Nottinghamshire County Council

Report to Health and Wellbeing Board

11th January 2012

Agenda Item: 4(a)

REPORT OF NEWARK AND SHERWOOD CLINICAL COMMISSIONING GROUP (CCG)

STRATEGY AND COMMISSIONING INTENTIONS

Purpose of the Report

1. This report describes the vision for healthcare and commissioning intentions for Newark and Sherwood. Key health needs are outlined. The CCG has some big ticket priorities, which are also highlighted. The NHS has to make quality and efficiency improvements in order to ensure that healthcare resources are spent as wisely as possible. Implications for Newark and Sherwood are identified.

2. The planning cycle is currently ongoing. In particular, the CCG are holding a series of public engagement events to help with planning and prioritisation decisions ('Your Health, Your Say'). Financial plans, contract cost envelopes and budget allocations are currently under development. Further outputs from these processes will be included in the presentation to the Board.

Information and Advice

3. We want Newark and Sherwood residents to be proud of their local NHS. We want the local NHS to provide the safest and most effective services possible within available resources. We want patients to be treated with compassion and respect at all times. People will be able to take control and responsibility for their own and their loved ones' health and care as far as possible.

4. We want joined up services that are sensitive to the whole person. This includes mental health and social needs as well as physical health. We also want services to be accessible to all, based on individual needs.

Strategic Objectives

5. Our strategic objectives will operate as the principles for how we work and what we choose to commission. This means that what we say we want to achieve as a CCG overall will guide us in individual decisions about local services. We all need to work towards the same ends. For instance, we say that we want to commission services that tackle health inequalities. We therefore won't intentionally buy a service that disadvantages areas with a greater risk of a particular disease.

6. We know that there is not enough money in the health service to buy everything that people would like, so we will have to prioritise NHS resources. Sometimes, decisions will be a difficult balance of achieving the best possible outcomes within an affordable limit. We will need to target resources on treatments that improve health and are good value for money. This will help us to maximise benefits for local people overall, but it will inevitably mean that some people disagree with certain decisions.

7. Our aims and objectives are shown in Table 1.

Table 1

OVERARCHING AIM	STRATEGIC OBJECTIVE
Best quality within available resources (incorporating safety, effectiveness and patient experience)	• Design, procure and monitor services to achieve the best possible clinical and patient experience outcomes • Ensure that pathways are integrated and more joined up for patients and carers • Enable patients and carers to take control of their own health • Ensure financial breakeven and value for money within local services • Commission services that tackle health inequalities • Design services that comply with national standards and the NHS Outcomes Framework • Ensure organisational statutory duties are achieved
Best service design	• Move care closer to home for patients where appropriate • Commission care in centres of excellence where this is safer and more clinically and financially sustainable
Partnership working to achieve the safest and most effective services within available resources	• Ensure a wide range of clinicians from primary, community and hospital settings are actively engaged in the commissioning process • Work with local government, commissioners and providers to maximise use of public sector resources and to achieve best local services

8. We are committed to developing a clinical and care model that will keep Newark Hospital vibrant and viable. We are also committed to ensuring that Sherwood residents have access to high quality local services in a range of settings.

Health Needs in Newark and Sherwood

The Population

9. The population of the district of Newark and Sherwood is 113,000[1], while the GP registered population of Newark and Sherwood CCG is 127,000 approximately. Thus, the CCG is responsible for the health of a substantial number of people living outside of the District and it is likely that some of the population of the District are registered within neighbouring CCGs.

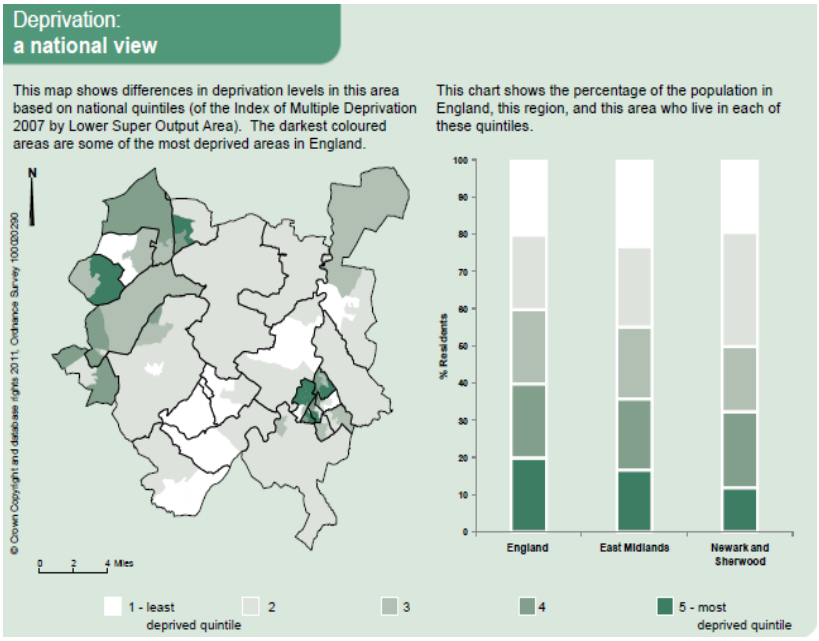
10. This population has a lower proportion of young children and men and women aged 20 to 34 than England and a higher proportion than England in all age groups older than 45 years. Within Nottinghamshire, the CCG has the highest proportion of over 65 year olds. This will increasingly have an impact on demand for health services, since older people have more illnesses and are likely to require more care.

Deprivation and Health Inequalities

11. It is well established that deprivation is very closely associated with poor health outcomes, including shorter life expectancy and higher mortality rates. Generally, in deprived communities there is higher prevalence of lifestyle risk factors such as smoking, obesity and harmful levels of alcohol consumption.

12. For Newark and Sherwood, deprivation is lower than the national average overall but there is wide variation across the District (See Figure 1) and just over 4,000 children (17% of children under 19 years, 2008 data) live in poverty.

Figure 1: Levels of deprivation across Newark and Sherwood[2]



[1] Mid-2009 population estimate, Source: National Statistics website: www.statistics.gov.uk

[2] *Crown Copyright and database rights 2011, Ordinance Survey 100020290*

13. The map in figure 1 shows differences in deprivation levels in the area based on national quintiles at lower Super Output Area (SOA Index of Multiple Deprivation). Areas shaded darkest are some of the most deprived areas in England. Newark and Sherwood is one of the most diverse districts in Nottinghamshire in relation to deprivation and therefore health need.

14. Life expectancy (a measure of overall health of a population) for both men and women is similar to the England average but within the District, is 8 years lower for men and 7 years lower for women in the most deprived areas when compared with the least deprived areas.

Commissioning Priorities for 2012/13

15. We have prioritised illnesses that have the biggest impact on people living in Newark and Sherwood. These include respiratory disease, cardiovascular disease, diabetes, mental illness, dementia, early years and end of life care. More information about what we will do to help deal with these diseases is shown in Table 2 below.

16. The proposals in Tables 2 are based on patient feedback about how we could improve services, national guidelines for best practice and local GP insights into how services could be improved.

Cardiovascular disease (heart disease and diseases of the circulation)		
Why we chose this	**What we are trying to achieve**	**What we are doing**
Cardiovascular disease is one of our biggest causes of premature death. It also causes considerable ill health and disability. In Newark and Sherwood, there are 67 early deaths caused by cardiovascular disease per 100,000 people. Each year, premature deaths from stroke equate to over 150 years of life lost, while early deaths from heart disease equate to over 600 years of life lost across the district. Deaths from these causes have reduced significantly over the last 10 years, but there is more that we can do.	We want to prevent heart disease where possible by helping people to adopt healthier lifestyles. This includes smoking, diet, exercise and alcohol. We want patients who are diagnosed with heart disease to have timely investigations and interventions to help people lead a normal life for as long as possible. We want to reduce deaths and disability in people who have heart attacks. We want to develop services that help people with heart disease to live as normal a life as possible. Home monitoring and support to prevent people becoming ill will be a priority. We want to improve continuity of care for people with heart disease who are at the end of their life.	We have a nominated clinical GP lead to oversee improvements in the way that care is organised. We are looking at evidence from around the world about best possible care across community and hospital settings. We have a heart failure specialist nurse who monitors and supports patients at home. We will ask the views of the public at our engagement events in December 2011. We will incorporate local views into our commissioning plans for 2012.

Diabetes		
Why we chose this	**What we are trying to achieve**	**What we are doing**
Diabetes is a major cause of ill health and premature death in Newark and Sherwood. There are over 4,500 people with diabetes in Newark and Sherwood and the rate is increasing by 2.5% each year.	We want to prevent the onset of diabetes where possible through diet and exercise. We want to detect diabetes as early as possible so that later complications can be prevented. We want people with diabetes to lead as normal a life as possible, so we will make health monitoring as convenient and close to home as possible. We want to reduce hospital admissions that are due to the complications of diabetes. We want to increase the lifespan of people with diabetes.	We are increasing insulin initiation in community settings and we are training community health professionals to be more aware of diabetes and to monitor the condition. We are looking at international evidence of best practice to help us improve our local pathways. We are looking at evidence from around the world about best possible care. We will ask the views of the public at our engagement events in December 2011.

Mental illness		
Why we chose this	**What we are trying to achieve**	**What we are doing**
A large proportion of people who go to see their GP do so because of mental health problems. Many health services are involved in mental health. These services need to work well together to deliver the best care for people. A large proportion of unplanned (emergency or urgent) care is due to mental health problems. Around 1 in 4 people suffer from mental illness at some point in their lives. We know that some areas of the district have above average levels of mental illness, including Newark and the north west.	We want to improve rehabilitation for people with mental illness to help them recover more quickly. We want to improve the physical health of people with enduring mental illness. We want GPs and community services to provide care closer to home where possible and to reduce the need for people to be admitted to hospital. This means that health services will need to work together more. Primary care nurses and doctors will need more training to take on more of an active role. We want to increase people's choices when they need talking therapies.	We have a GP who is leading this work, supported by managers as required. We are reviewing inpatient rehabilitation for people with mental illness to see where improvements can be made. We now have regular commissioning meetings involving primary care, psychiatry, service users and allied health professionals. We will ask the public about their views at our engagement events in December 2011. We will incorporate local views into our commissioning plans for 2012.

Respiratory disease		
Why we chose this	**What we are trying to achieve**	**What we are doing**
Respiratory disease (including cancer) is a leading cause of illness and death in Newark and Sherwood. Smoking is a major cause of lung disease. The number of people with respiratory disease is increasing by 2.5% each year across the	We want to prevent people from becoming ill in the first place by helping them to give up smoking. We want to stop young people taking up smoking to save them suffering later in life. When people have respiratory disease, we want to accurately diagnose this to ensure the right	We have a GP clinical lead and managerial lead who are developing better monitoring of patients and earlier intervention when complications occur. We are looking at evidence from around the world about best possible care. We are

Respiratory disease		
Why we chose this	**What we are trying to achieve**	**What we are doing**
district. Last year, 227 district residents were admitted to hospital with a respiratory condition.	type of treatment is given at an early stage. Where possible, we want to prevent respiratory disease deteriorating to a point where people need to be in hospital. We want each person and their carers to have support to deal with the disease at home where possible. We also want people to get specialist advice, equipment and treatment as conveniently as possible when they need this. We want to improve continuity of care for people with respiratory disease who are at the end of their life.	working with service users, health professionals in hospitals, general practice and community services to design better services for service users and carers. We will ask the views of the public at our engagement events in December 2011. We will incorporate local views into our commissioning plans for 2012.

Dementia		
Why we chose this	**What we are trying to achieve**	**What we are doing**
Newark and Sherwood has a higher than average elderly population, so the numbers of people with dementia is set to increase year on year. Elderly frail people with dementia will be the largest growing group. On average, people live around 10 years with dementia and need a great deal of care and support.	We want to improve early recognition and diagnosis of this condition so that early support can be put in place. We want a coordinated and timely response to crises. We want to improve end of life care for people with dementia. Elderly frail people with dementia are the largest growing group of people who will need end of life care. We want to train professionals to better understand dementia care.	We have a GP clinical lead to take this work forward, backed up by managers. We are reviewing the memory assessment service. We are bringing together clinical professionals from primary and secondary care to see where improvements can be made. We also work closely with Nottinghamshire County Council on dementia care. We are reviewing respite care.

End of life care		
Why we chose this	**What we are trying to achieve**	**What we are doing**
Newark and Sherwood has a higher than average elderly population. Currently, people who say they want to die at home are not always supported adequately to be able to do this	We want to give people who are near the end of their life more choice about where they would like to die. We want to support families and loved ones so that patients can die in their place of choice. We want to improve symptom control and ensure that people have a peaceful and dignified end to their life where possible. We want to reduce inappropriate admissions to busy emergency departments when people are at the end of their life and need a more peaceful environment.	We have a GP clinical lead to take this work forward, backed up by managers. We have modelled future numbers and causes of death for our local population, so that we can identify gaps and develop better services. We will learn lessons from cancer services to ensure that there are more joined up care for people, regardless of their diagnosis. We will review provision of emergency care and crisis response.

Early years development		
Why we chose this	**What we are trying to achieve**	**What we are doing**
Giving babies and children the best possible start in life reduces social, educational and health problems later in life. Over 4,000 children live in poverty in Newark and Sherwood. There are over 1,200 births per year in the district. This is projected to increase by 9% over the next 20 years. High numbers of children under 1 year are admitted to hospital as an emergency when compared with other areas of the county.	We want to safeguard vulnerable children from harm by ensuring that services work together and communicate more effectively when a child is thought to be at risk. We want to improve parenting support for those who are most in need, to help give children the best start in life. We want to work with local communities to provide support that improves health and emotional outcomes for children and their families. We want to improve the use of the Common Assessment Framework (CAF) so that it is an effective means of information sharing and care planning across agencies.	We are training GPs and primary care health professionals to recognise signs of child abuse and to take appropriate action. We are increasing the numbers of health visitors in line with government policy. We are reviewing emotional wellbeing services for children. We are training professionals to use the CAF more frequently and more effectively.

Mental Health, Learning Disabilities and Autism

17. The Clinical Commissioning Group hosts the joint commissioning group for mental health, learning disabilities and autism. The strategic joint commissioning plan for these areas will be presented to the Health and Wellbeing Board as separate items once plans are refreshed.

18. The CCG is also the coordinating commissioner for Nottinghamshire Healthcare Trust. Specific commissioning intentions for the trust have been jointly agreed across the CCG's and are as follows:

- Ensure services can evidence that they promote recovery, focus on improving quality of life and the independence of people with poor mental health (reflecting the Mental Health strategy)

- In conjunction with CCGs collaboratively **develop and deliver agreed improvement goals** in 2012/13 (high quality, cash releasing, cost saving and can encompass a number of areas e.g. reducing length of stay in out of area placements, reduced **consultant to consultant referrals and other internally generated referrals and activity**)

- Reduce in-patient length of stay and focus on providing and utilising community mental health services

- Continue to focus on reducing delayed transfers of care working with all partners to achieve this objective

- Deliver the Department of Health requirements for the **implementation of Payment by Results**, by adopting an approach with minimal financial risk to CCGs and NHT

- **Review primary / secondary care referral thresholds**

- Work with providers to **implement the recommendations from the utilisation review** of inpatient rehabilitation services undertaken in 2011

- Develop a Quality Assurance framework for **Learning Disability** service providers.

Efficiency requirements

19. The CCG has a 5.1% efficiency target in 2011/12. Current efficiency schemes relate to prescribing, referral to the appropriate setting first time and better disease management in the community to prevent avoidable and costly hospital admissions. The efficiency target for 2012/13 is currently being calculated, but is likely to be similarly challenging. Patterns of service provision will need to change if we are to provide healthcare based on clinical need for a growing elderly population. We also need to work with members of the public to encourage judicious use of the health service.

Statutory and Policy Implications

20. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

21. The implications for local health services are that the patterns of healthcare provision are likely to change in the following ways:

    - More care will be delivered outside of hospital environments. This will include patients' homes and community healthcare settings.

    - More patients with long term conditions and their carers will be supported to manage their conditions themselves. This will help to avoid unnecessary appointments for patients. This will be supported by the use of home monitoring equipment.

    - Doctors and nurses will work together across hospital and community settings to avoid unnecessary duplication and admissions to hospital.

    - Unwanted variations in clinical referral patterns and patient pathways of care will be eliminated.

22. The financial climate is very challenging for commissioners of healthcare as well as providers of services. The CCG will work with local providers to make services more efficient and to target resources on treatments that have the biggest health impact. We will need to commission affordable services, but will work with providers to minimise risks of financial instability.

RECOMMENDATION/S

It is recommended that:

1) Members of the Health and Wellbeing Board are invited to comment on the health priorities and proposed service developments.

2) the Board notes the key health needs of Newark and Sherwood residents and the link between commissioning intentions and the Joint Strategic Needs Assessment findings.

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For any enquiries about this report please contact:
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Constitutional Comments (NAB 07/12/2011)

23. This report is for comment and for noting only and no legal issues arise at present.

Financial Comments (RWK 09/12/2011)

24. The report sets out the health priorities and proposed service developments for the Newark and Sherwood CCG. These priorities and developments will need to be delivered within the financial resources available.

Background Papers

None.

Electoral Division(s) and Member(s) Affected

Balderton - Councillor Keith Walker
Blidworth - Councillor Geoff Merry
Collingham - Councillor Vincent Dobson
Farndon and Muskham - Councillor Sue Saddington
Farnsfield and Lowdham - Councillor Andy Stewart
Newark East - Councillor Stuart Wallace
Newark West - Councillor Keith Girling
Ollerton - Councillor Stella Smedley
Rufford - Councillor Les Ward
Southwell and Caunton - Councillor Bruce Laughton.

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