Mansfield and Ashfield NHS Clinical Commissioning Group

Strategic Plan 2011-13

(Consultation Draft 5 December 2011)

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1. Foreword

1.1. In order to achieve authorisation as a Clinical Commissioning Group Mansfield and Ashfield NHS Clinical Commissioning Group (MACCG) must demonstrate that, as an organisation we achieve key competencies in the following areas:

- Clinical focus and added value
- Capacity and capability (including governance)
- Engagement with patients and communities
- Leadership capacity and capability
- Collaborative arrangements
- Governance

And that we have a:

- **'Clear and credible plan** to meet its duties to serve the population of Ashfield and Mansfield and its objectives as a Clinical commissioning group.'

We want to be known as an organisation that contributes to making a real difference to **improving the health and wellbeing of people in Mansfield and Ashfield.**

1.2. This document is our first strategic plan as an organisation that has the ambition to become authorised as a Statutory Clinical Commissioning Group by 1 April 2013 (subject to the passage of the Health and Social Care Bill through Parliament).

1.3. Our starting point for developing the plan has been to look closely at the health needs of the people who live in Mansfield and Ashfield. We are working closely with the Health and Wellbeing Board who are doing a great deal of work to produce a Health and Wellbeing Strategy for Nottinghamshire as a whole. In the meantime, we have used the County Health Needs Assessment and the District Health Profiles which set out these health needs (please refer to Appendix 1).

1.4. Our second consideration has been the financial position. As a CCG we need to establish our organisation and deliver better health, whilst at the same time making productivity and efficiency gains of over 4%. This is necessary to address rising demand for healthcare at a time when financial resources that we will receive from the Department of Health will not increase in line with that increase in demand. This will be delivered through ensuring that the services we commission deliver high **Quality,** exploit **Innovation,** maximise **Productivity,** and take a strong approach **to Prevention** of ill health. This is known as the **QIPP** challenge. This is a significant challenge indeed, and to succeed we intend to work in partnership with patients, members of the public, clinicians, managers, local authorities and voluntary organisations across our area.

1.5. It is with this in mind that our Board has approved the following values:

***P** atient*	Our focus will always be on our service to patients
***A** ccountable*	We will be accountable for, and honest and open about, the decisions we make
***R** esponsive*	We will listen and respond to what people tell us about the services we commission
***T** rue partners*	We will work collaboratively with all of our partners who can help to **Improve the Health and Wellbeing of People in Mansfield and Ashfield**
***N** ear to home*	Services Near to home, so long as they are Safe, Clinically Effective and Cost Effective
***E** quitable*	We will recognise the diverse needs of our population and ensure services are available on a fair and equitable basis
***R** espect*	We will be mindful of how we work and of the impact our actions might have on others
***S** eamless*	We will work hard with others to provide integrated services to improve the patient experience

1.6 Mansfield and Ashfield CCG has been established as a sub-committee of the PCT Cluster Board since July 2011 and is accountable to NHS Nottinghamshire County for its performance. The PCT Cluster remains accountable for all functions delegated to its CCGs, until the CCGs become statutory bodies in their own right. (Which, for us, we anticipate will be October 2012). Therefore the PCT Cluster Chief Executive remains the accountable officer during the transition period.

Mansfield and Ashfield CCG's Board minutes and financial reports are reported to the PCT Cluster Board during the transition. CCGs have also adopted the PCTs policies and standing financial instructions.

1.7 We have made great progress in the past six months. We have:

- Broadened and deepened clinical involvement and engagement
- Established a cohort of clinical leaders across the Mansfield and Ashfield areas
- Overhauled Board governance arrangements in line with what is expected from the Health and Social Care Bill
- Extended Board membership and have appointed secondary care clinician and nurse board member posts
- Put in place innovative arrangements for patient and public involvement at every level of our organisation

In addition, we plan to:

- Re-develop our inter-practice agreement so that it better reflects the requirements of practices as clinical commissioners.
- Appoint a lay person/non-executive with responsibility for Audit, once the requirements of such a post have been clarified.

We aim to continue on this trajectory of success and need your help in making this happen so that we can make the most of this opportunity to target effort and services to make a difference in Mansfield and Ashfield.

A shortened version of this plan is available on request from Julie Andrews (julie.andrews@nottspct.nhs.uk 01636 673329)

This strategic plan is written as a consultation document with the intention that you, our partners, will contribute to it, and support us to make it a clear and credible plan for health and wellbeing in Mansfield and Ashfield.

Thankyou for your contribution.

Statement of Board Approval

This Strategic Plan was considered and approved at the Mansfield and Ashfield CCG Executive Team Meeting on 10 November 2011. Board members are confident that this plan, and the actions contained within it, will address the health needs of the people we serve and will enable the Mansfield and Ashfield NHS Clinical Commissioning Group to deliver a balanced financial position.

We look forward to receiving feedback as part of this consultation process in order to approve the Final Plan at our Board meeting on 12 January 2012.

		Photo Chair Signature chair
Dr Raian Sheikh Clinical Lead	Deborah Jaines Chief Operating Officer	XXXXXXX Chair (to be confirmed)

2. Working together to Improve the Health and Wellbeing of People in Mansfield and Ashfield

2.1 About Mansfield and Ashfield CCG Clinical Commissioning Group

2.1.1. Our geography

Mansfield and Ashfield CCG is one of 6 Clinical Commissioning Groups in the Nottinghamshire cluster. We formed in April 2011 from the 31 GP practices which made up the former Mansfield and Ashfield Practice Based Commissioning Group (formerly known as High Point Health). We cover all of the Mansfield and Ashfield areas with the exception of Hucknall. GP practices in Mansfield and Ashfield first came together to work as commissioners when Ashfield and Mansfield PCTs were created in 2001. Throughout a series of changes to the NHS we have retained continuity as like-minded practices who are committed to working together for the best interests of patients in our area. We see this as a strength going forward.

2.1.2. Leadership and accountability

We anticipate that Mansfield and Ashfield CCG will be authorised in October 2012. At that point, we will take on the responsibilities of a statutory organisation (such as being responsible for negotiating contracts) and will have full budgetary accountability from April 2013. (Subject to the passage of the Health and Social Care Bill). Until that time, we are operating with delegated responsibility – through a Memorandum of Understanding – with NHS Nottinghamshire County. Therefore, our Board acts as a sub-committee of the NHS Nottinghamshire County Board. Our authority and decision-making powers are delegated to us from the PCTs Board, and we are accountable to the PCT Cluster Chief Executive and PCT Board. Detailed arrangements about how this works in practice can be found in the "Transfer of Commissioning Functions Memorandum of Understanding", and details of how to access this are in Appendix 1.

Mansfield and Ashfield CCG has an elected Clinical lead and elected Board GPs. These posts are supported by a management team led by a Chief Operating Officer (COO) and appointed lay Chair and secondary care and nurse board members. Public Health advice to the Board is through a named Public Health Consultant.

A diagram showing our leadership and decision-making arrangements is to be found at Appendix 2.

We have put in place a programme of Board and leadership development to take us through the transition period to ensure we have the right structures, staff and skills needed to perform our statutory duties as a CCG.

Mansfield and Ashfield CCG is responsible for a budget of £236million and for purchasing healthcare for a population totalling 183,000 people.

It is important that the CCG commissions effectively for our **registered** and **resident** populations. The map at Appendix 3 illustrates the good alignment between our practices and registered population. ('Registered' population refers to the people who are registered as a patient with one of our 31 practices. 'Resident' population refers to those people who live in our geographical area, but who are registered as a patients elsewhere).

2.1.3. Partnership working

Health and Wellbeing Board

The Nottinghamshire Health and Wellbeing Strategy will guide our vision and direction. The CCG will have the opportunity to help develop the strategy and, once approved, the Health and Wellbeing Strategy will provide the framework for our future plans.

Partnership working will be embedded through joint commissioning with the Local Authority, where this is relevant.

Newark and Sherwood Clinical Commissioning Group

Mansfield and Ashfield Clinical Commissioning Group is one of six CCGs in the Nottinghamshire cluster.

Amongst these, Newark and Sherwood is our key partner for commissioning. Between Mansfield and Ashfield and Newark and Sherwood CCGs, we account for approximately 85% of the income of Sherwood Forest Hospitals NHS Foundation Trust, (SFHFT). It is important, therefore, that we have a shared approach to agreeing commissioning intentions for this trust. Clinical leaders from Mansfield and Ashfield and Newark and Sherwood CCGs meet with clinical leaders from SFHFT as a 'Clinical Executive' group to discuss, debate and agree key clinical issues and consider proposals for pathway changes.

In order to commission effectively, we have a number of managers who are responsible to both CCG Boards (Mansfield and Ashfield **and** Newark and Sherwood). In this way, and through sharing management costs, both CCGs are able to benefit from the expertise of a range of high calibre managers who lead the contracting process on behalf of both organisations. (Please see Appendix 1 for additional information).

Other Nottinghamshire CCGs

In addition, for the other larger NHS provider contracts, each of the Nottinghamshire CCGs has taken a role as 'first amongst equals' as leaders of the contracting process.

Mansfield and Ashfield CCG has taken this leadership role in respect of:

- Sherwood Forest Hospitals NHS Foundation Trust
- East Midlands Ambulance Service NHS Trust (linking in to Derbyshire CCGs)
- Central Nottinghamshire Clinical Services (our 'out of hours' primary care provider)

Patients and the Public

Mansfield and Ashfield CCG currently has a lay Chair, lay Vice Chair, and one further lay members as full voting members of our board.

Our Board has recently agreed the principles for developing a Citizen's Reference Panel (CRP) that will be made up of a range of key individuals such as :

- Representatives from practices' Patients Reference Groups
- Interest Groups and Voluntary Groups working in our area
- Interested members of the public
- District councillors

We will consult with the CRP in relation to proposed service changes and will ask them to be our 'sounding board' to ensure we know what we need to change and how we might need to commission differently.

The Citizens Reference Panel will elect 2 of it members to be the lay Board members – in this way we will ensure that the voice of the patients and public in our own locality is heard and is listened to. This should help us to enshrine the 'ward to board' principles of good governance. A further lay member/non-executive will be appointed to have oversight of our audit committee, once the requirements of this board member are better understood.

Details of how to access our Patient and Public Engagement Strategy are set out in Appendix 1.

Practices

All but 2 of our practices will have Patient Reference Groups (PRG) by the end of 2011/12 (some are developing more quickly than others), and these are the foundation of our Engagement Strategy. Discussions are ongoing with the remaining 2 practices who do not yet have PRGs in place to see how we can facilitate this development.

We have established 5 'Federated Commissioning Groups' (FCGs) consisting of between 5 and 7 practices that have agreed to work in partnership as commissioners. All of our 31 practices are members of an FCG. (Please refer to Appendix 4 for full details).

We are developing a new constitution to replace the current 'Inter-Practice Agreement' to which all practices are signatories. We are enlisting the help of the NHS Alliance with this work and expect this to be completed by January 2012.

2.2 About health in Mansfield and Ashfield

The vast majority of people registered with our Clinical Commissioning Group live within the boundaries of either Mansfield or Ashfield District. Since the CCG is responsible for the *resident* as well as the *registered* population, this is an advantage to the CCG in the way it plans services.

Life expectancy is a quick and easy way of indicating health in the population. For both Mansfield and Ashfield, **life expectancy overall is significantly worse than the England average**. So whilst health has been improving here, it has not been enough to close the health inequalities gap.

Health status is shaped by many factors outside the control of the NHS, and these are often described as the 'wider determinants' of health. The level of multiple deprivations in the community is a good proxy for describing this, so it is perhaps unsurprising that both Districts have scores higher than the national average. At District level these figures mask more inequalities, for instance in Mansfield 40% of residents live in the worst 20% of deprivation nationally. (Please refer to Appendix 5 to see our Health Profiles).

This helps to define the health needs of our population and, in turn, impacts on the delivery of primary care services and the commissioning of health services in the area. For instance, we know that in our populations we have higher than average levels of unhealthy behaviours e.g. smoking and obesity. These,

in turn, mean that we have higher than average levels of chronic and life-threatening diseases such as Cancer, Diabetes and Chronic Respiratory Diseases. We therefore recognise the importance of working with the Health and Wellbeing Board to ensure that we take a joined-up approach to developing the Health and Wellbeing Strategy and tackling the causes of ill health. At the same time we are driving up the quality of clinical care (including chronic disease management) provided in our practices, so that we can reduce unplanned admissions to hospital, and optimise health for our populations.

We also need to plan for, and develop services to address, the changing profile of our populations. We know that the incidence of dementia is growing all the time and, with more people living longer, the incidence of that disease will increase yet further.

The 2011 health profiles recently published for Mansfield and Ashfield (Appendix 1) tell us that the topmost priorities for both localities are smoking, obesity and alcohol – all of which have impact on the prevalence of the long-term conditions referenced above.

Our Diverse population

We confirm our commitment to ensure our priorities meet the needs of our diverse populations in Mansfield and Ashfield. The Equality Act 2010 requires public services to ensure that all people have a good access to, and experience of, those services. This includes people specifically listed with the 'protected characteristics' relating to:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

For Mansfield and Ashfield, the level of disability appears to be of greatest significance and this is recognised within our strategic priorities.

In addition, the most significant factor affecting health in Mansfield and Ashfield, although not addressed specifically be the 'protected characteristics' is deprivation. Our populations are significantly over-represented in the 'most deprived' groups. Approximately a third of our registered population live within the 20% most deprived areas of England.

- We will ensure that we comply with our duties under the Equality Act as an employer and as a commissioner of health services.
- We will engage with the local communities of Mansfield and Ashfield in order to shape and prioritise service changes that meet diverse needs, and address local health inequalities.
- We will ensure that our commissioning plans systematically take account of equality and diversity within the local population.

Please refer to appendix 1 for details of how to access the Single Equality and Diversity Strategy 2011-13 for Nottinghamshire.

2.3 What is included in our Strategic Plan

The plans set out on pages 12-18 are a high level summary of the work of Mansfield and Ashfield CCG between now and 2013. Here we focus on the health priority areas where we, together with our partners, really need to make a difference, in order to improve the health and wellbeing of people in Mansfield and Ashfield.

As well as identifying areas for health improvement, in section 4 we outline our financial position going forwards and the challenges that this poses where we expect demand to outstrip the available resources. We refer to this as the QIPP (Quality, Improvement, Productivity and Prevention) programme. It will be necessary for us to take action in relation to QIPP in order to achieve a balanced financial position.

Mansfield and Ashfield CCG is committed to working in partnership with all statutory and voluntary sector organisations locally, in order to optimise our impact on promoting good health and treating ill health. Our CCG model strengthens Clinical leadership, and strengthens clinical and patient/public engagement to make what are often difficult decisions and choices about how we prioritise health spending. We believe this will help us to ensure our plans offer realistic and achievable measures of health improvement, that are locally sensitive, and affordable.

3. Our priorities for action: 2011-13

3.1 Work streams

Mansfield and Ashfield CCG's priorities for action are grouped into ten work streams. (Please refer to pages 12-18).

Each work stream ensures we address at least one of the following:

- **Promote better health through addressing our key areas of health need (smoking, alcohol, obesity)**
- **Prevent unnecessary hospital visits and/or admissions**
- **Demonstrate utilisation of high quality and cost effective prescribing**
- **Tackle preventable ill health and disability and help people live independently**
- **Support more people to die at home if that is their choice**

3.2 QIPP & service redesign

We have recently reviewed our service redesign work streams to ensure priorities are focussed on QIPP (Quality, Innovation, Productivity, and Prevention). Each work stream is led by a Clinical Lead from the CCG Board or Executive and supported by a delivery plan and a designated member of the management team.

Although not included in this document, detailed plans for each of the workstreams have been developed (or are currently being developed in consultation with practices). These include the outcomes that are to be achieved through the work along with timescale for delivery.

Details of how to access the delivery plan are contained in Appendix 1.

We have a duty to promote research and to ensure that patients receive the best evidenced based care. Quality research will inform our commissioning decisions in line with the National Commissioning Board. We will encourage our health care professionals to be research active to assist patients to know about appropriate research opportunities.

Mansfield and Ashfield CCG Workstreams	Workstream objectives	Working in partnership	*Rationale* **(Link to Health needs and/or financial position/QIPP in MACCG)**
1. Care of the elderly in the community	Increase access to consultants in health care of the elderly, particularly in the community.		***Tackle preventable ill health and disability, and help people live independently***
	Implement MACCG Care Homes co-ordinator pilot across Mansfield and Ashfield.		
	Bring about a reduction in the number of falls, which lead to fractures. Ensure referrals to the community falls team have a multi-factorial falls assessment in primary care, and that the recommendations of the falls team are actioned.	✓	
	Engage with all care homes to ensure EMAS protocols are up to date and the good practice guidance is followed.		
	Improve the early diagnosis of dementia.		
2. Planned care	Implement a MACCG community dermatology service, to include primary care education.		***Prevent unnecessary hospital visits***
	Decommission anticoagulation services from SFHT and provide community based alternative	✓	
	Implement an increased range of direct access diagnostic services.		
	Optimise the use of Advice and Guidance on Choose and Book in the pilot specialties (Cardiology and ENT) and expand the range of specialties for which Advice and Guidance is available.		
	Audit reasons for Ophthalmology referral and referral outcome.		
	Develop and use a Minimum Data Set (MDS) for referrals to ensure better triage.		
	Ensure reduction in unwarranted clinical variation when referring for procedures of limited clinical value and where referral thresholds can be applied.		
	Revise and implement Limited Clinical Value Policy and adopt and implement evidence-based thresholds for referral.	✓	***Prevent unnecessary hospital admissions*** ***Prevent unnecessary hospital visits***
	Adopt uro-gynae stress and urge incontinence pathways		
	Systematically apply the evidence-based pathway for heavy menstrual bleeding.		

Mansfield and Ashfield CCG Workstreams	Workstream objectives	Working in partnership	*Rationale* **(Link to Health needs and/or financial position/QIPP in MACCG)**
	Implement the alcohol pathway, to include primary care training.		Reduce the impact of harmful drinking
3. Mental Health and substance misuse			Reduce the number of alcohol-related admissions to hospital
	Undertake PBR data validation for high volume service users (and put bespoke action plans in place for high volume service users) such as individual case management.	✓	***Prevent unnecessary hospital visits***
			Prevent unnecessary hospital admissions
	Improve access to dementia services and improve services for younger people with dementia, and their carers.		***Tackle preventable disability and help people live independently***
	Reduce use of atypical anti-psychotics for people with dementia through review of patients in nursing and residential homes, initially.		***Demonstrate utilisation of high quality and cost effective prescribing***
	Increase the availability of talking therapies, review demand for specialist mental health services.		Prevent unnecessary demand on specialist mental health services
4. Prescribing	Ensure adherence to agreed formulary and achievement of incentive scheme objectives.	✓	***Demonstrate utilisation of high quality and cost effective prescribing***
	Develop and implement local prescribing formulary.		
	Agree prescribing improvement plans, e.g. waste reduction.		
5. End of Life	Ensure comprehensive implementation of the end of life (EOL) pathway.	✓	***Support more people to die at home if that is their choice***
	Provide anticipatory prescribing for patients who are terminally ill.		***Demonstrate utilisation of high quality and cost effective prescribing*** ***Prevent unnecessary hospital admissions***
6. Cardio-vascular disease and prevention	Review and progress the Heart Failure integrated care pathway.	✓	Increase number of smoking quitters ***Prevent unnecessary hospital admissions*** ***Tackle preventable disability and help people live independently***
	Implement vascular checks to provide earlier intervention and reduce cardiac disease.		
	Reduce the number of people that die and who have life-limiting disability after suffering a stroke, by improving primary prevention.		
	Reduce inappropriate urgent care activity through introduction of integrated primary care front door to Emergency Department (ED).		***Prevent unnecessary hospital admissions*** ***Prevent unnecessary hospital visits***
	Targeted use of emergency care practitioners for community pathways such as intravenous antibiotics.	✓	

Mansfield and Ashfield CCG Workstreams	Workstream objectives	Working in partnership	*Rationale* **(Link to Health needs and/or financial position/QIPP in MACCG)**
7. Access and urgent care	Improve access to primary care as a means of reducing use of secondary care.		
	Reduce the number of patients who do not attend their GP appointments.		
8. COPD (Chronic Obstructive Pulmonary Disease)	Review and strengthen the primary care element of the COPD pathway		Increase number of smoking quitters ***Prevent unnecessary hospital admissions*** ***Prevent unnecessary hospital visits***
	Implement the MACCG plan for increased community oxygen assessment, through practice review of oxygen registered patients	✓	
	GP review within 6 weeks of a hospital discharge, patient personalised management plan, medication review, seasonal vaccination.		***Tackle preventable disability and help people live independently*** ***Demonstrate utilisation of high quality and cost effective prescribing***
9. Children's health	Reduce the rate of teenage conception.		Addressing the identified health needs of our population. *Taking a positive approach to promoting good health and preventing ill health.*
	Improve mental health and well-being of children		
	Reduce childhood obesity e.g. by improving rates of breastfeeding.	✓	
	Implement Multi-Disciplinary Teams (MDTs) in primary care.		
10. Cancer	Improve early diagnosis and prevention.		Addressing the identified health needs of our population.
	Reduce the rate of smoking.	✓	

3.3 A strategy for primary care

To date, we have not yet completed work on a primary care strategy. To achieve success, each of the 10 priorities listed above, require significant effort and input from primary care clinicians – reflecting the commitment of local practices to manage patients in primary care, where possible, to provide care to patients in the most appropriate setting. However, more work remains to be done on an over-arching primary care strategy, which will:

- Demonstrate the overall service strategy, including the ways in which we intend to improve the quality of, and access to, primary care in Mansfield and Ashfield.
- Indicate how we will use the Estate to support the primary care service strategy
- Address workforce development and education issues
- Indicate how, through management of local resources, we could incentivise more services to be carried out in primary care settings to achieve best value for money.

Work will continue on this emergent primary care strategy and this will be taken to the CCG Board in May for approval.

4. Our Financial Plan

4.1 Financial context

At its meeting in March 2011, the PCT considered the key planning assumptions that reflected the latest Operating Framework and SHA guidance. These assumptions fed into the 4-year financial plan (2011 to 2015), developed in support of the overarching PCT strategy, Strategic Operational Plan (SOP) and CCG financial positions. The revised financial plan for 2011/12 onwards was developed using the following base case inflation planning assumptions:

	BASE CASE	
	11/12	12/13
Growth	2.20%	0.00%
Uplift Assumptions (net of efficiency)		
Service Level Agreements (SLAs) - Tariff Inflation	-1.50%	-1.50%
SLAs - CQUIN (09/10 0.5%, uplifted to 1.5% in 10/11)	0.00%	0.00%
Primary Care (net)	1.00%	1.00%
Dental (net)	0.20%	0.20%
Prescribing (gross)	5.00%	5.00%

4.2 Financial position compared to likely growth in activity

As the majority of spend relates to provider activity, activity models are developed. These activity models include growth assumptions for the next four years, derived from activity trends across the Health Community and are specific to the differing healthcare points of delivery. We have checked and validated these growth assumptions to ensure they are in line with PCT expectations. These are represented below.

	BASE CASE	
	11/12	12/13
NHS East Midlands Growth Assumptions		
A&E Attendances Growth	3.60%	3.60%
Out-Patients Growth	1.50%	1.50%
Non-Elective Growth	2.80%	2.80%
Elective Growth	3.40%	3.40%
Other Growth	0.70%	0.70%

Combining the nil funding growth from 2012/13 onwards with the anticipated continued growth in activity, which will also impact on other areas of spend, means that the financial outlook is challenging. There will be insufficient resources available to meet the investment requirements to allow the CCG to focus on prevention and quality and continue to meet increasing demands. Delivery of recurrent 'QIPP' savings, therefore, is essential for the ongoing financial balance of the CCG (and PCT Cluster) and for delivery of the organisation's strategic objectives. The required level of savings to be delivered in total through cost improvements and improving Quality, Innovation, Prevention and Productivity (QIPP) has been identified. The table below shows the QIPP target over the life of the Plan, based on current planning assumptions.

4.3 Financial allocation going forwards

Considerable work is being undertaken at a national level to determine the financial allocations at CCG level. Until this work is concluded, (which was expected to be by December 2011) we have made an assumption that the CCG will be no better off, nor no worse off, than if we inherit our current budget share of the PCT allocation. This means that in 2012/13 the value of our QIPP requirement is £9.5m, which represents 4.1% of our total resource.

	Year	2011-12	2012-13	2013-14	2014-15
	PCT Resource Limit	£1,068m	£1,057m	£1,048m	£1,047m
At PCT level	QIPP Requirement	£46.4m	£36.7m	£33.1m	£28.0m
	% of total Resources	4.34%	3.47%	3.2%	2.7%
At CCG level	**QIPP Requirement**	**£12.0m**	**£9.5m**	**£8.6m**	**£7.3m**
	% of total Resources	**5.1%**	**4.1%**	**3.7%**	**3.2%**

4.4 QIPP alignment

Work has already been undertaken in the current planning year (2011/12) to align the CCG QIPP requirement with the priorities for action.
Financial values are as set out in the table below.

4.4.1 Alignment of QIPP requirement with priorities for action 2011/12

Mansfield & Ashfield Clinically led schemes	2011/12 £'000
1 Care of the elderly in the Community	430
2 Planned care	1,515
3 Mental health and substance misuse	218
4 Prescribing	1,314
5 End of Life	285
6 Cardiovascular disease and prevention	47
7 Access and urgent care	4,151
8 Chronic obstructive pulmonary disease (COPD)	164
9 Children's health (*)	
10 Cancer (*)	
Subtotal	**8,124**
11 Data validation	108
12 Other QIPP Schemes	1,260
TOTAL	**9,492**

(*)QIPP requirement not yet agreed

QIPP schemes led by other CCGs/PCT Cluster	2011/12 £'000
Management & Admin	1,453
Estates	852
Continuing Care	1,094
Long Term Conditions and Specialised Commissioning	108
Primary Care	43
NUH	1247
Mental health	655
Community	1,401
TOTAL	**7,320**

TOTAL MANSFIELD & ASHFIELD SCHEMES	**16,775**

In line with best practice, the CCG has identified potential QIPP schemes higher than its QIPP target. (138% identified). This is to ensure that in the event that schemes do not deliver the full savings, the target is still met.

4.4.2 Alignment of QIPP requirement with priorities for action 2012/13

The alignment of QIPP requirement with priorities is underway for 2012/13. We expect this to be broadly in line with 2011/12. Two exceptions to this are mental health and prescribing expenditure because benchmarking information indicates a low level of savings opportunity.

It will be necessary to review the 2012/13 alignment of QIPP with the priorities at the end of March 2012 because we will need to:

- Review QIPP delivery by priority areas for 2011/12
- Review any available benchmarking information

4.5 Clinical leadership

Each of the priorities for action will be sponsored by one of the GPs on the Executive Team or Board and supported managerially. Progress will be monitored at the Executive Team and reported to Board.

5. Commissioning with our partners

Our success as a Clinical Commissioning Group will rely upon successful working and collaboration with others.

5.1 Current arrangements

We have a range of arrangements in place already.

- The clinical lead is a member of the Health and Wellbeing Board.
- As previously detailed, we work closely with Newark and Sherwood CCG to commission the services of SFHT.
- There is close clinical dialogue between SFHT and the CCGs through the Clinical Executive group.
- We work closely with the other Nottinghamshire CCGs on a 'first among equals' basis to enable each of the CCGs to take responsibility for leading contracting processes on our behalf.
- In order to deliver QIPP across organisations, we participate in Productive Nottinghamshire.
- The clinical lead is a member of the Mansfield Area Strategic Partnership to ensure that our thinking is aligned with the Mansfield District stakeholders.
- Similarly, we are seeking to develop strategic links with Ashfield District Council to ensure that our thinking is aligned with the Ashfield District stakeholders.
- We are developing a service level agreement to describe the support we commission from the Nottinghamshire Commissioning Support Hub. This provides a range of services (technical contract and procurement support, legal services, Estates support and advice, Human Resources support)
- We intend to put in place joint commissioning arrangements with the Local Authority where this is relevant to improving services currently offered.

5.2 Future Plans

- We already have some plans in place for financial risk sharing within Nottinghamshire. Since we are smaller organisations, variation in activity can have a more dramatic impact on our separate financial positions. In order to mitigate the impact of the risk of variation, we are working with the other CCGs to develop a managed financial risk-sharing approach. We are seeking advice from an external organisation to develop the terms of the risk sharing arrangements.

5.3 Benefits of collaboration

We see the benefits of collaboration as:

- Enabling us to increase our knowledge base and provide greater management and clinical capacity and capability, whilst remaining within our running costs allowance.
- Affording us the opportunities for integrating commissioning and provision in the medium term.
- Sharing best practice and the opportunity to implement good ideas more quickly.
- Enabling us to scale our size and commissioning influence appropriately. (using the opportunity for CCGs to influence what only CCGs can influence and, at the same time, commissioning as a group of CCGs where a larger scale is more appropriate).

6. How will we know we are making an impact?

6.1 Ensuring a good process

Planning and performance as part of our structure

As the CCG has developed in recent months a number of changes to our structure and processes have strengthened planning and performance management. For example:

- Workgroups have been revised and aligned with our priorities for action.
- Although not included in this document, detailed plans for each of the workstreams have been developed (or are currently being developed in consultation with practices). These include the outcomes that are to be achieved through the work along with timescale for delivery.
- Federated Commissioning Groups (FCGs) of Mansfield and Ashfield CCG practices were introduced in April, and are working actively. They are accountable to our Executive, which reports to the CCG Board, which is in turn accountable to the PCT Cluster.
- Clinical leadership in Mansfield and Ashfield CCG is now fully embedded at FCG, Executive and Board level, and has been further boosted by the appointment of a Consultant and Senior Nurse to the Board.
- Mansfield and Ashfield CCG took over the management of Protected Learning Time (professional training for GPs and practice clinical and administrative staff) with effect from September 2011. This enables us to tailor the local education agenda to meet our own local needs and priorities, and ensure that training and service developments run hand-in-hand.
- The PCT Cluster has set up a robust Performance Management Office (PMO) at which our financial and activity plans are objectively challenged and our performance and outcomes are regularly monitored.
- Mansfield and Ashfield CCG has established a mechanism for independently considering and approving cases for change that are generated by our practices. A panel of officers considers innovative ideas, or business cases, from practices and/or FCGs. This group is called the 'business case panel' and, through its membership, removes any potential conflict of interest for individual clinicians and/or practices and this also improves the likelihood of rapid spread of good practice).
- Each of the workstreams has a clinical lead – who will report progress on a quarterly basis to the Executive Team. In this way, clinical leads and workstream groups will be held accountable for progress and delivery of plans.

6.2 Ensuring improved outcomes

Measuring what it is important to measure

Our workstreams each aim to address at least one of the following:

- **Promote better health through addressing our key areas of health need (smoking, alcohol, obesity)**
- **Prevent unnecessary hospital visits and/or admissions**
- **Demonstrate utilisation of high quality and cost effective prescribing**

- **Tackle preventable ill health and disability and help people live independently**

- **Support more people to die at home if that is their choice**

We will, therefore, ensure that performance reports to the Board provide additional metrics and assurance of progress on both the workstreams themselves as well as progress against the aims set out in the box, immediately above.
These will also become embedded in our Organisational Risk Register and Board Assurance reports.

6.3 Equality Impact Assessment

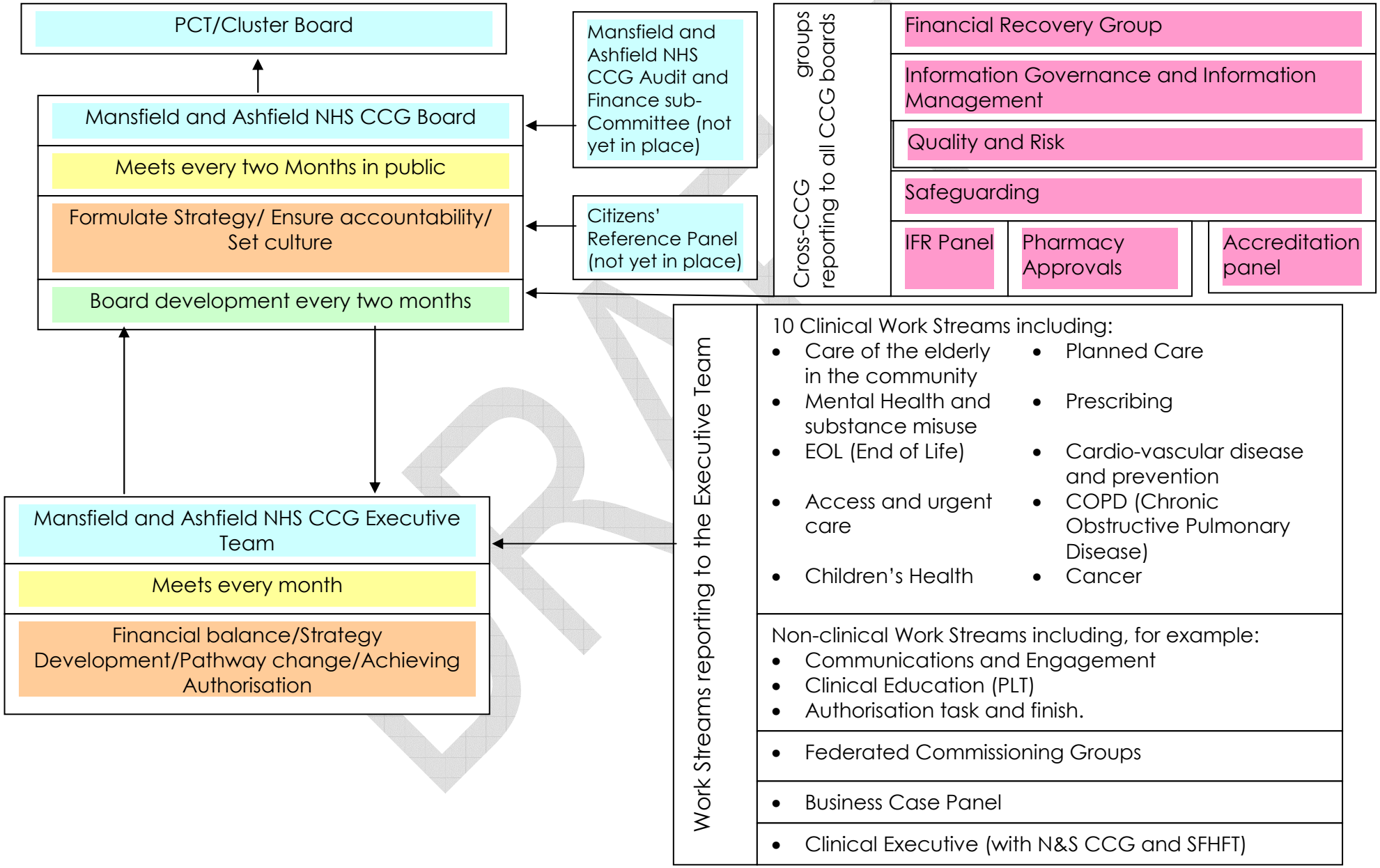
Through delivery of these plans, we will make a positive impact on Equality within Mansfield and Ashfield. This is shown in the Equality Impact assessment, which accompanies this plan. Please refer to Appendix 1.

Appendix 1

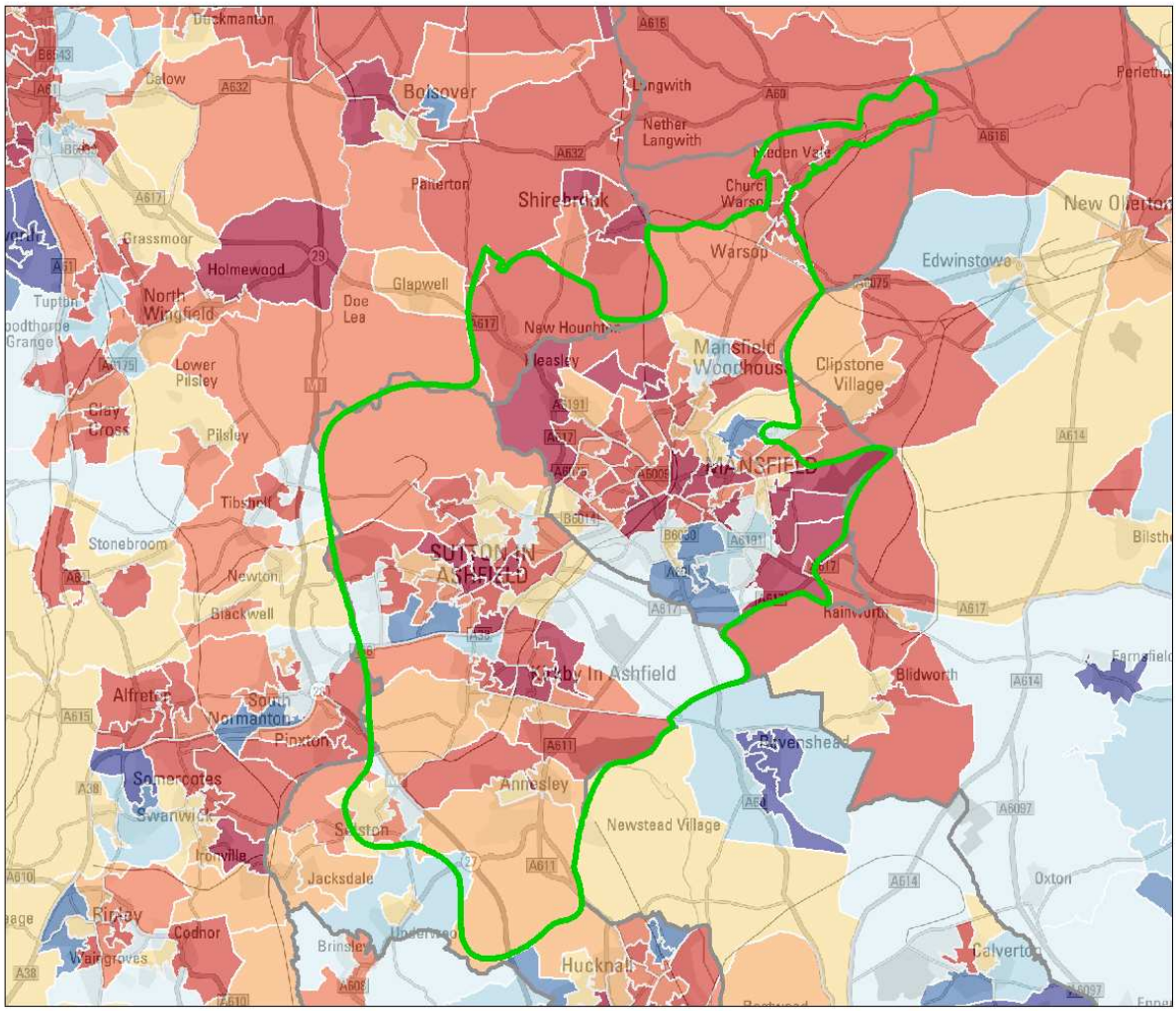
Links to further sources of information
(These will be available on the CCG website)

	Additional information	Location
1.	Transfer of Commissioning Functions Memorandum of Understanding	HPB.11.27b final MOU as amended by
2.	Joint management structure showing shared posts	M&A CCG Structure Oct - no names.doc
3.	Mansfield and Ashfield CCG Patient Engagement Strategy	Approved at November Board
4.	Delivery plan and clinical lead arrangements for 10 workstreams	Rachel.Bradley@nottspct.nhs.uk 01623 673116
5.	List of the names of key officers, Board and Executive team members, work stream leads and Board appointees.	Contact List.doc
6.	Equality Impact assessment	NHS Notts County EIA template - MACC
7.	Single Equality and Diversity Strategy 2011-13	Single Equality and Diversity Strategy inc
8.	Mansfield and Ashfield CCG Public Health Practice Profile	App 1 - Mansfield Ashfield 2011 final.dc

Diagram showing leadership and decision-making arrangements



Map showing alignment between practices and resident and registered populations



Appendix 4

Federated Commissioning Group (FCG) organisation and support

Background to Federated Commissioning Group working within Mansfield & Ashfield

Constituent practices of Mansfield & Ashfield Clinical Commissioning Group (CCG) made a collective decision early during its organisational development to adopt the concept of groups of practices working together as Federated Commissioning Groups (FCG).

1. **Rationale**
   The model was proposed for a number of reasons:
   - To develop a way for practices to work together effectively in order for the CCG to be successful
   - Enable all practices within Mansfield & Ashfield to be involved in Clinical Commissioning
   - Improve opportunity for clinical engagement across 31 practices simultaneously
   - Facilitate variation in level of engagement for clinicians, from local level through to wider leadership roles

2. **How have the groupings been derived?**
   - Largely a geographical allocation to groups
   - Groups of no more than 6-7 practices
   - Approximately same sized population in each grouping
   - Each group containing at least one member of the former PBC Implementation Team for continuity
   - Where possible, groupings took account of individual practice preferences

3. **The Federated Commissioning Groups are <u>not</u> intended to:**
   - Coerce practices to merge or to share provider functions
   - Take away a practice's individual accountability for its allocated share of the consortium commissioning budget

4. **The Federated Commissioning Groups <u>will</u>:**
   - Meet regularly
   - Tackle performance and clinical or practice variation in the group
   - Review referral data
   - Generate ideas for service redesign and innovation
   - Be supported by a strengthened consortia management team
   - Include a clinical lead for the group to represent the group at the CCG Executive Team, and provide two way feedback between practices and strategic groups
   - Have agreed terms of reference within which to work

5. **The benefits of federated working:**
   - Improved communication and accountability across the consortium
   - Supports smaller practices, and those practices previously less engaged with PBC
   - Good practice can be shared

Group 1	Group 2	Group 3	Group 4	Group 5
Name of Group **Vantage Point**	Name of Group **JAKS**	Name of Group **Hardwick**	Name of Group **ROSEWOOD**	Name of Group **Kirkwood**
Practices: Oakwood Surgery Oaktree Lane Surgery Meden Vale Medical Centre Bull Farm Primary Care Centre Riverbank Medical Services Pleasley Surgery	**Practices:** Ashfield House Selston Surgery Jacksdale Medical Centre Kirkby Surgery Kirkby Health Centre Kirkby Community Primary Care Centre Kirkby Family Medical Centre	**Practices:** Healdswood Surgery Ashfield Medical Centre Dr R Sharma (St John Street) The Pantiles Medical Centre Orchard Medical Practice Sandy Lane Surgery Drs Law and Mountcastle	**Practices:** Rosemary St Health Centre Millview Surgery Drs Ward, Pearce & Simm Roundwood Surgery Acorn Medical Practice	**Practices:** Woodside Surgery Huthwaite Health Centre Willowbrook Medical Practice Woodlands Medical Practice Harwood Close Kirkby Healthcare complex
Chair: Dr Khalid Butt	**Chair:** Dr Julian Law	**Chair:** Dr James Mills	**Chair:** Dr Milind Tadpatrikar	**Chair:** Dr Shan Hussain
CCG Board GP(s):	**CCG Board GP(s):** Dr Julian Law Dr Peter Macdougall	**CCG Board GP(s):** Dr Dean Temple	**CCG Board GP(s):**	**CCG Board GP(s):** Dr Piyush Oza Dr Hilary Lovelock
Locality SDM Support: Jacqui Kemp	**Locality SDM Support:** Ruth Hetherington	**Locality SDM Support:** Tim Dumbleton	**Locality SDM Support:** Jane Thornley	**Locality SDM Support:** Kirsty Ball
Finance Support: TBC	**Finance Support:** TBC	**Finance Support:** TBC	**Finance Support:** TBC	**Finance Support:** TBC
Information Support: Michael Seagrave	**Information Support:** TBC	**Information Support:** Julie Shortland	**Information Support:** Julie Shortland	**Information Support:** TBC

How we have consulted on the development of our priorities

Consultation on the Strategic Plan 2011-13 has been undertaken with clinicians, patients, carers and members of the communities of Mansfield and Ashfield. The purpose of the engagement has been to:

- Raise awareness of the Strategic Plan 2011-13 and to offer the opportunity for involvement with key stakeholders.
- Provide appropriate and proportionate mechanisms for patients, carers, the public and other stakeholders to contribute to the setting of priorities and underpinning objective to address health needs and reduce health inequalities in Mansfield and Ashfield. This has been delivered through:
    - Discussion of the outline plan by the Board followed by further detailed discussion at a subsequent Board Development session. Both sessions included input from Lay Advisors.
    - Discussion with clinicians and practice staff facilitated through Federated Commissioning Groups
    - Federated Commissioning Groups engaging with their constituent Patient Reference Groups
    - Seeking patient, carer and public views through a dedicated engagement event that included presentations and facilitated group discussions with clinical input provided by GPs
    - Utilisation of existing meetings to obtain views

The focus of discussion has been on reviewing the ten commissioning priorities and the underpinning objectives for each priority.

Following the engagement process all comments have been reviewed and the Strategic Plan 2011-13 has been amended and refined to reflect those comments.

Participants involved in the consultation will be informed of the impact of their deliberations on the Strategic Plan.

Wider consultation of stakeholders will be undertaken on the Strategic Plan following formal sign off by the Board on 10 November 2011.

Glossary/Abbreviations

A&E
Accident and emergency departments assess and treat people with serious injuries and those in need of emergency treatment. They are sometimes referred to as casualty departments or emergency departments.

Anticipatory prescribing
Anticipatory prescribing describes the prescribing of a defined list of medicines for patients who are identified as being in the last stages of life, to ensure they have all medicines needed to manage their symptoms, e.g. pain, sickness.

Atypical anti-psychotics
Atypical antipsychotic drugs are a group of medicines used to manage symptoms such as agitation, anxiety, mania and aggression in people with conditions such as schizophrenia or dementia. Evidence shows that the use of these drugs for elderly patients with dementia increase their risk of suffering cerebro-vascular events including stroke and this outweighs the likely benefits in the treatment of behavioural symptoms of dementia. Guidance suggests they should not be prescribed and GPs are reviewing those patients who have been prescribed atypical anti-psychotics to decide whether it is still appropriate.

Authorisation
Authorisation is a process that will determine Clinical Commissioning Groups (CCGs) readiness to be established as a statutory organisation. CCGs will be judged on a number of areas, e.g. governance arrangements, clinical and professional focus and leadership.

Care Homes Co-Ordinator Pilot
The Care Homes Co-Ordinator Pilot is a time limited jointly funded project through health and social care to support care homes and their residents in the prevention of inappropriate admissions to hospital.

Care pathway
A care pathway defines a patient's journey through care for a specific health condition. The pathway identifies what care and treatment is required along the pathway and the expected outcomes of that care and treatment.

Choose and Book
This is a system whereby patients referred mainly to hospital usually by their GP are offered a choice of hospital and a choice of time and date for their booked appointment.

Clinical Commissioning Group
Clinical Commissioning Group is the term given to a form of commissioning that is clinically led by a group of GPs and other staff working together within a defined area, e.g. geographical. They are currently operating in shadow form and, subject to authorisation, will become statutory organisations from 2012/13 (subject to passage of legislation).

Clinical Executive Group
The Clinical Executive Group comprises GPs and management team reporting to the Mansfield and Ashfield NHS CCG Board, which meets on a monthly basis to take forward the strategic direction of the Clinical Commissioning Group.

CQUIN
Commissioning for Quality and Innovation (CQUIN) is a framework that enables commissioners of care to financially reward providers where they can demonstrate they are delivering high quality care to agreed standards.

Commissioning
Commissioning relates to the purchasing and contracting of health care services. It involves identifying health needs, service planning and design and purchasing services from appropriate providers and subsequently managing the contracts put in place.

ED
An emergency department (ED), also known as accident & emergency (A&E), or casualty department, assesses and treats people with serious injuries and those in need of emergency treatment without prior appointment, who arrive there either by their own means or by ambulance. The emergency department is usually found in a hospital.

Elective Care
Elective care is pre-arranged, non-emergency care that includes planned operations. It is usually provided by consultants in a hospital setting. Patients are usually referred from a primary care professional such as a GP.

Federated Commissioning Groups
Federated Commissioning Groups are a local initiative that brings together groups of 6-7 practices, usually in a geographical area, to work together to share good practice and generate ideas for service redesign and innovation.

Health Needs Assessment
Health needs assessment is a method for reviewing the health issues facing a population, leading to agreed priorities and allocation of resources that will improve health and reduce inequalities

Health and Wellbeing Board
Local authorities will have a responsibility to establish a Health and Wellbeing Board that will lead on improving the strategic co-ordination of commissioning across NHS, social care and related children's and public health services. Clinical Commissioning Groups will be represented on the Health and Wellbeing Board.

Health and Social Care Bill
Proposals for a Health Bill were included in the Queen's Speech for the first Parliamentary session of the coalition Government. The Health and Social Care Bill will bring forward the legislative changes required for the implementation of the proposals in the White Paper: Equity and Excellence, Liberating the NHS which includes the establishment of Clinical Commissioning Groups.

Inter-practice agreement
A locally developed agreement between Mansfield and Ashfield GP practices which defines the governance arrangements and underpinning principles of working together as a group.

Mansfield Area Strategic Partnership (MASP)
MASP is the Local Strategic Partnership (LSP) for the Mansfield District. LSP's bring together a wide range of people and organisations in a single co-ordination framework. It sets the strategic aims for the area and ensures they are delivered with all partners contributing, e.g. health, crime and disorder.

Memorandum of Understanding
A Memorandum of Understanding is a written agreement put in place to establish a clear understanding of how an arrangement will practically function and each party's role and responsibilities. Such an agreement is in place between the Primary Care Trust and Clinical Commissioning Groups.

MDS
Minimum Data Set describes key information that is required to ensure that the next stage of care in a patient care pathway is high quality, timely, safe, and appropriate, e.g. referral to secondary care.

Multi-factorial falls assessment
The multi-factorial falls assessment is a process followed to assess the likelihood of a patient experiencing a fall. It is usually undertaken with older people who have fallen or who are at risk of falling.

NHS Alliance
The NHS Alliance is an organisation that champions, supports and represents NHS primary care and all those working within it..

NHS East Midlands
NHS East Midlands forms part of the NHS Midlands and East Strategic Health Authority (SHA) cluster. Its role is to ensure that services for patients are developed, financial control is maintained and to lead the implementation of the Government's reforms of the NHS including the provision of support to emerging Clinical Commissioning Groups.

Non-elective
Non-elective refers to a patient who is admitted to hospital but not in a planned way from a waiting list, for example the patient would be admitted as an emergency.

Non-Executive Director
Non-executive directors bring expertise and experience, and often particular, knowledge as a member of the local community, to the work of the Board. Their focus is at a strategic level and is impartial, providing an independent view that is removed from the day-to-day running of the organisation

NHS Operating Framework
The NHS Operating Framework is a document issued by the Department of Health annually in December giving the planning and priorities for the year ahead. This enables NHS organisations to plan for the financial year starting in April.

Patient Reference Groups
Patient Reference Groups, or Patient Participation Groups as they are sometimes known, bring together a group of registered patients of a GP practice with the aim of involving them in decisions about the range and quality of services provided, and, over time, commissioned by their practice through the Clinical Commissioning Group.

Primary Care Trust
Primary Care Trusts are currently responsible for the planning and paying for health care services in its area. The responsibility for this is due to transfer to Clinical Commissioning Groups by April 2013 when Primary Care Trusts will cease to exist.

PCT Cluster
A Primary Care Trust (PCT) Cluster is a partnership of PCTs working together with a joint management team. Within Nottinghamshire, NHS Nottingham City and NHS

Nottinghamshire County have joined together to form a cluster. Each organisation continues to have a separate Board.

Prescribing formulary
A prescribing formulary is a list of medicines recommended for prescribing based on latest evidence for medicines including efficacy, safety, outcomes and cost.

Primary Care Services
Primary Care Services are services provided by GP practices, dental practices, community pharmacies and high street optometrists.

Procedures of limited clinical value
A list of procedures of limited clinical value has been drawn up that will only be paid for by the local NHS in certain restricted circumstances, and also a number of treatments which don't work well enough to justify any use within the local NHS. A similar list has been drawn up for medications, to ensure that the local NHS gets the greatest possible value for the local population.

Productive Nottinghamshire
In recognition of the need across the Nottinghamshire health community to improve efficiency and productivity whilst delivering quality and innovation, all NHS organisations in Nottinghamshire have joined together to form an alliance known as Productive Nottinghamshire. This will ensure that the Nottinghamshire Health community makes best use of limited resources to deliver the QIPP agenda.

Quality, Innovation, Prevention and Productivity (QIPP)
QIPP is a programme that supports the NHS to deliver Quality, Innovation, Productivity and Prevention programmes. QIPP programmes are necessary because the funding the NHS is set to receive is lower than funding estimated to be required to meet increasing demand on health services (due to the aging population, increase in long terms conditions, more expensive drugs and technologies). The 'QIPP gap' is a term sometimes used to describe the extent of the funding gap between what is available and what is estimated to be needed. By adopting QIPP programmes, we will deliver more for our money to be able to meet the health need of our patients.

Registered population
Registered population refers to persons registered with a GP practice in a particular area.

Resident population
Resident population refers to persons usually resident in a particular area.

Secondary care
Secondary care is defined as a service provided by medical specialists who generally do not have first contact with patients. Secondary care is usually delivered in hospitals or clinics and patients have usually been referred to secondary care by their primary care provider (usually their GP).

Triage
Triage is a process used to assess symptoms and severity of illness or injury to determine when, where and by whom the patient should be seen as the next part of the care pathway. It is often used in emergency departments and may be used in primary care to assess referrals made to specialist services.