HEALTH AND WELLBEING BOARD – FEBRUARY 26th 2014

Title of paper:	**The CCGs two-year operational plan in response to *Everyone Counts: Planning for Patients 2014/15 to 2018/19***	
Director(s)/ Corporate Director(s):	**Dawn Smith Chief Officer NHS Nottingham City CCG**	**Wards affected: all**
Report author(s) and contact details:	**Dawn Smith, Chief Officer, NHS Nottingham City CCG Email: Dawn.Smith@nottinghamcity.nhs.uk**	
Other colleagues who have provided input:	**Louise Bainbridge, CCG Chief Finance Officer Ray Davey, CCG Deputy Finance Officer**	
Date of consultation with Portfolio Holder(s) (if relevant)		

Relevant Council Plan Strategic Priority:	
Cutting unemployment by a quarter	☐
Cut crime and anti-social behaviour	☐
Ensure more school leavers get a job, training or further education than any other City	☐
Your neighbourhood as clean as the City Centre	☐
Help keep your energy bills down	☐
Good access to public transport	☐
Nottingham has a good mix of housing	☐
Nottingham is a good place to do business, invest and create jobs	☐
Nottingham offers a wide range of leisure activities, parks and sporting events	☐
Support early intervention activities	☒
Deliver effective, value for money services to our citizens	☒

Summary of issues (including benefits to citizens/service users):

On December 20th 2013, NHS England published planning guidance, which set out its proposals for how the NHS budget is invested in order to secure sustainable models of care over the next five years. The CCG has a statutory duty to take account of this guidance when preparing its commissioning plan for the forthcoming financial year and to present the plan to the Health and Wellbeing Board.

This paper provides a summary of NHS England's ambitions for what CCGs and the wider commissioning system will deliver and also presents a summary of the CCG's draft plan.

Recommendation(s):	
1	The Health and Wellbeing Board is asked to note the planning guidance produced by NHS England and comment on the CCGs draft plan in relation to whether it sufficiently supports the Joint Health and Wellbeing Strategy.
2	The Health and Wellbeing Board is asked to approve the decision of the CCG to continue the uptake of bowel screening as a local priority associated with the Quality Premium.

1. REASONS FOR RECOMMENDATIONS

1.1 The Health and Wellbeing Board is required in consider whether the CCG's commissioning plan for the coming financial year takes proper account of the Joint Health and Wellbeing Strategy.

1.2 Cancer accounts for around one in four deaths in Nottingham, and half of all such deaths are from lung, bowel, breast and prostate cancers. Cancer is the joint largest contributor to our life expectancy gap for women, and the second largest for men. Cancer is more common in areas with higher levels of deprivation, and is the second highest cause of death in BME groups. Overall, cancer mortality rates in Nottingham are higher than regional and national rates, and the number of new cancers for men is higher than the rest of the East Midlands. Nottingham City has significantly poorer survival rates for cancer, with one-year survival rates for breast, bowel and prostate cancer in the bottom 20 per cent for England. This is thought to be largely as a result of patients leaving it longer before seeing a health professional, meaning that their cancer is more advanced when diagnosed.

2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

2.1 A summary of NHS England's ambitions for what CCGs and the wider commissioning system will deliver is presented in Appendix 1. In relation to the priorities set out in the Joint Health and Wellbeing Strategy, the guidance requires the following:

2.1.1 Preventing Alcohol Misuse

The guidance is largely silent with respect to any requirements on the CCG to address alcohol misuse specifically. This is largely a reflection of the responsibility for this agenda shifting to the Local Authority. However, the CCG's commissioning and financial plans for 2014/15 enable it to continue with its strategic ambitions to improve cancer prevention and reduce emergency admissions to hospital by supporting public health to tackle alcohol misuse.

2.1.2 Integrated Care: Supporting Older People

This is a particular focus of NHS England's guidance, which places a requirement on the CCG to:

- Invest approximately £50 per over 75 year-old on improving quality of care for older people through support for the "accountable-GP" role
- Take steps to reduce spend on acute hospital services to support the establishment of the Better Care Fund in 2015/16 (see separate paper/presentation)

The CCGs plans allow for both of these requirements to be fulfilled and also enables early establishment of the Better Care Fund in shadow form from 2014/15.

2.1.3 Improving Mental Health

Achieving parity of esteem, (making sure that the CCG is just as focused on improving mental health, as well as physical health. Ensuring that patients with mental health problems don't suffer inequalities, either because of the mental health problem itself or because they then don't get good care for their physical health) is a strong theme in the

guidance. This continues to be a strategic objective of the CCG; its commissioning plan allows it to develop Improving Access to Psychological Therapies, increased community support and improving physical health. Investment will also continue for a scheme to support people with mental health conditions to return to work.

2.1.4 Priority Families

The CCG will continue its programme of work as set out in its three year strategy to improve care pathways for children and young adults. This includes working in partnership with the City Council to implement the family support pathway to identify children and families most at risk of poor outcomes in health, education, and social care.

2.2 Financial allocations

Details with respect to the CCG's investment schedule and shifts in planned expenditure from acute to community are shown in appendix 2.

From 2014/15 all Clinical Commissioning Groups will receive their program allocations based on the new NHS England funding formula. The funding formula aims to balance the three main factors in healthcare needs - population growth; deprivation and the impact of an aging population. For Nottingham City Clinical Commissioning Group the formula shows that the CCG is currently overfunded against its target allocation by 2.11%, so under the agreed pace of change policy it will receive the minimum 2.14% uplift (£8.2m) in 2014/15 and 1.7% (£6.7m) in 2015/16.

The allocation for CCG running costs in 2014/15 remains at the same level nationally; however, individual CCG allocations have not yet been notified. From 2015/16 the running cost allocation will reduce by 10%.

2.2.1 Financial Planning Assumptions 2014/15

CCGs should plan to:

- Deliver a minimum 1% surplus
- Hold a minimum 0.5% contingency
- Set aside 2.5% of funding for non-recurrent expenditure, 1% of which should be focussed on local transformation and preparation for the introduction of the Better Care Fund

2.2.2 Financial Planning Assumptions 2015/16

CCGs should plan to:

- Deliver a minimum 1% surplus
- Hold a minimum 0.5% contingency
- Set aside 1% of funding for non-recurrent expenditure
- Create the Better Care Fund in line with notified amounts.

2.3 Quality Premium

The Quality Premium rewards CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities. There are seven measures relating to NHS England's outcome ambitions (see appendix 1) and the CCG is required to select a local measure. The Health and

Wellbeing Board is asked to support the proposal for the CCG to include improved screening rates for bowel cancer as its local measure.

3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

4. FINANCIAL IMPLICATIONS (INCLUDING VALUE FOR MONEY/VAT)

See appendix 2

5. RISK MANAGEMENT ISSUES (INCLUDING LEGAL IMPLICATIONS AND CRIME AND DISORDER ACT IMPLICATIONS)

This is addressed through the CCGs risk framework and relates to the requirement to shift spend from the acute sector and to achieve large scale efficiencies in order to deliver the required level of investment in its priority areas.

6. EQUALITY IMPACT ASSESSMENT

Has the equality impact been assessed?

Not needed (report does not contain proposals or financial decisions)	☐
No	☐
Yes – Equality Impact Assessment attached	☐

Due regard should be given to the equality implications identified in the EIA.

7. LIST OF BACKGROUND PAPERS OTHER THAN PUBLISHED WORKS OR THOSE DISCLOSING CONFIDENTIAL OR EXEMPT INFORMATION

8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

NHS Nottingham City CCG Commissioning Strategy 2013-16
http://www.nottinghamcity.nhs.uk/images/stories/docs/About_us/Publications/Strategy_web.pdf

Everyone Counts: Planning for Patients 2014/15 to 2018/19
http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

Appendix 1: Summary of *Everyone Counts: Planning for Patients 2014/15 to 2018/19*

1.1 Five outcome domains and ten measurable ambitions

The guidance reiterates that NHS England wants to see better outcomes in five domains

1. Preventing people from dying prematurely
2. Obtaining the best quality of life for people with long-term conditions, including those with mental illness
3. Ensuring that patients recover quickly and successfully from episodes of ill-health or following injury
4. Ensuring that patients have a great experience of all their care
5. Keeping patients safe and protecting them from avoidable harm whilst they receive care

The critical indicators of success against which progress will be tracked are as follows:

1. Securing additional years of life for the people of England with treatable mental and physical health conditions.
2. Improving the health related quality of life of people with one or more long-term condition, including mental health conditions.
3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
4. Increasing the proportion of older people living independently at home following discharge from hospital.
5. Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.
6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

In addition to these seven measures that fall within the five outcome domains, NHS England has set out a further three measures where they expect to see rapid improvements:

8. Improving health, which must have just as much focus as treating illness
9. Reducing health inequalities.
10. Parity of esteem, making sure that we are just as focused on improving mental as physical health and that patients with mental health problems don't suffer inequalities.

1.2 Direction of Service Development

In response to the Call to Action NHS England has identified that the health care system in England will have to have the following six characteristics if it is to be sustainable and continue to deliver high quality care:

1. A new approach to ensuring that citizens are fully engaged in service design and change and that patients are empowered in their own care

- Extending the Friends and Family Test to community and mental health services and GP Practices by December 2014 and to the rest of NHS services by the end of March 2015

- *Roll-out of personal health budgets to all patients who may benefit, with a right to a Personal Health Budget for NHS Continuing Healthcare patients from October 2014*
- *Expanding the range of patient reported outcome measurements*
- *All patients with a long-term condition to have a personalised care plan available electronically and linked to their GP health record so that they don't have to repeat their details at every new contact*
- *Greater use of telehealth and telecare*
- *Ensuring that by the end of March 2015, data from 90% of GP practices is linked to hospital data*
- *Universal use of the NHS number as the prime identifier with CCGs to asked to secure immediate improvement from providers who do not comply; GP practices must use this in all clinical correspondence from April this year and to transfer patient records electronically*

2. Wider primary care provided at scale

- *Enabling primary care to play a much stronger role with provision of more proactive services, particularly for the frail elderly and those with complex needs, enabled by an integrated system of community-based services*
- *NHS England to work with CCGs to support general practice to work at greater scale and in closer collaboration with other health and care organisations, supported by innovative forms of commissioning and contracting*

3. A modern model of integrated care

- *CCGs will be expected to support practices to transform the care of over 75 year olds and to commission additional services that practices have identified will support an "accountable" GP role. This should include allocating approximately £5 per head of population/£50 per over 75 year old for this purpose*
- *CCGs must demonstrate how individual practices can have the influence that they need over the commissioning of community services, especially end of life care and district nursing to enable them to deliver the accountable GP role in an integrated way*
- *The 2014/15 General Medical Service contract will support this agenda through ensuring that*
    - *all over 75 year olds have an accountable GP who is responsible for overseeing their care*
    - *proactive care management for those with complex needs under the supervision of a named GP, underpinned by more systematic risk profiling*
    - *giving GPs more specific responsibilities for helping monitor the quality of out-of-hours provision and supporting more integrated working with out-of-hours services*
- *It is anticipated that all integrated models will feature a senior clinician working within a team taking full responsibility for people with multiple long-term conditions along with co-ordination of care including lifestyle support, social care, general practice and co-management of hospital episodes*
- *CCGs must include in their plans the actions they will take in 2014/15 to ensure that this programme of work is affordable. Irrespective of whether*

CCGs have released this money, funding will be diverted from their allocations in 2015/16 to create what is referred to as the "Better Care Fund"

4. ***Access to the highest quality urgent and emergency care***

- *NHS England and CCGs to produce a new service specification for 111*
- *Continued requirement for Urgent Care Working Groups to oversee system-wide urgent care resilience planning*
- *Urgent Care Working Groups will be expected to be the vehicle by which investment plans are agreed in relation to the use of funds released as a result of the application of the marginal rate tariff for emergency activity above an agreed baseline*

5. ***A step change in the productivity of elective care***

- *The guidance highlights the need to maximise productivity gains in acute trusts in-line with international comparisons that suggests that more patients can be treated at the same or lower cost*

6. ***Specialised services concentrated in centres of excellence***

- *NHS England anticipates that it will concentrate expertise in 15-30 sites in order to improve quality and ensure that standards are applied consistently.*

The guidance acknowledges that setting out these six characteristics does not mean that there is an expectation that services will be delivered in the same way everywhere; it is for local communities to determine the delivery vehicle that best suits local geographies and capabilities.

1.3 Maintaining the focus on essentials

NHS England has set out four essential elements that will apply to all of the above characteristics in every health community:-

1. ***Quality***

- All commissioners are required to put quality at the centre of what they do with the CQC making definitive judgments on quality in providers.
- There are three "non-negotiables" which relate to delivering expectations set out in *The Francis Report*; *transforming care: A national response to Winterbourne View Hospital* and the *Bewick review into patient safety*
- Continued zero tolerance of MRSA and an ongoing focus on reducing *Clostridium difficile*
- Commissioners required to take prompt action if providers are judged by the CQC as "requiring improvement" or "inadequate" and to inform the CQC if they become aware of a quality or risk issue in a provider
- Commissioners are required to respond more proactively to patient complaints and to develop a strong relationship with their local Healthwatch
- Plans should address how measurable improvements will be made in patient experience and that there is continued investment in generating feedback
- CCGs should ensure that local areas of action in the "Compassion in Practice" implementation plan for the 6Cs[1] strategy for nursing, midwifery and care giving are reflected in the services that they commission.
- Attention should be given to staff satisfaction surveys and the staff Friends and Family Test as an indicator of quality

[1] care, compassion, competence, communication, courage and commitment

- An action plan for delivering the Seven Day Services Forum Standards for urgent and emergency care should be reflected in local contracts for 2014/15 and consideration given to a local CQUIN for the standard relating to time taken for a consultant assessment
- Demonstrating how safeguarding duties will be discharged must be reflected in local plans

2. Access to services

- Improving outcomes for patients by ensuring that services are available for people when they need them and in a way which is convenient for them and fits with their daily lives; tailored services for disadvantaged and minority groups is considered key to this
- All plans must address how access will generally be improved but specifically detail how constitutional standards will be delivered

3. Driving change through innovation

- Commissioners should actively understand where research is taking place within their contracted providers and support this activity wherever possible, as well as seeking out other research opportunities

4. Value for money

- Commissioners must demonstrate a systematic approach to securing value for money

Appendix 2: Investment Schedule
Table 1

Investment funds available over the 5 year planning period.

Investments:	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m
Recurrent	6.2	9.5	3.0	3.1	3.1
Non Recurrent:					
Transformation Fund	3.9	4.0	4.1	4.1	4.2
Local Investments	7.4	4.7	1.8	1.1	1.0
Total Non Recurrent	11.3	8.7	5.9	5.2	5.2
Total Investments	**17.5**	**18.2**	**8.9**	**8.3**	**8.3**

Table2

Efficiency challenge over the five year period:

Efficiency Requirement	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m
QIPP Challenge	**6.0**	**6.6**	**5.0**	**5.5**	**6.4**

Chart 1: Acute to Community split of Planned Spend at 2014/15

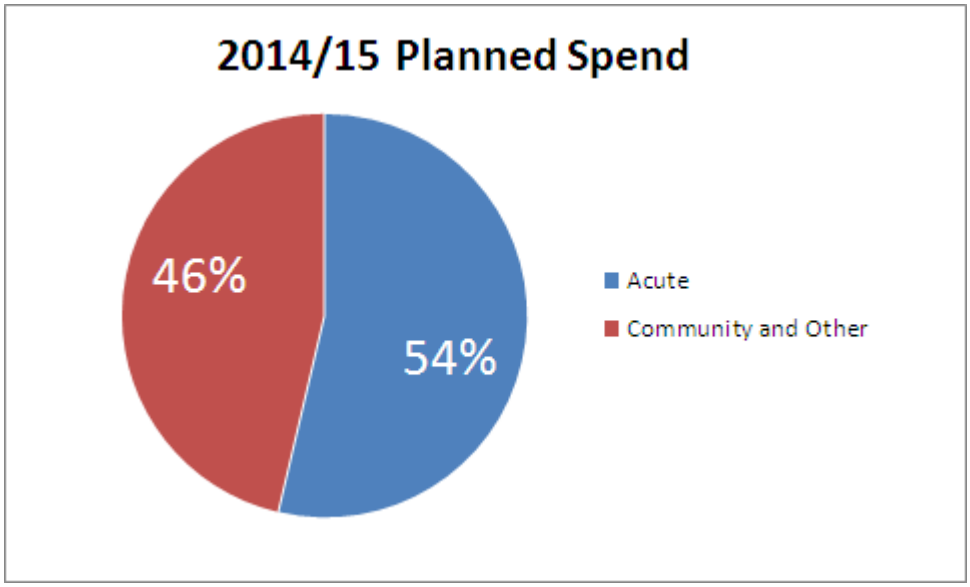

Chart 2: Acute to Community split of Planned Spend at 2018/19 to show movement from Acute to Community

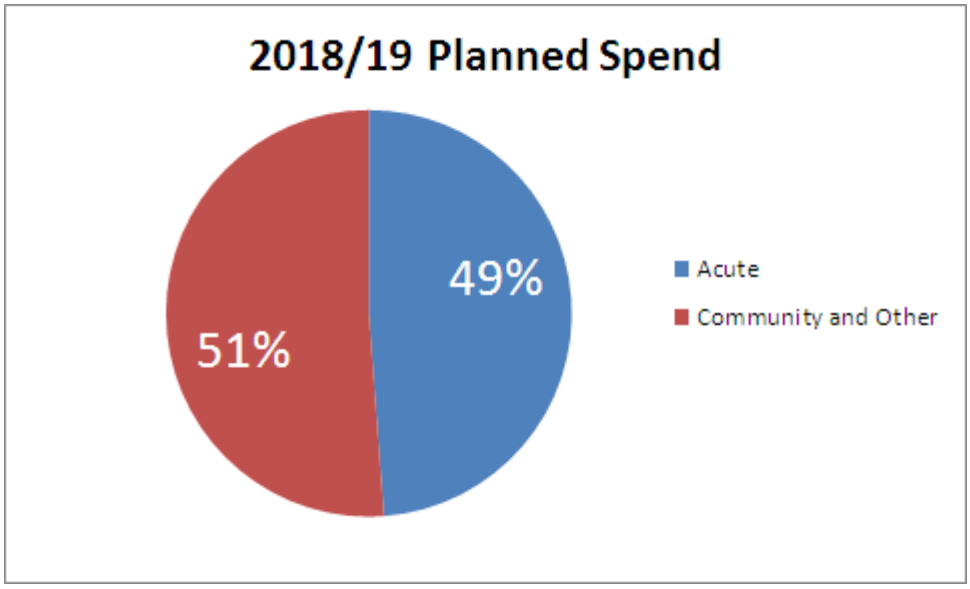

Chart 3: Movement in spend to show Acute, Mental Health, Community and Other