VALUES:	**P**atient focused **A**ccountable **R**esponsive **T**rue partners **N**ear to home **E**quitable **R**espectful **S**eamless NHS Mansfield and Ashfield Clinical Commissioning Group
STRATEGIC AIMS: Prevent unnecessary hospital admissions and / or visits Tackle preventable ill health and disability and help people to live independently Promote better health through addressing key areas of health need STRATEGIC RISKS: Rising demand for healthcare, causing pressures on non-elective care system (LxI: 4x4 = 16) Financial sustainability of local acute provider (LxI: 5x5 = 25) Non-delivery of QIPP / financial balance (LxI: 3x4 = 12) Quality failure as a result of poor monitoring or financial challenge (LxI: 3x5 = 15) **FINANCIAL PLAN:** Healthcare - £226,289,000 Running Costs - £4,540,000 QIPP requirement: £6,563,000 (2.9%)	**TRANSFORMATIONAL CHANGE:** **National planning requirements will be met. Additional local ambitions are:** **BUILDING SYSTEM CAPACITY TO MANAGE THE RISING DEMAND FOR HEALTHCARE** • Develop and implement integrated long-term conditions care in the community • Develop the workforce for new integrated ways of working across organisational boundaries and care settings • Develop data sharing processes and mechanisms to improve care • Develop care pathways for patients with co-morbidities • Review intermediate care / sub-acute care capacity and ensure this is adequate to prevent unnecessary acute hospital admissions **LOCAL PRIORITY OUTCOMES FOR QUALITY PREMIUM:** • 10% reduction in non-elective admissions for COPD, heart failure and diabetes • Increase primary care capability to prevent ill health and manage demand – 75% of practice achieve care bundles for CHD and diabetes in Q4 • Increased deaths in place of choice – 10% increase in deaths at home **JOINING UP SERVICES TO IMPROVE CARE** • Increase community / sub-acute capacity and capability to increase deaths in place of choice • Develop clinical navigator services to ensure that patients are signposted appropriately. This service should be accessible to GPs, ambulance crews, community and hospital staff to ensure patients are treated in the most appropriate location first time • Expand consultant-led community-based services • Review and refine referral triage, diagnostic pathways and community pathway provision to maximise care closer to home **TACKLING THE MAJOR CAUSES OF ILL HEALTH AND DISEASE** • Roll out COPD pathway and ensure the pathway is comprehensive across primary and community care settings (10% reduction in admissions) • Care of the elderly –Roll out ANP care homes scheme for universal coverage, implement one stop shop with comprehensive geriatric assessment at AHV • Diabetes – 10% reduction in non-elective admissions • Mental illness – 10.4% coverage target for IAPT, 50% recovery rates • Dementia – Increased memory clinics and intermediate care provision • Early years – 1% reduction in smoking in pregnancy rates • Cancer – 16% reduction in deaths <75 years • CHD – 10% reduction in admissions for heart failure **PROMOTING WELLBEING, IN LINE WITH THE HEALTH AND WELLBEING STRATEGY** • Work with local authorities to reduce smoking, obesity and alcohol misuse • Joint commissioning for learning disability services to meet Winterbourne View SCR recommendations
ENABLERS: Clinical work streams for disease priority areas Asset utilisation – Ashfield Health Village being developed as a hub for care of the elderly, long-term conditions and early years Transformation Partnership Board and strategic review of services across Mid-Nottinghamshire Robust contracting and quality monitoring across services Organisational Development Plan Procurement Strategy – to be developed in 2013/14 Communications and Engagement Plan	