTs will be agreed by SHA clusters. Any unspent capital allocation will not be carried forward.

Tariff

- the development of the national tariff for 2012/13 is driven by increasing the quality of care and outcomes, driving integration of services and incentivising delivery of QIPP
- the scope of the tariff will be extended to: require the recently developed currency to be used when contracting for adult mental health services; introduce mandatory currencies for chemotherapy delivery, external beam

radiotherapy and ambulance services; introduce non-mandatory currencies for HIV outpatient services and some community podiatry; introduce a 'quality increment' for patients at regional major trauma centres, to facilitate the move to trauma care being provided in designated centres; introduce national 'pathway' tariffs for maternity care, cystic fibrosis and paediatric diabetes; and introduce tariffs for post discharge care for some procedures, which will be mandatory where acute and community services are integrated in one trust

- best practice tariffs will be expanded to: incentivise more procedures being performed in a less acute setting and same-day emergency treatments where clinically appropriate; increase the payment differential between standard and best practice care for fragility hip fracture care and stroke; and promote the use of interventional radiology procedures
- the 30 per cent marginal rate will continue to apply for increases in the value of emergency admissions, as will the policy of non-payment for emergency admissions. The DH is working with the Foundation Trust Network to produce more detailed guidance on the operation of this policy in 2012/13
- commissioners will be required to adjust the tariff price if the type of patients that a provider treats results in it incurring lower costs than the average of the tariff category. This is intended to respond to concerns about 'cherry picking'
- the national efficiency requirement for 2012/13 is set at 4 per cent, which will be offset by pay and price inflation. The tariff price adjuster will be a reduction of at least 1.5 per cent and will also be applied to non-tariff services. This will be confirmed in the 2012/13 Payment by Results guidance following allocations
- some best practice tariffs have a built in efficiency assumption, allowed for in the overall tariff price adjusted. Others will lead to reduced payments where best practice is not achieved and this is not allowed for in the tariff price adjuster
- for 2012/13 the DH will continue to work on existing long term condition tariffs to support the development of higher-quality primary and community-based services.

CQUIN framework

- CQUIN will be developed in 2012/13 so that for all standard contracts, the amount providers can earn will be increased to 2.5 per cent
- national goals on venous thrombo-embolism (VTE) risk assessment and on responsiveness to personal needs of patients will continue alongside two new national goals: improving diagnosis of dementia in hospitals and increasing using of the NHS Safety Thermometer
- where CQUIN funding has been used to achieve higher quality, funding may be made recurrent only when the commissioner is satisfied it is necessary to maintain any improvement
- commissioners and providers should refer to the NHS Chief Executive's Innovation Review (due in December 2011) when developing CQUIN schemes for 2012/13.

Clinical audits

- work is underway to transfer the cost of established clinical audits within the National Clinical Audit and Patient Outcomes Programme (NCAPOP) to providers of relevant and tariffed services from 2012/13.

SHA bundle

- the proposed value of the SHA bundle of funding is £6.4bn, the same amount as in 2011/12. Further detail will be released with financial planning guidance. Clinical networks will continue to be funded through the SHA bundle in 2012/13.

Joint working with local authorities

- PCT clusters will need to work with local authorities to jointly agree priorities around investment of funds allocated for reablement in 2012/13. This could include funding new services such as the social care aspects of the national dementia strategy and impact actively on delayed transfers of care
- PCT clusters will need to continue to transfer social care funding within allocations to local authorities to invest in social care services.

Procurement

- the DH is preparing a procurement strategy to be launched by April 2012 to help trusts improve their procurement performance. Trusts that spend more on goods and services than the benchmark will have to justify why they are doing so.

Contract management arrangements

- the 2012/13 NHS Standard Contract will be a single agreement for use by commissioners when commissioning services from providers seeking to deliver NHS-funded secondary and community services. Contracts will be limited to 12 months for 2012/13
- work will continue on the transfer of clinical contracts from current commissioners to the new commissioning authorities. Guidance on the later stages of the transfer process will be issued during 2012.

Principles and rules for cooperation and competition (PRCC)

- PCT clusters must review their practices in line with the Cooperation and Competition Panel's report on the operation of AQP in elective care to ensure they are compliant with the PRCC. Any decisions restricting patient choice must be taken at board level and published annually with the associated rationale, impact and period of operations. SHA clusters will have oversight of the PRCC locally in 2012/13.

PLANNING AND ACCOUNTABILITY

- in 2012/13 SHAs will continue to work through SHA clusters to hold PCT clusters to account. From 2013/14, the NHS Commissioning Board will be held

to account by the DH, and commissioners should anticipate a more outcomes-based approach
- each PCT cluster is required to have an integrated plan for the period 2012/13 to 2014/15, building on previous plans. Integrated plans should have a clear focus on quality and the national priorities set out in the Operating Framework. Technical planning guidance will be published in December 2011, setting out key milestones and financial planning guidance is due to be published in January 2012
- at a minimum, PCT clusters must ensure that CCGs explicitly support plans for 2012/13 and beyond to ensure a strong base on which to build their own planning from 2013/14. Plans should reflect the outcomes of local Joint Strategic Needs Assessments and the public health transition elements should be supported by local authorities.

Performance monitoring and assessment

- three groups of indicators will be used to nationally assess the performance of PCT and SHA clusters: quality (covering safety, effectiveness and experience); resources (covering finance, workforce, capacity and activity); and reform (covering commissioning, provision and patient empowerment)
- PCT clusters will also be monitored against the key milestones for the transformational change elements of QIPP and reform, agreed with SHA clusters as part of the planning round.

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

26 January 2012

PUBLIC HEALTH TRANSITION UPDATE

Purpose of the report

To advise the board on progress made with transferring Public Health responsibilities from Derbyshire County PCT to successor organisations, particularly Derbyshire County Council.

Background

Public Health responsibilities that have been with PCTs are being transferred to a number of organisations. These include the NHS Commissioning Board (NHSCB) and Public Health England, but the most significant transfer is to upper tier or unitary local authorities. This update has been prepared for the Shadow Health and Wellbeing Board as it will have overall responsibility for all matters pertaining to the heath and wellbeing of the people of Derbyshire and should therefore be in a position to assure itself that the transfer is proceeding well.

Progress to date

General
In Derbyshire the PCT and the County Council have been working together on the transfer of the public health team and its functions since the publication of the Healthy Lives White Paper in November 2010. It is expected that by April 2012 new arrangements will exist in shadow form and that by April 2013 full legal responsibility will have been transferred, subject to the passage of the Health and Social Care Bill.

In the past six months planning has been greatly strengthened by the development and work of a Transition Steering Group which oversees a number of relevant work streams.

The Transition Steering Group (TSG)
The TSG is chaired by Trish Thompson, the PCT Director of External Relations and vice-chaired by David Lowe, the Director of Policy and Community Safety at DCC. It brings together officers of the two organisations and has developed joint plans across a range of areas. These are listed below with a brief comment on progress and issues arising.

HR: This is involved with the transfer of staff contracts from the NHS to DCC. Some guidance has been published by the DH and the Local

Government Association; however we are waiting on the more detailed guidance in respect of terms and conditions. The transfer will be governed under TUPE rules. The Cluster has identified existing staff and functions through the people and functions mapping exercise. Staff side representation and involvement in staff transfer related elements as appropriate, is assured via a monthly Consultative Committee meeting which includes all appropriate unions.

Accommodation: This involves physical transfer of staff locations. Public health staff will be based in Matlock (Chatsworth Hall), Chesterfield, Ripley and Buxton. Good progress is being made in identifying space, but there are over 70 staff to move and at a time when DCC are rationalising and upgrading Council accommodation, so logistic issues are significant. However it does not seem likely that it will be a major problem to comply with timescales providing the IT issues can be addressed in a timely manner.

IT: This is a complicated transfer as staff working on NHS systems will want to maintain access to NHS information during the transition period and potentially beyond, while also being able to access DCC systems. This has raised a number of technical and governance difficulties, which are being worked through presently, including awaiting future national guidance regarding access to NHS information by non NHS organisations post April 2013. In order to meet deadlines it may be that interim arrangements are put in place prior to implementation of a long term solution, but it is essential to avoid unnecessary costs in this process, and to maintain all information governance requirements throughout.

Communications: Initially the main stakeholders in this process are the transferring staff themselves, and the NHS is ensuring that regular consultation and communication is in place. This intention is that throughout the Shadow period, those staff who are identified as transferring will receive communications from NHS and from Derbyshire County Council as appropriate in order to more fully support integration of the workforce. Other work is underway to brief other relevant stakeholders particularly in the county council, wider partnership networks and of course the local community. By March 2012 a robust communication and engagement plan is required as part of the Department of Health Transition Planning requirements.

Finance: Transfer of budgets is a major part of the work of transition, and in Derbyshire there are a large number of contracts, with many different providers to be moved. Within the PCT due diligence work is being carried out in line with national guidance, on all NHS contracts which number over 1000 in Derbyshire (not all LA relevant). The council

has been involved in the work undertaken identifying the indicative PCT public health budget. It is expected that Shadow local authority public health budgets will be released in the next few weeks. These Shadow budgets will require review and alignment by both parties.

Governance: We have currently in place a Scheme of Delegation to the Director of Public Health to shadow the arrangements going forward which also details reporting mechanisms to the Cluster and the Local Authority. Specifically this work stream is looking at risk management, accountabilities and security of processes through transition. Terms of Reference have been agreed to ensure accountability and reporting structures within the PCT and County Council are robust regarding public health transition activities.

Overall the steering group is working well and has high level support on both sides. However capacity is limited as both organisations are working on transition with a reduced head count.

Specific issues and concerns

Policy development: Some of the challenges faced have been noted in the section on the transition workstreams. One general issue is that some of the detailed national policies relating to this transition have come out slowly and in small increments. It is likely that even when all guidance has come out there will still be quite a number of details and decisions that will need to be worked through on a local basis.

Parallel organisational changes: Another issue to be faced is the slow establishment of Public Heath England and the national development of public health policies and ways of working both within Public Health England and the National Commissioning Board. The Director of Public Health and by extension the local authority will relate in subtle ways to these other organisations and until more clarity is achieved it is difficult to fully solidify local arrangements. However in Derbyshire there are strong links between the local authority, the PCT, the health protection agency and other partners so solutions will be found and important services can be protected through transition. Work is also underway to provide public health support to CCGs through the mandatory “core offer”. In Derbyshire progress with this has been good.

Support structures in the PCT and public health: In the PCT the public health team worked as part of an integrated organisation supported by a number of different directorates such as commissioning and finance. Almost all the staff transferring to the local authority are from the public health directorate and these support staff are going to clinical commissioning groups or elsewhere. The issue of how the public health team will obtain the support it

had from these other functions during and after transition is not yet fully resolved. The PCT public health budget information submitted to the DH attempted to quantify back office spend using a formula guide. The county council questioned the approach with the DH and Local Government Association because of the likely inaccuracy and potential loss of funding. The indicative ring fenced budget allocation to be announced in the very near future will assist us in these deliberations.

Glossopdale: Glossop is part of Derbyshire, but for NHS purposes has always been part of the Manchester health community and its public health team has resided within Tameside and Glossop PCT. This adds some complexity to transition arrangements, but early work is now underway to ensure alignment and completeness.

Links to Derby City: Derbyshire County and Derby City PCTs have effectively become one “Cluster PCT” and certain public health functions are shared between the two areas. In addition the southern Derbyshire CCG spans the county city border. It is a working principle in the two public health departments that we seek to use these links constructively in ways that maximise overall efficiency while ensuring that each Health and Wellbeing board, and local authority, gets a service appropriate to the relevant population.

Performance management: The Strategic Health Authority is performance managing transition. The PCT, with the support of members of the Transition Steering Group and public health managers has just prepared an interim public health transition report as part of an overall Derbyshire Systems Integrated Plan (DSIP) for the Cluster PCT. This DSIP is to be submitted to the Strategic Health Authority on behalf of the DH by the end of January. A final Public Health transition plan will need to be produced by early March.

Next Steps/Way Forward

This is an update on a lot of ongoing work. In general progress is good, but much detailed work remains to be done around the transfer of staff, IT and contracts. The whole of 2012 will be a busy period when this transfer will be engineered, but when it is also important to keep public health services running well, and also to look at new opportunities that emerge from the transition process.

The public health team in the PCT works closely with many stakeholders, inside the NHS, such as hospitals and primary care, and in the wider community such as districts and boroughs and voluntary agencies. All these links will also need to be protected through the transition process where they contribute to the health of the population of Derbyshire.

Recommendation

That the Health and Wellbeing Board notes the progress made towards the transfer of public health responsibilities to the council and supports the general approach being taken.

Bruce Laurence, David Lowe and Trish Thompson

North Derbyshire Clinical Commissioning Group

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

26 JANUARY 2012

UPDATE ON THE NHS 111 IMPLEMENTATION IN DERBYSHIRE

Purpose of the Report

To inform the Derbyshire Health and Wellbeing Board on the progress towards implementing a new NHS non emergency telephone number: 111.

Background

In July 2010 the Government stated its commitment to a national roll out of the new NHS 111 service in 'The Coalition our programme for government' and the White Paper 'Equity and Excellence: Liberating the NHS'. The aim was to develop a coherent 24/7 urgent care service in every area of England that makes sense to patients when they have to make choices about their care. This will incorporate GP out of Hours services and provide urgent medical care for people registered with a GP elsewhere. The service will be more accessible by introducing, informed by evaluation, a single telephone number for every kind of urgent and social care and by using technology to help people communicate with their clinicians'.

There is a requirement to have full coverage England wide by the end of March 2013 although this can be through a pilot project initially with full procurement to follow. This is the approach being adopted in Derbyshire with a pilot working with Derbyshire Health United the current out of hours GP service with formal procurement due to be completed by October 2013 based on learning from the pilot.

The national NHS Direct telephone number will be discontinued from April 2013.

The Pilot So Far

North Derbyshire Clinical Commissioning Group (CCG) is leading this work on behalf of all CCGs in Derbyshire. The pilot has a phased implementation based on telephone number codes. The first phase of the pilot went live on 25 October 2011 in the Matlock, Bakewell and Chesterfield areas of Derbyshire.

The first phase of the pilot has been very successful. Activity is within expected levels and has increased gradually since the service went live. All

GP surgeries within the pilot area have been supplied with leaflets and posters publicising the NHS111 service. In addition to this there have been a number of articles in local media and there has been a door-drop of leaflets about NHS111 to all households in the pilot area.

Further Roll-Out

The 111 service is being implemented in four phases, detailed below:

Phase	Date	Areas Covered
1	Oct 2011	Bakewell, Matlock & Chesterfield
2	20 Feb 2012	Rest of North Derbyshire
3	March 2012	Derby City
4	August 2012	Rest of Southern Derbyshire
National	April 2013	All

De-commissioning of NHS Direct 0845 Service

NHS111 will replace the existing health information and assessment service offered by NHS Direct on 1 April 2013. However, it is likely that the NHS Direct service will stop earlier than this in some areas. In Derbyshire we are discussing with NHS Direct the possibility of stopping the service from September 2012 and possibly even earlier than this in those areas where the NHS111 pilot is already established. This will enable us to move funding from the existing NHS Direct service to support the NHS 111 pilot.

Procurement options

The NHS 111 Service is mandated for implementation by all regions by 1 April 2013. This can be achieved by one of three options:

- The implementation of a pilot service followed by competitive procurement.
- Procurement of a service
- 'Opting in' (this will be a solution provided for a community by NHS Direct working in liaison with the ambulance service and Out of Hours providers.

Derbyshire has chosen to pilot a service with the intention to have a procured joint NHS 111 and Out of Hours service in place by October 2013. This

timescale will allow sufficient time to learn from the pilot and to ensure the correct specification of the service. It will also allow learning from other procurements taking place elsewhere in the UK.

It is planned to hold a workshop in April to think through what other services could be attached to 111 to make a more integrated resource for all people in Derbyshire. For example could the service monitor telehealth and telecare for people over the full 24 hour period? Could the service be linked to the single point of access (SPA) being set up for all community health services?
Members of the Health and Wellbeing Board are welcome to attend.

Next steps

The procurement of the NHS 111 service is being coordinated regionally. We will ensure that Derbyshire is a separate "lot" within this process to allow for a separate service specification and control over the evaluation process to the other areas of the East Midlands. The planning for this procurement has already started.

Equity Impact Assessment

Not required locally as national completed and mandated project.

Recommendations

To note the progress being made on the implementation of NHS111.

Further Information

Further information if required is available from:

Jackie Pendleton, Chief Operating Officer, North Derbyshire CCG
Jackie.pendleton@derbyshirecountypct.nhs.uk or 01246 514185

John Hutchison, Project Manager NHS111, North Derbyshire CCG
John.hutchison@derbycitypct.nhs.uk or 01332 868663

DERBYSHIRE SHADOW HEALTH AND WELLBEING BOARD

26 January 2012

HEALTH & WELLBEING ROUND-UP REPORT

Purpose of the report

To provide the Board with a round-up of key progress in relation to Health and Wellbeing issues and projects not covered elsewhere on the agenda.

Round-Up

Progress of the Health and Social Care Bill through Parliament

The second reading of the Health and Social Care Bill was completed in the House of Lords on 12 October 2011. The House defeated Lord Rea's amendment seeking to halt further progress on the Bill, and Lord Owen's amendment for extra scrutiny of the Bill by a select committee.

The Bill was then put forward to a committee of the whole House for line by line examination which took place during the fifteenth day of committee stage on 21 December. Further line by line examination of the Bill is yet to be scheduled.

HealthWatch

At the beginning of January the Department of Health announced that the new start date for the establishment of the local HealthWatch is April 2013, rather than the previous date of October 2012. The local work to prepare for procuring HealthWatch will continue, including meetings of the small multi-agency task and finish group and planned meetings with the local voluntary sector. The Department of Health also expects that LINk funding will be extended locally until the end of March 2013.

The Department of Health also announced that there will be a small amount of funding in 2012/13 for the start up costs of establishing the local HealthWatch and that HealthWatch England will be operational from October 2012.

For further information contact Colin Selbie on 01629 532131 or email colin.selbie@derbyshire.gov.uk

Stakeholder Engagement

Work has been undertaken to identify existing mechanisms for engaging stakeholders in the work of the Health and Wellbeing Board. Further work is to be undertaken to clarify existing mechanisms and to identify ways for stakeholders to access information and be more engaged in the work of the Board. This approach will ensure that existing mechanisms are joined up and that duplication is minimised. A further report will be brought to the Health and

Wellbeing Board in March outlining a comprehensive plan. In the meantime a further meeting of the Stakeholder Engagement Forum has been planned for the end of March, with the primary focus of the event being to gain feedback on the draft priorities for the Health and Wellbeing Strategy.

For further information contact Jude Wildgoose on 01629 538439 or email judith.wildgoose@derbyshire.gov.uk

Adult Care Board Joint Commissioning Priorities 2012/1

At its meeting on 12 January, the Adult Care Board agreed to establish a limited number of joint commissioning priorities for 2012/13. A task and finish group has been set up with membership from Adult Care at the County Council, the Clinical Commissioning Groups, District/ Borough Councils and the voluntary and community sector. The proposed priorities will be considered at the next Adult Care Board meeting in March, with the final proposals being submitted to the Health and Wellbeing Board.

For further information contact James Matthews on 01629 532004 or email james.matthews@derbyshire.gov.uk

A Community Budget for families facing multiple problems in Derbyshire

Community Budgets for families facing multiple problems are currently up and running in 16 areas across the country – their aim is to turn around the lives of troubled families, to get the most disadvantaged children and young people learning and back into school and to support parents in overcoming their problems and getting work.

The County Council is participating in the roll out of Community Budgets as a Phase 2 area and has recently consulted with partners through the Derbyshire Partnership Forum about developing an approach and plan for Derbyshire to be in place from April 2012 onwards.

The development of a Community Budget for families facing multiple problems in the county presents a unique opportunity for partners to review, reshape and redesign services. Securing better outcomes for families with multiple problems at a reduced cost to the public purse and decommissioning ineffective services are likely to be key aims. Equally reducing the number of families developing complex needs through prevention and earlier intervention will be crucial. Plans are likely to focus on the piloting of the project in a small number of geographical communities across the county in the first instance.

For further information contact Sarah Eaton on 01629 538268 or email sarah.eaton@derbyshire.gov.uk

Troubled Families

A new Troubled Families Team at the Department for Communities and Local Government, headed by Louise Casey has also recently been established to work across government to push forward the Prime Minister's ambition that ***"by the end of this Parliament, I want us to try and turn around every troubled family in the country".***

A new Troubled Families initiative has recently been launched by the Team. This initiative is similar to existing Family Intervention models which support families through the use of key workers. £448 million is available nationally to support the scheme which will provide 40% of the total costs on a payment by results basis. The remaining 60% match funding to undertake the project would be sought from local authorities and their partners. All upper tier authorities have been asked to put plans in place, working with their partners, before the end of March 2012 to ensure the scheme is operational from 1 April 2012.

Nationally there are an estimated 120,000 families with multiple needs. The Department for Education estimate that of these, 1,335 families live in Derbyshire. A key piece of work to be undertaken as part of the scheme is the identification and mapping of families who meet established criteria by February 2012. This will ensure that there is an accurate and shared understanding about the extent of such families in Derbyshire. Work to establish how feasible this is within the county is currently taking place with key agencies and this is likely to inform any decision about participation in the Troubled Families initiative from April 2012 onwards. Further guidance on the initiative is anticipated in January 2012 and in the meantime work to progress the Community Budget approach will continue.

For further information contact Sarah Eaton on 01629 538268 or email sarah.eaton@derbyshire.gov.uk

Child Poverty Needs Assessment

A Child Poverty Needs Assessment has been produced and was presented to the last Children's Trust board. This was done in accordance with national guidance, but also, given the pressures that families will face in the coming years, it is an opportune time to highlight this subject. Having identified in some detail the scale of child poverty in Derbyshire, and its implications in terms of health, wellbeing and achievement, work will move into the next phase. This will involve looking at what is already in place for supporting children and families in poverty, talking to a range of stakeholders including affected families, and developing a strategic approach to taking further action within the resources available to the county.

For further information contact Dr Bruce Laurence on 01629 532047 or email bruce.laurence@derbyshire.gov.uk

Derbyshire Alcohol Advisory Service
The Derbyshire Alcohol Advisory Service (DAAS) is a county-wide service where all referrals for Tier 2 and above are received and then allocated to a service Tier dependent upon the needs of the client. The Derbyshire Drug and Alcohol Partnership Board recently received a report from Jane Bethea, Speciality Registrar in Public Health, which assessed equity of access to the Service. A brief summary of the main findings showed that:

- Older patients over 60 years of age had poorer equity of access;
- The more affluent individuals had poorer access which contrasts to virtually all other health services;
- There were wide variations in referrals by GPs and by geographical area.

This detailed report made a number of recommendations for further investigation and action. These are to be considered by the CCGs.

For further information contact Mick Burrows on 01629 538227 or email mick.burrows@derbyshire.gov.uk

Recent Policy Documents
A number of important policy documents have been produced recently. These include:

NHS Future Forum (second phase report)
http://healthandcare.dh.gov.uk/forum-report/

JSNAs and Joint Health and Wellbeing Strategies - draft guidance
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132326

JSNAs and Joint Health and Wellbeing Strategies Explained
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131702

Public Health Transition Planning Support for Primary Care Trusts and Local Authorities
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132179.pdf

Public Health Workforce Issues: Local Government Transition Guidance
http://www.dh.gov.uk/health/files/2012/01/public-health-workforce-issues.pdf

Public Health Human Resources Concordat
(http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131111).

The New Public Health System
http://healthandcare.dh.gov.uk/public-health-system/

The Operating Framework for the NHS in England 2012-13
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131360

Public Health in Local Government
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131889

Public Health England Operating Model
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131882

Operating Principles for Health & Wellbeing Boards
http://www.adph.org.uk/files/latest_news/Operating%20principles%20for%20health%20and%20wellbeing%20boards.pdf

Recommendations
That the Board note the contents of the report.

David Lowe
Strategic Director – Policy and Community Safety
Derbyshire County Council