

June 2014

# Strategic Plan 2014 - 2019

## Bassetlaw – A Community of Care and Support



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The health profile of the population of Bassetlaw is well known and has been presented in successive commissioning plans. Therefore, it is appended to this strategy for context and to confirm alignment to the Nottinghamshire Health and Wellbeing Board (to be hyperlinked).

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#### **Appendices**

- 1 Our Alignment to the Nottinghamshire Health and Wellbeing Strategy. [Appendix 1](#)
- 2 A Profile of Our Local Population. [Appendix 2](#)
- 3 How We Could Focus to Achieve Greater Commissioning Value. [Appendix 3](#)
- 4 Our Population and Disease Prevalence. [Appendix 4](#)
- 5 What People Have Said To Us. [Appendix 5](#)

#### **NHS England Plans for Bassetlaw**

##### **Appendices**

- 6 Public Health in relation to services directly commissioned by NHS England.
- 7 Specialised Services
- 8 Primary Care

## Foreward

This document describes the plans for clinical commissioning within Bassetlaw – outlining how we aim to improve services and health outcomes over the next five years.



*Dr Stephen Kell  
Chair*

This plan is different from previous plans, in that it looks beyond the CCG and beyond the NHS. This is a plan for Bassetlaw. With our key partners we have agreed five strategic priorities for Bassetlaw and will work in partnership to ensure these plans deliver real improvements.

To achieve better outcomes we need a sustainable local hospital and enhanced, responsive community services, primary care and social care. We will work with patients, local clinicians, providers and our district and county councillors to achieve our vision.

I am very proud of the work done so far by the team at the CCG. Their focus is on patients, clinical outcomes and on local services. We have invested in improved physical and mental health services significantly over the last year, and delivered real improvements in quality and access to services. This plan outlines the next stage for Bassetlaw health services, and describes a safe, sustainable local health system built on a firm foundation of partnership working and joint responsibility with our partners.

Dr Stephen Kell  
Chair  
NHS Bassetlaw Clinical Commissioning Group

# 1. Executive Summary

## Welcome to our Strategic Plan



Mr Phil Mettam  
Chief Officer

Bassetlaw CCG is a clinically-led membership organisation that places the quality of services at the heart of everything that we do. We believe in talking about patients, being out on the front-line, and involving local people. Therefore, this plan is presented in a way that tries to represent that. We hope it is concise, has a clear purpose, and reflects our involving and collaborative philosophy.

*“The CCG is developing well and has strong leadership and an inclusive approach with partners. The level of partnership engagement is extremely high and consequently strategic plans are holistic and more effective.”*  
Local Authority

This plan also contains essential detail about the changes we plan to make; we know from experience that it is important to keep this under continuous review. We will do this with our local partners and with local people.

*“I believe the CCG is committed to being transparent in its decision making and making the planning process inclusive.”*  
Patient/Carer

Throughout the development of this plan we have engaged extensively, and so we are confident that our vision is supported and that our focus is right. If you would like to be involved in our journey and you want to help make Bassetlaw an exemplary community of care and support it would be great to hear from you.



Joint CCG and CSU team photo

I would like to thank our clinical leaders for their continued commitment and insight, and thank our partners for their commitment to local services.

Finally, I would like to thank the commissioning team. It is a pleasure to work with such a loyal, hard-working and talented group.

Phil Mettam  
Chief Officer

## 2. Who we are.

### About Us

We are a clinically-led commissioning organisation that formed in 2011 and became a statutory body in April 2013.

We are proud of our achievements so far and we are determined to go further.

We have a value-based clinically led Governing Body.



*NHS Bassetlaw CCG Governing Body GPs*

Our Values are unchanged, we continue to:

- Collaborate and develop productive relationships
- Focus on patients
- Treat each other with dignity and respect
- Listen to others, share information, be transparent
- Embrace innovation, develop new behaviours.

We have been working with our NHS and local authority partners to develop a vision for the future. We want to make Bassetlaw a community in which local people receive exemplary care and support.

This plan sets out how we will achieve this over the next five years. It summarises our vision and includes five strategic programs to change services. We continue to have a relentless focus on the quality and safety of local services. Delivering value for money for the taxpayer is important to us and we work hard to ensure Bassetlaw services are cost effective and efficient.

What local people think about their health care is really important in helping us to shape and influence how we commission services in the future. Throughout this plan you will see patient and public comments, both good and bad, about current services. We pride ourselves in engaging with local people and responding to them.

The feedback we have received tells us that the people of Bassetlaw support our vision and the strategic direction of this plan. We commit to continuing to work with local people to improve care and support for them and for their families.

### 3. What we do.

#### Our Commissioning Responsibilities.

The CCG is responsible for commissioning a number of predominantly local services. These include:

- Acute services (mainly Bassetlaw, Doncaster and Sheffield Hospitals).
- Mental health services (mainly provided from Nottinghamshire).
- Community based and delivered services.
- Ambulance services (from East Midlands).
- Some services for vulnerable adults, and some childrens services.

#### The Commissioning Responsibilities of Other Commissioners.

Unlike the predecessor commissioning organisation (the Primary Care Trust) there are many services that are no longer the responsibility of the CCG. The table below provides a summary of these:

NHS England	Nottinghamshire County Council
General Practice	Smoking Cessation
Dental Services	Weight Management
Optometry Services	Substance Misuse
Prison Services	NHS Health-checks
Immunisations	Exercise on Referral

The above table is to provide a guide and is not meant to be comprehensive.

It is the continued intention of the CCG to work in collaboration with both NHS England and Nottinghamshire County Council. We seek service continuity on behalf of local people and want to work with our commissioning partners to improve service and health outcomes.

#### Developing Partnerships for 'Our Place'.

This plan represents the ambitions of all of our partners. These are both commissioners and providers. It is a plan for Bassetlaw 'as a place'. Section 5 of this plan sets out our shared vision and describes in more detail how partners work together to improve outcomes and services for local people.

## 4. Improvements to patient care - what we have done so far



During the last two years we have successfully delivered the commissioning intentions set out in our previous strategic plans developing and commissioning many improvements to services for people in Bassetlaw. Our achievements include

*Ms Lisa Bromley  
Executive Lead  
Service*

### Acute Care

#### Assessment and Treatment Centre (ATC)

The ATC is a multi-disciplinary 24/7 consultant led unit at Bassetlaw Hospital for medically ill patients that are admitted by A&E, GPs, community services or via ambulance. The unit which opened in November 2012 provides integrated care for patients, enabling rapid tests and assessment of their illness to be done within a maximum period of 48 hours. Patients are then discharged from hospital to go home or to a nursing home or alternatively moved to another hospital ward if acute care is still required. It has 24 beds with quick access to diagnostics and enhanced pharmacy and dedicated social care support. The unit has an acute physician present Monday to Friday and a general physician at the weekends resulting in consistent, high quality seven day consultant delivered care for patients. Additionally the community rapid response service supports patient discharge over seven days. The ATC also has a non-bedded ambulatory day care facility which cares for patients with conditions such as Deep Vein Thrombosis that clinically do not require the patient to be admitted on to the unit but attend for day care treatment and then go home.

#### Ascites Pathway –alcohol related liver disease

This new pathway enables patients with alcohol related liver disease to book into Bassetlaw hospital's day surgery unit to have ascites drained instead of being admitted at a later date as an emergency admission to A&E. The pathway also provides advice to GPs on how to manage uncomplicated mild to moderate ascites.

### Primary Care

#### Telehealth

We have implemented the telehealth model in practices across Bassetlaw to improve the care and support to people with long term conditions. The model includes vital signs monitoring for Heart Failure and Chronic Obstructive Pulmonary Disease (COPD), care navigation and health coaching for all other long term conditions. Telehealth enables patients to understand their illness and recognise their symptoms better. Any deterioration of their condition can be detected sooner and managed accordingly with nurse intervention often preventing the need for a GP visit or being admitted to hospital. Early evaluation of the project has shown a significant reduction in GP visits and A&E attendances related to LTC with those patients using telehealth. During 2014/15 we will roll out telehealth to all Bassetlaw practices and expand the number of patient conditions it can support.

### **Primary Care based Deep Vein Thrombosis (DVT) pathway**

Using a specific finger prick test, GPs are able to assess whether a patient is likely to have a DVT enabling them to only refer patients to hospital that need further treatment for their condition preventing unnecessary admissions. Previously all patients with a suspected DVT were referred to Bassetlaw hospital for a diagnosis this pathway now ensures that only those patients needing to go to hospital are sent by their GP.

### **GP Direct Access to Diagnostic tests- Echocardiogram for Heart Failure**

A Direct Access Echocardiogram (echo) pathway is now being used by GPs to improve and quicken access to tests for patients with heart conditions such as heart failure, atrial fibrillation and incidental heart murmur. An echo is a sonogram of the heart and is a safe and effective way of diagnosing cardiology conditions. GPs referring patients for the test directly to the imaging department in the hospital prevents the need to refer patients to cardiology outpatients for it meaning that the results are sent back to the GP more quickly. The GP will decide from the test results whether a referral to hospital is clinically needed. In addition to direct echo, Brain Natriuretic peptide (BNP) blood testing is available to local GPs to diagnose heart failure. The test detects the increased levels of BNP in the blood and whether a heart is under high levels of stress. It can also indicate the severity of a patient's heart failure. GPs may refer patients for both tests depending on their condition.

### **GP Referral & Treatment Guidelines**

To improve the quality of GP referrals to hospital, promote best practice and national guidance on appropriate referrals and management and to increase transparency with our patients a set of guidelines have been developed and used by all Bassetlaw GPs and other referring clinicians. The completed guidelines are published on the CCG website for the public to access.

### **Telemedicine**

A number of practices are piloting telemedicine through a video consultation platform for the use of remote healthcare consultations. This secure system (similar to Skype) can work on laptops, tablets and smart phones that have a webcam function. Several pathways and services have been selected to test through the pilot including GP video consultations with patients in care homes; in mental health with patients having video consultations for their Cognitive Behavioural Therapy (CBT) sessions and GP appointments for patients that can have their consultation done remotely from home. Pending successful evaluation of the pilot telemedicine will be rolled out to all practices in Bassetlaw during 2014/15.

### **Risk Profiling of Patients**

A new tool is being used by GPs that uses patient information from primary and acute care to stratify patients that have a higher risk of being admitted into hospital due to chronic complex illness or a long term condition that is difficult to manage. Once the patients have been identified by the practice an individual patient care plan is agreed in a multi-disciplinary meeting with community services professionals (such as district nurses and community matrons) who also provide care for the patient.

## **Community Care**

### **Community Diabetic Specialist Nurse Service**

A community diabetes specialist nurse service has improved the quality of care for diabetes patients in Bassetlaw. It provides advice and education to primary care professionals who deliver diabetes care, promoting best practice in complex diabetes care within primary care and care homes. The service works with secondary care colleagues to reduce unnecessary admissions to hospital for diabetes related illness and supports earlier patient discharge from hospital. It also increases patients care options and provides patient education for diabetes self-care.

### **Preventing Falls Pathway**

We have worked with our community services provider, Bassetlaw Health Partnerships, to develop a new integrated pathway to reduce the number of people in Bassetlaw falling, reduce fragility fractures and improve the morbidity and mortality associated with falls. The pathway has simplified and speeded up referrals into the community falls team and has standardised assessment and intervention through the integrated multi professional working across health and social care providers. It also ensures identification and ongoing management of people who have fallen is consistent, widespread and evidenced based and the falls team provides advice and risk assessment to professionals and patients to reduce the risk of falling in vulnerable people such as the frail elderly.

### **Cardiac Rehabilitation**

The Bassetlaw Cardiac Rehabilitation service has undergone a number of improvements to increase the number of other patient conditions that may clinically benefit from the service such as heart failure with further plans in 2014 to widen access for other conditions such as peripheral disease. The service is provided by Doncaster and Bassetlaw Hospitals FT with a choice of locations across Bassetlaw including in patients' homes.

### **Complex Wound Care**

This new pathway in the community tissue viability service treats complex or slow healing wounds such as leg ulcers and pressure sores closer to home. It assesses patients and develops care management plans for patients. The service works with the district nurses to develop skills in management of complex wounds. Patient outcomes include shorter healing times, improved patient compliance, a consistent approach to wound care, evidenced based prescribing protocols and reduced admissions to hospitals for illness relating to wounds.

### **Community Paediatrics**

We have worked with our partners and paediatricians at Doncaster and Bassetlaw hospital to jointly develop a community paediatrics service. Children with long term conditions and neuro-development conditions will receive care by specialist multidisciplinary teams. Children referred to the new service by their GP will have a general developmental assessment with a paediatrician to determine the most clinically appropriate community paediatric pathway for treatment and ongoing care. The first stage pathways (developmental delay and concerning behaviours) launched in April 2014 with other pathways being introduced during 2014-15.

## **Autism Spectrum Disorder (ASD) & Attention Deficit Hyperactivity Disorder (ADHD) pathways**

This new integrated pathway guides professionals through the identification, early intervention, referral, diagnosis and management for children and young people with suspected ASD or ADHD. Children will be assessed by a multi professional clinic appointment led by the Community Paediatricians. This 'panel' format ensures a multi-disciplinary approach to diagnosing children in line with national guidelines and to developing effective on going care management plans for children and their families.

## **Community Ophthalmology Service**

A new ophthalmology clinical assessment and treatment service starts in Bassetlaw in April 2014 which will provide a community based clinic for patients with common ophthalmic conditions and the monitoring of patients with stable glaucoma. Patients will be referred to the consultant led community service by their GP, usually at the request of their local optometrist who has examined the eyes. The new service will bring care closer to home and will reduce the amount of patients that need to travel to hospital ophthalmology outpatients for treatment of their eye problem. Patients with complex or sight threatening eye problems will continue to be referred directly to hospital.

## **Mental Health**

### **Older Peoples Mental health intermediate care team**

This service supports people over the age of 65 caring for both patients with dementia and mental health conditions. The intermediate care team is co-located with the community rapid response service and the teams work closely together to care for patients that might require both mental health support and physical healthcare. A memory assessment service that is based in community settings includes Alzheimer society dementia support workers to support patients from the point of diagnosis. The mental health hospital liaison service has no upper age limit and will offer support to older people during an inpatient stay.

### **Community Dementia Outreach Team**

The dementia outreach service provides support to care homes for patients with dementia and offers older people experiencing a mental health crisis the opportunity to receive intensive care in the community as an alternative to an admission to hospital.

### **24 Hour Mental Health Liaison and Crisis Intervention**

A 24 hour hospital mental health liaison service has been commissioned by the CCG which will work very closely with the community crisis intervention team to better support people in crisis over the age of 16 in the community and in A&E. The new service is due to start in May 2014.

### **Street Triage**

A two year Street Triage pilot commenced in April 2014 and is jointly funded service with Nottinghamshire Police, Nottinghamshire Healthcare Trust and Bassetlaw CCG. This early intervention model supports mental health service users in a more appropriate place in the community, rather than at hospital or in a police custody suite. The street triage team is a mental health nurse and a police officer who will attend situations at street level involving mental health

issues. An assessment will be done by the team prior to a decision to detain a person under the Mental Health Act. The service will improve the mental health awareness and management of people with mental health conditions that are frequently in the criminal justice system.

## 5. Our Vision of the Future

### **Bassetlaw – A Community of Care and Support**

Our vision was co-created by local clinical leaders and local managers from both health and social care.

During the next few years local people can expect:

- Better care for our frail and the elderly population.
- More and better care provided locally.
- A high quality local Hospital with 7 day working, easy access, and essential services, such as 24 hour Emergency Department, and consultant-led maternity unit.
- Same day GP led care, with access to the right health care professional.
- More support for independent living with enhanced sheltered housing choices.
- Patients with a mental health condition to receive improved care through teams, professionals and services working more closely together.
- Care homes to be an integral part of our local community.
- Our local organisation to take joint responsibility for improving care and support.
- Integrated delivery of care and support through team working.
- Organisations to work across boundaries.
- Professions to work together in teams with our patients at the centre of their care.
- Organisations to openly share and pool resources where it will benefit the patient.

To do all of this we will need to:

- Increase our 7 day services in hospital, the community and Primary Care and in Hospital
- Continue with our clinically-led philosophy.
- Retain our relentless focus on quality, safety and patient experience.

### **Bassetlaw Integrated Care Board**

The Bassetlaw Integrated Care Board was established in 2013. It is through the establishment of this Board that local organisations have committed to work together and take joint responsibility for the improvement of care and support for local people. Together we have developed our 5 strategic priorities for Bassetlaw for the next 5 years.

The Board membership includes management and clinical representations from the following organisations:

- NHS Bassetlaw CCG (Board Chair)
- Doncaster & Bassetlaw Hospitals NHS Foundation Trust (Acute Care)
- Nottinghamshire Healthcare NHS Trust ( Mental Health and Vulnerable Adults)
- Bassetlaw Health Partnerships (Community Care).
- NHS England (commissioner of our primary care and specialised services).
- Nottinghamshire County Council (Social Care)..
- Bassetlaw District Council.
- GP's on behalf of general practice (Primary Care).

Our Integrated Care Board has developed this vision, and will oversee its delivery. The shared values of this Board are:

- Trust each other.
- Collaborate for the patient and service user.
- Be transparent
- Share resources
- Invest our time.
- Talk to local people and our staff.
- Build long term solutions.
- Quality and safety come first
- Our community is more important than any one organisation
- Share skills
- Provide leadership
- Encourage people to innovate.



Integrated Care Board

It is through these values that we plan to work together to improve the following outcomes for local people;

- Improved access to services for people with urgent problems, including clear information and alternatives to face to face appointment where appropriate.
- Improved community services built around the primary care team and caring for more people in their own homes.
- Improved care home quality, more clinical input, co-ordinated care and transparency.
- Improved access to mental health services focusing on urgent problems, vulnerable patients and integration with primary health care teams.
- Improved discharge processes focusing on early senior review, access to alternative services and appropriate care planning.

The governance arrangements of the Board promote the principle of 'joint responsibility' with each individual organisation leading one of the five strategic programs.

New governance arrangements will be developed to ensure all of the joint working arrangements are both robust and transparent. This will include:

- Shared system leadership group overseeing implementation of the improvement interventions is achieved through our Integrated Care Board.
- Individual organisations leading on specific projects
- Agreed program management
- Financial framework and principles to share resources and incentivise change, and share and manage financial risk.

To support this, a Memorandum of Agreement is in place. Additionally, principles to guide the sharing of financial resources are under development, as is the increase of dedicated program management capacity to support the work being taken forward.

The Integrated Care Board is also our local governance mechanism for the development of the Better Care Fund (BCF) and its deployment on local services. Further information on the BCF is provided in the Section Delivering Value.

### **Urgent Care Board**

Our Urgent Care Board is a working group of local partner organisations that meets on a regular basis to review our overall health and social care system. Its role is to improve urgent access to services, and to ensure that standards are maintained, and to encourage all commissioners and providers to collaborate for the benefit of any patient that has an urgent care need.

## 6. Plan on a Page

### Bassetlaw – A Community of Care and Support

OUR VISION Better care for the frail & elderly, More & better care & support at home and in places nearby, A high quality local Hospital with 7 day working, easy access, and essential services like a 24 hour Emergency Department, and consultant-led maternity unit, Same day local care, with access to the right health care professional, More support for independent living with enhanced sheltered housing choices, Patients with a mental health condition to receive an excellent service, Care homes to be an integral part of our local community.			
	GOALS	PROJECTS	
Reduction in potential years of life lost (PYLL) from causes to health care.	<b>Urgent Care</b> <ul style="list-style-type: none"> <li>Improved model of same day care in Retford and Worksop.</li> <li>Improved model of same day care for villages.</li> <li>Improved care out of hours.</li> </ul>	<ul style="list-style-type: none"> <li>Increased capacity in primary urgent services.</li> <li>Joint working to sustain A&amp;E service.</li> <li>Review of out of hours model.</li> </ul>	<b>Delivering Transformational Service Models</b> <ul style="list-style-type: none"> <li>Developing joint responsibility for care and support</li> <li>Integrated delivery around the person.</li> <li>Organisations working across boundaries.</li> <li>Professions working together in teams.</li> <li>Resources openly shared and pooled.</li> </ul> Underpinned by: <ul style="list-style-type: none"> <li>Increase in 7 day services in Community and Primary Care and in Hospital</li> <li>Clinically-led philosophy.</li> <li>Relentless focus on quality, safety and patient experience.</li> </ul>
Health-related quality of life for people with long-term conditions.	<b>Care for Elderly in community</b> <ul style="list-style-type: none"> <li>Improved intermediate care.</li> <li>New model of community based geriatric care (inc. Care Homes).</li> <li>Primary Care Teams co-ordinating person centred care.</li> </ul>	<ul style="list-style-type: none"> <li>Primary care integrated led team-working.</li> <li>Developing community geriatric service.</li> <li>Identification and care planning for most vulnerable. Responsible lead clinician</li> <li>Improved communications and records sharing.</li> <li>Improved access to intermediate care services.</li> <li>Telehealth wider use of assistive technology</li> </ul>	<b>Planned Outcomes</b> <ul style="list-style-type: none"> <li>Improved access to services for people with urgent problems, including clear information and alternatives to face to face appointment where appropriate.</li> <li>Improved community services built around the primary care team and caring for more people in their own homes.</li> <li>Improved care home quality, more clinical input, co-ordinated care and transparency.</li> <li>Improved access to mental health services focusing on urgent problems, vulnerable patients and integration with primary healthcare teams.</li> <li>Improved discharge processes focusing on early senior review, access to alternative services and appropriate care planning.</li> </ul>
Composite measure on emergency admissions.	<b>Care Homes</b> <ul style="list-style-type: none"> <li>New enhanced range of accommodation for older people.</li> <li>Quality assurance framework across nursing and residential sector.</li> <li>Alternative short-term service in care home setting.</li> <li>New support living arrangements shared links and respite.</li> </ul>	<ul style="list-style-type: none"> <li>Develop a care home quality dashboard/transparent quality assurance.</li> <li>Care plans for patients with medical input.</li> <li>Pharmacy and community service input.</li> <li>Enhanced dementia nurse specialist access.</li> <li>Develop alternatives to care homes where appropriate</li> </ul>	<b>Shared Values</b> <ul style="list-style-type: none"> <li>Trust each other</li> <li>Collaborate for the patient and service user.</li> <li>Be transparent</li> <li>Share resources</li> <li>Invest our time.</li> <li>Talk to local people and our staff.</li> <li>Build long term solutions.</li> <li>Quality and safety come first.</li> <li>Our community is more important than any one organisation.</li> <li>Share skills Provide leadership</li> <li>Encourage people to innovate.</li> </ul>
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation	<b>Mental Health Services.</b> <ul style="list-style-type: none"> <li>Improved link between physical and mental health services.</li> <li>Increase emphasis on prevention and early intervention</li> <li>Increased integration with primary care teams.</li> </ul>	<ul style="list-style-type: none"> <li>24 hour access to mental health services in A&amp;E.</li> <li>Identification and care plans for frequent users and vulnerable patients.</li> <li>Integration and record sharing with primary care.</li> <li>Improve focus with mental health problems and increased physical illness risk.</li> </ul>	<b>Overseen through the following governance arrangements</b> <ul style="list-style-type: none"> <li>Shared system leadership group overseeing implementation of the improvement interventions is achieved through our Integrated Care Board</li> <li>Individual organisations leading on specific projects</li> <li>Agreed program management</li> <li>Financial framework and principles under development.</li> </ul>
Patient experience of hospital care.	<b>Supporting People after acute illness.</b> <ul style="list-style-type: none"> <li>Independence &amp; Re-ablement unit</li> <li>Re-ablement pathways</li> <li>Community based assessment</li> </ul>	<ul style="list-style-type: none"> <li>Enhanced early senior review and discharge planning with early involvement of patients and social care team.</li> <li>Improved access to intermediate care and alternatives to acute hospital beds.</li> <li>Communication around delayed discharges and identification of barriers.</li> <li>Discharge to assess model.</li> <li>Care plans for vulnerable patients and clearer community input to ATC and A&amp;E.</li> </ul>	
Composite indicator comprised if i) GP Services ii) GP Out of Hours			
Hospital deaths attributable to problems in care.			

## 7. Our Strategic Programs

To deliver on our vision we believe we need to focus on five specific areas of health and social care in Bassetlaw. The five Strategic Programs outlined in our plan on a page are listed below:

- **Supporting People after Acute Illness** – Helping people to become independent after leaving hospital, providing more re-ablement and rehabilitation support at home and in the community.
- **Care for the elderly** - Improving the pathway of care and integrating local services for people aged over 65.
- **Care Homes** – Health and social care working together to improve the quality of care and standards and in care homes across Bassetlaw.
- **Mental Health** – Improving links and integration between physical health and mental health services with an increased emphasis on prevention and earlier intervention and less reliance on hospital / acute based mental healthcare.
- **Urgent Same Day Care** - Providing equitable same day 24 hour urgent care services in Bassetlaw based on local population need and including the GP out of hours service.

Our work to date has also involved developing a phased investment plan. This is summarised below:

Program	Project	Recurrent Investment	Value £k
Urgent Care	Primary Care/OOH	Years 1 – 2	430
	Hospital 7 day working	Year 1	1,450
	1,880		
Care for the Elderly	Primary Care	Year 1	560
	Geriatrician	Year 2	100
	Community 7 day	Year 1	450
	Social 7 day	Year 1	200
	Telehealth	Years 1 – 2	300
	1,610		
Care Homes	Quality Assurance	Year 1	250
	Dementia	Year 2	100
	350		
Mental Health	24 hour access	Year 1	390
	Complex Patients	Year 2	150
	Inpatient services	Year 3	500
	1,040		
Independence & Re-ablement	Discharge to assessment	Year 1	500
	Re-ablement	Year 2	500
	1,000		

This table provides a basis of assurance that our proposed recurrent investment is proportionate, affordable, and balanced.

## **Further detail and scope of the 5 strategic programmes is set out below**

### **Supporting people outside of hospital after an acute illness**

Patients that have been admitted to hospital with an acute illness sometimes stay in an acute bed longer than is necessary even though they no longer need consultant-led acute care. There are various reasons why this can happen for example, a patient may have complex or specialist needs for support outside of hospital, or they may be waiting for a social care assessment, for special equipment needed at home, or waiting for a chosen nursing home bed to become available. Patients occupying beds they no longer clinically need is costly to the NHS and causes wider bed capacity problems in the hospital. The money spent on funding an acute bed could be used to support the patient elsewhere in the community such as a short term stay at a nursing home or assessment facility or supported with nursing care and/ or social care at home.

To reduce unnecessary lengths of stay in hospital the discharge and ongoing care planning needs to be well coordinated and planned with the staff that are involved in the patients care. Getting this process right and the pathways in place ensures patients are discharged in a timely way and a smooth transfer to the next phase of their care or to home. It also reduces unnecessary readmissions to hospital.

Through the Integrated Care Board we are currently working with Doncaster and Bassetlaw Hospitals and our other health and social care partners to improve the discharge process from hospital and developing new re-ablement and independence pathways. When a patient no longer requires acute care in hospital they will be discharged to their next clinically appropriate place of care. An expected date of discharge will be planned for all patients at the point of admission to hospital and a care plan will be agreed during their stay. There will be a single point of discharge assessment led by a multi-disciplinary team of professionals from acute, community services and social care. We will also develop a discharge to assess pathway which will transfer patients requiring social care to a separate place for assessment.

Some patients, particularly the frail elderly, require step down intermediate care where they receive nurse-led re-ablement and/or rehabilitation and social care support for up to of six weeks which is currently provided in nursing homes across Bassetlaw. In 2015/16 we will develop a dedicated Independence and Re-ablement Unit (IRU) which will provide multi professional, GP and nurse step down care and social care support. It will also provide step up care for GPs to admit patients to for earlier nurse led intervention if their condition is deteriorating, rather than admitting them later to hospital.

Communication between the hospital, primary care and community services will also be improved to ensure that the patients care plan is shared with the primary care team and that care is coordinated and centred on the patient's ongoing needs

#### **Summary of the key priorities for this strategic programme:**

- Develop multi-agency, single point for assessment and access led care tailored to patients and individual needs.
- Develop an information pack for patients and families regarding the discharge planning from acute care

- Developing local NHS services to provide more independence and re-ablement
- Increasing voluntary sector patient support post discharge.
- Implementing and sustaining new and best practice discharge practices.
- Establish the required community nursing and therapy and social care support.
- Develop new models of community care for frail elderly patients (jointly with the strategic programme Care of the Elderly).
- Work with primary care GP led risk stratification and the MDT meetings to proactively manage the care of individual frail and elderly patients with specialist geriatrician and community geriatric input.
- Integrate community nursing teams and social care teams with the new discharge, re-ablement and independence pathways.
- Promoting independence and re-ablement to patients and families, through the development of a dedicated Independence and Re-ablement Unit in Bassetlaw.

*A local patient was interviewed whilst on a Bassetlaw Hospital ward*

*“I have been on the ward for 3 weeks and the staff all work very hard and when I press my buzzer they always come straight away. I am going home on Monday and everything is planned and ready for me. The ward is nice and clean”*

## Care of the Frail and Elderly in the Community

We are committed to integrating health services where it will improve patient outcomes to do so. National evidence has demonstrated that integration of care and services can improve the early identification and management of long term conditions, support self-care and facilitate proactive identification of patients at risk of becoming ill and needing admission to hospital. Community services in Bassetlaw are currently not integrated with primary care and as such this fragmented approach can result in patients experiencing hand offs through their pathway from one professional to another and delays in accessing the right professional at the right time.

We are working with our community services provider Bassetlaw Health Partnership to develop a community integrated care model that works seven days a week to effectively manage the health and social care needs of frail elderly people in Bassetlaw. This will see the introduction of primary care teams where community services (community matrons, district nurses and therapists) mental health professionals, palliative care specialists and social workers will work closely with GPs as a multi-disciplinary team providing coordinated care for patients. In addition we will also develop a seven day virtual ward model of community care for patients with more complex needs. This proactive coordinated way of working will put the patient and their family at the centre of their care, promoting self-care and improve patient outcomes. It will also facilitate quicker discharge from hospital and because patients will be proactively case managed will avoid unnecessary hospital readmissions.

A Bassetlaw community geriatrician model of care is also being developed with DBHFT which will provide consultant led geriatric care in the community in addition to acute geriatric care in Bassetlaw Hospital. This service which will be part of the virtual ward model will undertake comprehensive geriatric assessments in the community and will provide advice and support to GPs and community services managing the care for older people.

The use of telehealth and telecoaching in Bassetlaw during the last year for people with long term conditions has evaluated well and patient feedback has been very positive. The technology helps patients to understand and manage their condition better. They learn how to detect changes in the observations taken on a daily basis (such as blood pressure or weight) which could mean that their condition is deteriorating. This earlier detection enables patients to get help sooner to stabilise their condition. This improved self-management and awareness means patients require fewer GP visits and hospital admissions. During 2014/15 we will expand the use of telehealth across all practices offering it to more patients with long term conditions.

### **Summary of the key priorities for this strategic programme:**

- Develop a community virtual ward model establishing the benefit to patients in terms of improved outcomes and experience
- Reconfiguration of Bassetlaw community services into integrated primary care teams/virtual ward aligned with primary care providers, incorporating social care and mental health, incorporating a proactive case finding approach
- Review and redesign of intermediate care, reablement and rapid response services to improve access and maximise efficiency – (this will also be a key part of the supporting people after acute illness priority )

- Case management and co-ordinated care utilising the expertise of hospital outreach such as a Community Consultant Geriatrician, Consultant in Palliative Care and Mental Health Teams
- Timely supported transfer from hospital and post hospital transfer of care follow-up
- Enhance the 'Recovery Model' to all patients with Long Term Conditions so that they may improve/maintain their quality of life
- Improved access to palliative and end of life care
- Increased use of telehealth to support self-care and recovery
- Increased use of and improved co-ordination and access to support from voluntary sector services

*A patient from Worksop, who had a heart attack last year, has a telehealth monitoring device in his home. The device allows the patient to control his illness by having a community nurse monitor his condition remotely by sending health information from the device back to the nurse, allowing the condition to be proactively managing his symptoms preventing his condition from becoming worse.*

*"Having the telehealth device at home has increased my confidence as it had taken a big knock after the heart attack. It asks me questions about my health and wellbeing and takes my blood pressure and weight so it is just like going to the doctors, only it's a lot easier and I can do it at my own pace. I can understand and manage my condition, it's great, I wouldn't like to be without it now!"*

## Improving the Quality of Care Homes

During the last year we have been working with Nottinghamshire County Council to develop a local understanding of the care home provision for older people across Bassetlaw. This information has now been incorporated into a strategic care home review for Nottinghamshire which has identified the key areas of development for care home provision for the next five years. It includes detail on how local provision needs to adapt to accommodate the changing health and social care needs of the Bassetlaw population.

The vision is to develop and implement an accommodation strategy for older people in Bassetlaw. The Strategy will plan for future residential and nursing home capacity and will develop care support into extra care /sheltered accommodation enhancing independence and re-ablement and improve the experience and quality of life of people in residential care.

A key focus is on quality of care, ensuring quality standards in care homes are met and developed through partnership working with local providers. This will ensure people are safeguarded against significant harm whilst enabling people to live with risk in order to lead an independent and fulfilled life with as much choice as possible.

We will support this by working with our partners on the Integrated Care Board, developing and embedding leadership into the care home sector by identifying work force issues and proactively developing a work force strategy to address gaps and sustain a competent and effective workforce that can deliver specialist nursing and dementia care with an increase in local care home providers obtaining the dementia quality mark. There will also be a more personalised approach to the care of individuals.

### **Summary of the key priorities for this strategic programme:**

- Develop a range and choice of accommodation for older people across Bassetlaw.
- Develop an older persons accommodation strategy jointly with partners e.g. the District Council, housing providers.
- Ensure sufficient capacity for nursing and residential care to meet the growing demand for nursing and dementia care.
- Provide alternative short-term services in care home settings to maximise people's independence including care support: supported living, Shared Lives and respite care.
- Implement a care home quality dashboard/transparent quality assurance process across Nottinghamshire County Council and Bassetlaw CCG to improve standards of care and experience for service users.
- Establish links between care home providers, primary care, social care, community and acute care.

All care homes have a workforce development plan including accredited training.

## Urgent Same Day Care

We have made real improvements to our urgent care services in the last two years, including the introduction of the Assessment and Treatment Centre and improved staffing within the A&E department at Bassetlaw Hospital. We work closely with other commissioners and providers through our Urgent Care Board and have identified areas where we can deliver improvements together. We aim to build upon our delivery of seven day services for patients, focusing on unplanned care to ensure patients have better access but also better quality. We will simplify access wherever possible, improving consistency and education around services for urgent care in Bassetlaw.

### Urgent Same Day GP Led Care

We recognise the importance of improving access for primary care urgent patients (minor illness and minor injury), access to rapid access to community services and the need to deliver robust ambulance and nursing home services. All Bassetlaw GP practices offer on the day GP and nurse appointments for urgent problems and during the next year we will work closely with practices to improve access to same day primary care. Different approaches are required across our practices as the needs of the patients in different areas of Bassetlaw will define the appropriate same day appointment model and the necessary pathways for each practice. Practices already provide different ways for patients to be seen or given advice, for example some have implemented, walk in services; telephone triage / GP telephone consultation; remote care using a video platform, (similar to Skype) and email for clinical advice.

A number of practices are developing the role of urgent care nurse practitioners and increasing the numbers of nurse prescribers to treat patients with minor illness/ injury and we will share good practice and learning across Bassetlaw. We also want to encourage patients to responsibly manage their minor illness themselves where possible and we will continue to provide information for patients about how to manage common ailments. We will also be working with local pharmacists to develop ways they can provide help and advice to patients. NHS 111 is also a resource available for patients to get advice from and signposting to services at any time of the day. A review of the GP out of hours service will be undertaken in 2014/15 by the CCG to look at how we can improve the service for our patients. Any changes will be made during 2014/15 and will be in line with any national guidance that is mandated about the model for GP out of hours care.

In 2015/16 we will work with our GP practices to explore the feasibility of a GP led urgent care centre co located at Bassetlaw A&E. Many patients attend A&E for advice about a primary care illness or condition. Patients in A&E that clinically do not need to be take up valuable resources in a busy A&E department and cost the NHS a significant amount of money that could be invested elsewhere. The new service being considered would stream the minor illness patients using agreed clinical pathways into the urgent care centre where they would be seen by a nurse or a GP or another professional such as social care worker or a pharmacist.

### Summary of the key priorities for this strategic programme:

- Improve access to same day primary care – Practice specific led improvements to increase GP and Nurse led appointments and develop equitable and sustainable ways of managing urgent care in Bassetlaw

- Review of seven day primary care options including the out of hours service with proposals for change
- Options appraisal for a GP led Urgent Care Centre co located with A&E at Bassetlaw Hospital

A local resident gave feedback whilst accessing A&E

*“The Triage nurse was very professional and approachable in A&E”*

### **NHS 111 Service**

The data and intelligence provided by NHS 111 and East Midlands Ambulance Service about how Bassetlaw patients are using the service helps us to better understand capacity and pathway issues in our out of hours service and in the wider urgent care system locally. The NHS 111 service which was implemented in Bassetlaw last year has been successful and the CCG and its members continue to support the service. However, it is important that the service consistently performs its core functions such as call back times within 10 minutes before any expansion of the service’s role and functions. To this end our local South Yorkshire and Bassetlaw clinical governance and monitoring systems enable a continual dialogue between NHS 111, the CCG and providers.

We will conduct a review of our GP out of hours services in 2014/15. The future model will comply with the national requirements for out of hour GP services and we will include intelligence gathered from the ambulance and NHS 111 services.

We are encouraging closer partnership working between NHS 111, GP out of hours, secondary care, community services and GP primary care. An example of partnership working to benefit patient care and improve outcomes is the GP admissions avoidance enhanced service which is driving closer working and integration between primary care and other partner services.

## Mental Health

### **Therapy, Treatment and Rehabilitation.**

We plan to review our overall balance of provision, and will then develop improved pathways and models of care for the future. To assist us in assessing our current services we may commission external expertise to produce analysis and opinion.

### **Developing Parity of Esteem**

The CCG is working towards the national 'parity of esteem' call to action requirements. Parity of esteem requires health services to consider the mental health of patients as much as the physical health needs of patients. We need to consider how a patient's mental health can be supported across all care pathways and this particularly relevant for patients with a long term condition where evidence shows that a patient's mental health can suffer as a result of living with a long term condition.

Through the next five years we will improve access across all mental health provision and develop a single point of access to all mental health teams including telephone support. Mental Health teams will be integrated with primary care to ensure that patients treatment support plans are consistently delivered working closely with GPs and primary care colleagues. This will ensure that patients are moved through services using the right care option for a patient's needs. All patients will have a clear recovery plan that will be shared with all relevant care professionals for the individual.

### **Crisis Care Concordat**

This concordat sets out the requirement for CCGs to have local mental health crisis care declarations. Working with our local emergency services partners we will offer streamlined support to individuals across all emergency services. We have recently developed a 24 hour mental health hospital liaison service that will be based in A&E and a street triage service that will operate across Nottinghamshire County offering support to police officers and a community psychiatric nurse attending to patients with a mental illness. We are developing a more therapeutic community mental health service in line with the recommendations of the closing the gap strategy and will offer a more preventative approach to mental health care with more support for families and carers of people with a mental illness.

### **Closing the Gap – Priorities for Essential Change in Mental Health**

The CCG has benchmarked itself against the 25 priorities outlined in the 2013 Closing the Gap national strategy. We have identified the need to offer more choice to patients and improve access. We will develop services that will offer earlier intervention with a focus on crisis prevention in line with recommendations in the Concordat. The CCG is working closely with all providers to improve care during transition from children's services to adult services. We will gather more patient experience information and ensure that the friends and family test is rolled out to all mental health services to help influence service change locally. We are working with wider Nottinghamshire CCGs and Notts Healthcare Trust to develop new payment mechanisms to ensure that services receive fair funding to continually improve and develop. The CCG will support partner organisations to raise awareness of mental health across workplaces, health and social care and educational settings.

## **Children's and Adolescent Mental Health Services (CAMHS)**

The mental health of children is recognised as a key issue nationally. The current service model in Nottinghamshire is being reviewed across all areas of care from lower level care to children's mental health inpatient services. A strategy is being developed and the CCG is working with adult mental health services to ensure that transition is improved.

### **Summary of the key priorities of this strategic programme:**

- Review the overall balance of therapy, treatment and rehabilitation.
- Develop parity of esteem.
- Streamline support across all emergency services.
- Offer local patients more choice.
- Sustain services for children and adolescents.

A local patient gave feedback after accessing local services

*"Feeling like I was valued by the whole team. I cannot thank them enough. All my needs were understood. The care and understanding of the crisis team were wonderful"*

## 8. How we have engaged local people about our vision



Mrs Sam Senior  
Lay Member, Patient &  
Public Engagement

Bassetlaw CCG has an excellent reputation for engagement with stakeholders and we are keen to build on our strong relationships to ensure that our five year plan is based on the views of patients and the public. However, we are also keen to ensure that engagement is an ongoing process and not a one off exercise. We have therefore set out three principles which underpin our approach:

- We will use the views of patients and the public to shape what we do, not to tick a box.
- We will use existing information from patients and the public instead of repeating the same questions.
- We will develop a range of mechanisms for giving views making sure that we receive feedback on an ongoing basis as well as specific events/initiatives

### Our Approach

The CCG has undertaken a mapping exercise to collate the patient and public feedback received by the CCG and our partner organisations over the past year. This included service providers, voluntary sector and regulators. We have reviewed all this information and summarised feedback which relates to the 5 strategic priorities. We are now using this information to develop a framework of engagement priorities by setting out the specific areas in which more feedback would be useful. These engagement priorities will be used to:

- Develop a programme of events for each programme area.
- Provide staff and members with a set of questions which can be used opportunistically when meeting with patients and members of the public
- Link to relevant national and local events/campaigns
- Set out topics for rolling programme of engagement with the media

### Engaging with Members

The CCG is a membership organisation and input from our clinical members is key to ensuring that we focus on the right things. We will use a variety of mechanisms to obtain the views of our members including:

- Members Forum
- BEST focusing on priority areas and plans
- Practice Managers / Feedback from practices
- Rolling programme of visits to practices.

### Engaging with Stakeholders

We have recently undertaken a stakeholder survey to ensure that the CCG is still perceived as a organisation which is easy to engage with. The results of this were very positive so we are continuing to develop with the forums we have already established for meeting with our partner organisations and to use them as a place for two –way conversations about our plans. They will also provide an opportunity to identify how we integrate feedback that our stakeholders receive through their own

engagement work into our plans and to share key messages that we would like disseminated. These forums are:

- Bassetlaw Integrated Care Board
- Big Breakfast (BCVS)
- Meetings with Bassetlaw District Council
- CCG Partnership Advisory Forum
- Member Practice Patient Participation Groups
- South Yorkshire Commissioning Collaborative (SYCOM)
- Nottinghamshire Health and Wellbeing Board
- Working Voices
- Bassetlaw Nursing Home Forum
- Bassetlaw Youth Council
- Bassetlaw Schools
- Nottinghamshire HealthWatch

We will also continue to utilise feedback that we receive through the Call to Action Programme.

Additionally we will continue to utilise both traditional and new media to keep our stakeholders up to date and to encourage feedback. For example we will:

- Maintain a rolling programme of articles in local newspapers
- Ensure our website is kept up to date and include monthly updates on priority areas
- Use Twitter/Facebook to give updates on priority areas

#### **Ongoing engagement (this is what we do).**

The Patient Engagement Committee is a key part of the CCG Governance structure with responsibility for ensuring that the all the decisions of the CCG are informed by the views of patients and the public. The Committee reviews plans for service development and gives assurance to the Governing Body that there has been sufficient patient and public engagement in their development.



All CCG Staff will have responsibility for increasing the level of patient and public engagement and individualised objectives for this will be set out in their appraisal plans.

The CCG will ensure that it feeds back to stakeholders on what it has done as a result of the feedback it receives. This will be an overarching principle for communication rather than a one-off exercise relating to specific projects.

At the Governing Body meetings the Lay Members will present a “What we’ve heard” paper which outlines the key messages received from patient and members of the public. This will ensure that the Officers remain focused on need to obtain feedback on an ongoing basis as well as keeping the Governing Body up to date with key issues of interest to patients and the public.

The CCG will continue to collate and log feedback received by the CCG and our partner organisations. This will allow the CCG to keep up to date with feedback and ensure that we do not ask the same questions more than once. A monthly digest of new feedback can be included in the “You Said, We Did” report.

Our [patient feedback](#) is outlined on our website.

### **Engaging to support the delivery of our strategic programs.**

It is our intention to engage local people in an ongoing conversation about the changes to services that we propose. Learning from our previous engagement exercises suggests that thematic and ongoing engagement with partners such as the local voluntary sector is the most effective. Each program lead will be developing an engagement proposition as part of their overall delivery plan. We will test these with Healthwatch and the CCG Patient Engagement Committee before we move to implementation.

### **What local people have said to us.**

Our overwhelming conclusion is that local people agree with our strategic priorities. They want high quality general practice and a high quality hospital. They also want NHS and social care professionals to work together for the benefit of patients. We will keep listening, and keep acting on what people tell us, this is what clinical commissioning is all about.

## 9. Meeting Nationally Determined Outcomes.

NHS England has challenged all CCG's to improve seven outcomes that were determined at a national level. These are:

- Reduction in potential years of life lost (PYLL) from causes to health care.
- Health-related quality of life for people with long-term conditions.
- Composite measure on emergency admissions.
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services.
- Patient experience of hospital care
- Composite indicator comprised of i) GP Services ii) GP Out of Hours.
- Hospital deaths attributable to problems in care.

We have developed a local level of ambition to improve these outcomes.

We have also considered these in the context of our 5 strategic programmes and we are confident that they are aligned.

For example the ambition to improve quality of life for patients with a long-term condition, and our ambition to reduce emergency admissions to Hospital will both be addressed by our focus on care in the community, and same day care. Equally, our ambition to improve patient experience outside of Hospital will be enhanced by our focus on urgent care and supporting people after acute illness. We are also confident that our ambition to reduce deaths in Hospital attributable to problems in care will be delivered through our focus on Care Homes, and our Mental Health programme.

## 10. The NHS Constitution and Our Pledge.

The CCG has pledged to meet all of the standards that have been set out in the NHS Constitution. These are a range of targets and standards, they include:

- Referral to treatment waiting times.
- Diagnostic test waiting times.
- A&E waits
- Cancer waits – 2 week, 31 days and 62 days standards.
- Ambulance response times.
- Mixed sex accommodation
- Cancelled operations
- Mental illness follow-up times.

Additionally, there are a range of quality and safety standards which are referenced in section 12 of this strategy.

It is the intention of the CCG to continue to have a relentless focus on service quality, patient experience and outcomes. We believe that this approach allied with our clinical insight will enable us to continue to meet our pledges to local people.

## **11. Supporting Improvements in Quality.**

### **Developing Primary Care**

The CCG recognises the importance of primary care in delivering its outcomes and improving services for patients. We are working closely with our members and local patients to improve quality, commission enhanced services where appropriate and we have an active relationship with NHS England supported by a memorandum of understanding to ensure primary care commissioning is effective and locally responsive.

The introduction of named clinicians for vulnerable patients offers an opportunity to redevelop primary care teams, built around the patient's needs and with enhanced cooperation, communication and coordination between the patient's GP and community services. We will aim to deliver improvements seven days a week, including out of hours' services.

Risk stratification and care planning with a named accountable clinician is supported by the CCG and its membership which will help to reduce emergency admissions and improve proactive health and social care planning around a patient's needs. All practices hold regular multi-disciplinary team meetings with their community nursing teams to discuss the ongoing care of patients with long term conditions who are at risk of hospital admission. We will develop this collaborative team working into integrated primary care teams and a virtual ward community services model during the next year.

We have agreed protocols to securely share patient records (with patients consent) with our community services and we will working towards record sharing with other health professionals where it benefits patients to do so and enables clinicians to provide the best services possible.

The CCG recognises its important role in education, and continues to deliver regular primary care education sessions, membership events and events for the wider system including community teams and nursing home colleagues.

It is our intention to co-commission primary care services with NHS England. This will involve the CCG requesting delegated authority to commission some services (for example enhanced services) whilst requesting greater influence over the future commissioning decisions made by NHS England in some other areas.

We plan to continue to collaborate with other CCG's in South Yorkshire to develop a consistent approach so that our co-commissioning of primary care is transparent and benefits from a joint approach where it is in the interest of local patients for us to do so.

The NHS England plans for commissioning Primary Care are set out in Appendix 8.

### **GP Prescribing**

Prescribing is an important indicator of quality and efficiency for the CCG and primary care. GP prescribing has improved significantly over the last two years and we aim to continue these improvements through regular education, quality and cost reporting.

We are introducing pharmacy support into practices and have agreed a work programme for 2014/15 which will support our aims to improve outcomes, improve efficiency and reduce health

care acquired infections through effective antibiotic prescribing. A key indicator will be the reduction of antipsychotic prescribing in patients with dementia. Our prescribing programme will involve significant collaboration with local providers, including mental health teams, to ensure consistency for patients and to gain specialist insight.

## **Continuing Healthcare**

Continuing Healthcare (CHC) is a way of funding care for individuals with some of the most complex needs in our community. The CCG has a statutory obligation to fund care outside of hospital for individuals who are assessed as having ongoing healthcare needs. This funding is used to support people to live at home with a care package or to fund care in other residential settings. Continuing Healthcare operates within a national framework for eligibility and is used to support both children and adults.

Linked to this and to the national objective of increased personalisation of care, personal health budgets are being introduced as an option for patients in receipt of continuing healthcare from April 2014. This funding could then be allocated directly to the individual, based upon a detailed support plan, which shows how the money would meet health and wellbeing objectives. There have been pilot schemes across the country and feedback from these suggest that people with the most complex needs get the most benefit from having a personal health budget and there is much psychological and emotional benefit from having increased choice and control. We are working closely with the Local Authority to ensure that our systems and processes around personal health budgets are robust and do support choice and achieve the planned health outcomes for our clients.

We will work closely with care services that provide NHS care packages for CHC to seek enhanced assurances around quality of care. In addition commissioned services that provide assessment and support to CHC decision making panels will be subject to enhanced assurance requirements through the contract. Our partnership approach to quality reviews and monitoring with the Local Authority will continue.

## **Specialised Services**

When local people require specialised hospital care (such as bariatric surgery or organ transplants) it is commissioned for them by NHS England. The quality of the services provided is determined through a national process of 'derogation'. This requires hospital providers to meet national minimum standards. Meeting these standards may require hospitals to work together, or may require services to change or move.

We will work in collaboration with other local commissioners to ensure that the interests of the people of Bassetlaw are at the forefront of any discussion about changes to services.

The NHS England plans to commission Specialised Services are set out in Appendix 7.

## **Working Together**

In South Yorkshire the hospital providers are already working together to improve efficiency, and to sustain services, and to share the workforce. Additionally, the commissioners are also working together, and with the hospital providers to ensure that service quality can be sustained into the future. Therefore, it is proposed that a number of pathways and services are jointly assessed. These will include a number of small specialities, trauma, and paediatrics.

We will be an active participant in these discussions, and will act as an advocate for service quality, patient experience, and outcomes on behalf of local people.

## **Learning Disability**

National publicity around the failures of care at Winterbourne Hospital has demonstrated the importance of commissioning services that meet the needs of people with learning disability and autism and in particular those who present with challenging behaviour. Nationally there is a commitment that individuals with learning disability and autism in assessment and treatment units and secure hospitals will reduce both by the Winterbourne Concordat deadline of June 2014 and into the future. In order to achieve these aspirations the CCG will be working with its providers to review its community based support and ensure early intervention improves both in terms of responsiveness and outcomes for the individuals and families. We will do this whilst balancing safety and effectiveness with compassion.

The CQC and DH are developing fundamental standards which will apply to contracts to support good care and independence for individuals with learning disabilities and the CCG will ensure these are embedded and monitored.

Through our joint working with the Local Authority we will focus effort on joint plans to commission a range of health, housing and support. Through our CCG Learning disability register we will support improvements in primary care to deliver health assessments in a timely and comprehensive manner. We will support our GPs to deliver a quality annual health check to people with learning disability in order to offer proactive and preventative care.

The Special Educational Need and Disability programme has supported the development of partnerships between health and the local authority. As a CCG we have supported this integrated approach in order for integrated packages of care to be coordinated around the child.

## **Prevention, Health Promotion and Intervention**

Public Health Services and NHS England are the responsible commissioners for a number of services that include screening, children (0 – 5 years), and health visiting. Details relating to these responsibilities are set out in Appendix 6. It should be noted that these have a South Yorkshire emphasis, Bassetlaw links directly to the Nottinghamshire Health and Wellbeing Board and services are directly commissioned by Nottinghamshire County Council.

## 12. Quality of Care

The CCG works constructively with its partner CCGs, providers and with the Local Authority to secure continuous improvements in the safety and quality of services along integrated clinical pathways.

Whilst the CCG seeks assurance across a number of domains contractually, it actively engages with clinical staff, families and carers to triangulate data with experience.

Strategically the CCG positions itself to facilitate discussions across providers around the integration of care services and also the sustainability of small specialty teams.

The CCG has in place a Quality and Patient Safety Committee (sub-committee of the Governing Body), an incident management forum, a clinical governance forum supporting quality development within primary care with leads from each practice and an infection prevention and control committee to scrutinise root cause analysis.

In addition we are actively supporting quality development within nursing care homes through a practice development forum, IPC initiatives and tissue viability specialist input.

We are a small and responsive CCG who use contract and quality incentives to address issues of cardiac arrest data highlighting failure to detect deterioration of patients. We have commissioned a CQUIN to analyse and dive down into the reasons for these failures, with the provider incentivised to demonstrate concrete measures have been taken to prevent recurrence. We will engage the Academic Health Science Network in evaluating this work. Furthermore where CQUINS across organisations have not yielded the result required we are supporting the transparency agenda through the incentivising of data collection at ward, department and community team level in order to support focus and accountability.

Further development of quality and safety and assurances are gained through:

- Assurance that providers' cost improvement plans (CIPs) have robust quality impact assessments and can be delivered without compromising quality and safety. It is requisite that CIPs be signed off by providers' medical and nurse directors and provide a 'line of sight' to ensure the commissioner is aware of any risks to clinical safety resulting from the requirements to make efficiencies. We have extended this approach to ensure these impacts are discussed system wide within the Integrated Care Board to establish whole system impacts including the Local Authority.
- Monthly contract quality meetings with main providers where discussions include outcomes, experience, hospital mortality rates, providers Cost Improvement Plans, Commissioning for Quality and Innovation (CQUIN), Serious Incidents, patient safety agenda, Care Quality Commission inspections, audit, safeguarding, friends & family test (FFT), patient survey reports and staff surveys and staff FFT.
- The CCG has worked closely with DBHFT to develop a transparent culture which underpins mortality monitoring and reviews, as well as Serious Untoward Incident Reporting. The CCG are a member of the Trusts Review of Mortality and Clinical Governance Standards Committee. We have sought and received case note reviews of areas of mortality spikes.



Mrs Denise Nightingale  
Executive Lead for  
Quality & Safety (Chief  
Nurse)

We have also commissioned our own mortality analysis and driven case note reviews through this. Our view corresponds with the Keogh Review in that we see the priority as identifying areas of avoidable death and effecting change to address this. Mortality statistics are used as a way of helping us direct these reviews, but are not an end in themselves.

- Learning from mortality and SUIs has driven the commissioning agenda within the CCG to develop new models of service with subsequent improvements in outcomes, specifically this includes the development of the Assessment and Treatment Centre with senior decision makers operating 7 days and the change to the emergency surgery pathway resulting in many patients staying locally for acute but non-surgical management by Consultant Surgeons.
- Through whole system root cause analysis of Clostridium Difficile cases and management we have identified and agreed support to primary care in the monitoring of patients post infection and the escalation for advice should a relapse occur. This service will be provided by specialist IPC practitioners.
- In addition we support the zero tolerance of MRSA bacteraemia and have through a partnership with our acute trust screened and eliminated all MRSA from our nursing home population which by its very nature is high risk. Going forward we are to screen new entrants and high risk cases.
- Patient Experience is hugely important to us. With regards inpatient care we are currently 16<sup>th</sup> best of 210 CCG's in the Country (with regards primary care this improves further to 4<sup>th</sup> best). We will continue to drive this through a range of experience and engagement initiatives including measuring real time patient experience data and through supporting patients, their carers and staff to raise any concerns at the point of care, rather than waiting and making a complaint after the event. We have had success with initiatives such as involving carers in mealtimes and personal care (if they choose to be) and will continue to expand this approach, by for example ensuring better post-operative feedback to relatives and carers and an invitation to be present at ward rounds. "Safe and Well" checks have been introduced post discharge for some patients, and this will continue. Our community provider has established a system that includes Mencap and Aurora contacting patients, helping with advice and signposting as well as gauging satisfaction and learning where services can improve.
- We are funding and participating in developing support tools for care homes specifically a DVD tissue viability training tool and IPC accreditation tool and telehealth vital sign monitoring. We will track the impact of these developments through our nursing home barometer which we have developed in conjunction with the homes through a quality improvement framework.
- Clinical and Lay members of the CCG undertake quality visits not only into clinical areas but into other areas where governance is key, for example the complaints handling system and governance around reviews of pressure ulcer investigations.

With the increased emphasis on assurance driven by the Francis, Keogh, Berwick and Winterbourne reviews, the CCG has developed a look back approach to challenge whether the level of change across the system has been appropriate and what else could and should be done. In addition the CCG has been working closely with its providers to identify small isolated services and services

where workforce sustainability may be a challenge over the next five years. This will form part of our strategic plans at provider and specialty level moving forward.

The CCG is a member of the South Yorkshire and Bassetlaw Quality Surveillance Group which brings together all commissioners and regulators to co-ordinate their assurance. Where the CCG has concerns over assurance we gather further information and escalate concerns according to our Appreciative Inquiry Policy.

### **Quality Premium 2014/15 - Pressure Ulcers**

Our Local Quality Premium target for 2014/15 is as follows:

*'In 2014/15 reduce the incidence of category 3, 4, and un-gradable pressure ulcers acquired at Doncaster and Bassetlaw Hospitals by at least 10% vs 13/14 levels'.*

This Quality Premium is an outcome measure to support the pressure ulcer reduction strategies to be employed across the community and in particular at Doncaster and Bassetlaw Hospitals NHS Trust.

In 2012/13 a total of 157 patients acquired these high grade pressure ulcers whilst inpatients at Doncaster and Bassetlaw Hospitals. In the first 3 quarters of 13/14 this figure was 112, suggesting a slight drop, but we wish to accelerate progress. DBH have consistently accepted difficult CQUIN targets in this hugely important area and the CCG Governing Body feels we should do the same.

There has been a major investment in equipment and the provider will be measured on conducting rapid skin assessment and providing high quality pressure ulcer prevention equipment to all patients admitted through A&E. Part of the new system is simplicity and an assumption of high risk until otherwise known. Instead of having two types of pressure relieving mattress, with the patient risk assessed and triaged to one or the other, the provider will only use the better of the two in future.

### **Friends and Family Test**

We will roll out FFT within Community Services, Mental Health Services and GP/out of hours' services within national timescales, working closely with the SY&B Local Area Team. For the former 2 this is within contracting arrangements and we will wait for the national guidance and learning from the pilot sites before proceeding. This is particularly important for the methodology and patient cohort etc.

With our main acute provider we have already begun the agreed steps to improve participation rates in A&E and have started to work through issues within maternity FFT. Net promoter scores should be helped through the introduction of real time raising concerns processes which should deal with issues pro-actively rather than relying on post discharge feedback.

### **Role in GP Quality**

A Memorandum of Understanding between the CCG and NHS England sets out how the two organisations, will respect each other's responsibilities, share information and work together on Improving Quality in Primary Medical Services.

The CCG supports successful protected learning time events for general practitioners, practice nurses and practice managers to meet together in the practice manager forum. We also have a Primary Care Forum in which GP representatives of every member practice attend specifically as providers of care, not commissioners.

We have recently agreed that NHS England SY&B Area Team attend routinely the Clinical Governance Forum to share practice monitoring data openly with GP leads.

### **Safeguarding**

NHS Bassetlaw CCG has invested in safeguarding supporting the adult and children agendas within primary care with a Named Professional and in addition a Named Doctor post. A Safeguarding Consultant Nurse supporting the adult and children's agenda operates as Designated Nurse for the CCG. With regard to children and young people the CCG endorses its duty to safeguard and promote the welfare of children; ensure robust governance arrangements are in place and to be active members of the Nottinghamshire Safeguarding Children and Adults Board.

For looked after children (LAC) CCGs are to retain the Responsible Commissioner status for all Bassetlaw LAC. This responsibility includes providing looked after Children with regular planned health assessments, upon placement and an annual/bi-annual review thereafter; Although the LAC service is provided through our local community provider as is the Designated Nurse function, the quality and patient safety group within the CCG receive quarterly reports around this service and the children out of area.

The CCG has ensured training for its staff around PREVENT is completed and that training both for the CCG staff and primary care incorporates the child sexual exploitation issues.

## 13. Delivering Value

### Introduction

With allocations for Clinical Commissioning Groups (CCG's) primarily based on population size, Bassetlaw CCG is considered to be at the "smaller" end of the spectrum. The funding available to the CCG though is still a significant amount of money, with the recurrent allocation for the commissioning of healthcare for our population being £143.57m for 2014/15. This equates to around £1,268 for each person registered with a Bassetlaw GP. In addition, we receive an allocation to fund the running costs of the organisation, which in 2014/15 totals £2.74m.



Mr Alan Burbanks  
Chief Finance Officer



Mr John Bell  
Lay Member, Audit &  
Risk

By 2018/19 we anticipate that the healthcare component of our allocation will have risen to £156.14m, however our running cost allocation is likely to have reduced to £2.44m. In addition to our recurrent allocation, we are allowed to utilise (over time) the surplus made in prior years. We have, over the last year, built up this surplus to use over the duration of this Strategic Plan, in order to support the projects outlined earlier in this document that will transform aspects of healthcare within Bassetlaw.

The paragraphs that follow outline our compliance with the financial rules and guidelines laid down by NHS England, describe in detail our plans for the forthcoming year 2014/15, outline our plans for 2015/16 to 2018/19 and finally look at some of the financial risks we are likely to face. The wider efficiency and sustainability challenge is dealt with in the next section of the plan.

The tables at the end of this section outline at a high level the financial plan over the duration of the strategic plan (Table 1) and a more detailed view of the use of "new" resources for 2014/15 (Table 2), and how the totality of our resources are spent over a range of care groups in 2014/15 (Table 3).

### Financial Rules and Guidelines

In its latest planning guidance NHS England has prescribed a small number of financial rules and guidelines for CCGs which it expects to see contained within the financial (and therefore) strategic plans of organisations. These cover: the expected year end surplus (a minimum of 1% of the recurrent allocation); the level of contingency (a minimum of 0.5%); the level of non-recurrent use of the allocation (2.5% in 2014/15, 1.0% for future years); the likely growth in allocations; the need to plan for a growing and ageing population; and the likely level of efficiency requirement and inflation/cost pressure uplift for the providers of healthcare. All these rules/guidelines have been incorporated into our plans.

Later guidance received on the accounting for Legacy Provisions (an issue relating to all former Primary Care Trusts) and future years NHS Pension contributions has also been reflected in the plans. In the case of the 2016/17 NHS Pension element, this has been accounted for in the risk section of the plan rather than in the expenditure section.

### 2014/15 Plans

For 2014/15 the CCG sees an increase in its allocation of £3.01m. In addition, four other factors contribute to an overall total of £13.97m "new" funding available to meet anticipated costs and

develop services in-year. These are: the funds currently within our allocation that have not previously been committed on a recurrent basis (although technically this is not “new” funding and there will be an element of this each year as guidelines do not allow an allocation to be “fully” committed); the efficiency challenge passed on to service providers through a reduction in their contract values (currently 4%); the value of the CCG efficiency programme and utilisation of the prior year surplus.

From this available funding the CCG has to meet a number of costs in addition to investing funds into new services and projects through a mix of recurrent and non-recurrent funding. Funds have been set aside to meet the inflation uplifts and other costs pressures that will be faced by providers (guided by the National Tariff changes) and internal budgets, the anticipated costs of a growing and ageing population (guided by changes to populations forecast by the Office of National Statistics) and an anticipated costs of increased demand for services (guided by previous planning rounds and softer intelligence). Overall this totals £8.56m.

Our long term plan is to reduce the surplus brought forward from 2013/14 (£5.76m) down to £2.00m over the lifetime of the plan, with no reduction (in line with NHSE England’s expectation for CCGs) in 2014/15. Having set our target surplus for the end of 2014/15 therefore at £5.76m, the consequence of this act and the costs outlined in the previous paragraph, is that we have £4.64m to spend on new services and projects, having set aside a general contingency of £0.77m.

We are able to support through this additional funding (which is both recurrent and non-recurrent (on-off) in nature) a range of developments which link directly to our strategic goals, outlined earlier in this document. They range from investment in the quality of care to be delivered from the local acute trust, through care pathways including paediatrics, long term conditions and mental health to specific schemes in community and primary care. The main ones are outlined in Table 2 below, many of which will be made recurrent in subsequent years.

## **2015/16 Onwards**

A similar process has been used for developing the financial plans for 2015/16 onwards, with the main drivers being the guidance received to date and the local “Goals and Projects” outlined earlier in this document. The financial consequences are shown below at a high-level in Table 1.

One major change to occur within this timescale though (in 2015/16) is the setting up of the Better Care Fund, a pooled budget arrangement with Local Authorities. This is a single pooled budget for health and social care services covering the Bassetlaw locality as one of three sub-plans within a Nottinghamshire wide proposal. The outline plans will be agreed by the Nottinghamshire Health and Wellbeing Board and they will demonstrate how the national conditions will be achieved against national and local metrics. The Bassetlaw locality fund will total £8m - £9m through a combination of (predominantly) health and local authority funding. The national metrics include the reduction of emergency admissions, reducing delayed transfers of care and enhancing the patient/service user experience.

## **Financial Risk**

Whilst we feel that the assumptions we have made in developing the plans are generally robust, the demand for NHS services is not entirely predictable, and we are planning over a relatively long timescale. Because of this there are a number of factors which put the delivery of these plans at risk and for which we must have alternative strategies. The main risks are:

- Activity demands over and above that built into our plans, particularly around acute care and continuing healthcare;
- Any further implications of the Risk Share arrangements for dealing with Legacy Provisions;
- Any changes to the structure of the National Tariff
- Prescribing growth higher than forecast, due either to changes in pricing or NICE guidance/drug approvals;
- The uncertainty around the operation of the Better Care Fund particularly within a two-tier Local Authority area;
- The consequence of the revision to the allocation formula which has resulted in Bassetlaw being £6m over its target allocation, meaning lower growth levels and therefore less funding to meet the costs of a growing and ageing population and deliver its strategic priorities.

**Table 1 – High level Financial Plan 2014/15 to 2018/19 - Healthcare**

	2014/15	2015/16	2016/17	2017/18	2018/19
<b>Funding</b>	£m	£m	£m	£m	£m
Opening Recurrent Allocation	140.560	143.570	148.289	150.960	153.527
Allocation Growth for Year	3.010	2.442	2.671	2.567	2.611
Better Care Fund Allocation (previously direct to Local Authority)	0	2.277	0	0	0
Non Recurrent Surplus from Previous Year	5.759	5.759	4.800	3.500	2.500
Provider Efficiency (through contracts)	4.212	4.757	4.286	4.344	4.403
CCG Efficiency Programme	2.350	3.000	3.000	3.000	3.000
<b>Total Funds Available</b>	<b>155.891</b>	<b>161.805</b>	<b>163.046</b>	<b>164.371</b>	<b>166.041</b>
<b>Expenditure</b>					
Opening Recurrent Budgets	136.754	138.459	144.457	147.906	150.581
Inflation/Cost Pressures/Population and Demand Growth	7.961	8.218	8.640	8.822	8.888
Contingency	0.770	1.758	2.421	2.335	2.351
Better Care Fund (as above)	0	2.277	0	0	0
In-Year Investments	4.647	6.293	4.028	2.808	2.471
<b>Total Expenditure</b>	<b>150.132</b>	<b>157.005</b>	<b>159.546</b>	<b>161.871</b>	<b>164.291</b>
<b>Surplus for Year</b>	<b>5.759</b>	<b>4.800</b>	<b>3.500</b>	<b>2.500</b>	<b>1.750</b>

**Table 1b – High Level Financial Plan 2014/15 to 2018/19 – Running Costs**

	2014/15	2015/16	2016/17	2017/18	2018/19
<b>Funding</b>	£m	£m	£m	£m	£m
Opening Recurrent Allocation	2.750	2.742	2.461	2.454	2.449
Amendment to Funding	-0.008	-0.281	-0.007	-0.005	-0.006
<b>Total Funds Available</b>	<b>2.742</b>	<b>2.461</b>	<b>2.454</b>	<b>2.449</b>	<b>2.443</b>
<b>Total Expenditure</b>	<b>2.742</b>	<b>2.461</b>	<b>2.454</b>	<b>2.449</b>	<b>2.443</b>
<b>Surplus for Year</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

**Table 2 – Detailed Plan For Use of “New” Resources In 2014/15**

Scheme (£m)	Recurrent	Non-Recurrent	Total
Acute – Urgent Care, A&E and Nurse Level Staffing	0.00	1.75	1.75
Primary Care – Personalised and Urgent Care	0.00	0.57	0.57
Mental Health – Liaison and Other Services	0.39	0.07	0.46
Community - Nursing and Other Services	0.25	0.20	0.45
Pathways – Acute e.g. Paediatrics, Assessment	0.14	0.49	0.63
Pathways – Community e.g. Telehealth	0.00	0.30	0.30
Care Home and Social Care Related	0.00	0.23	0.23
Other	0.08	0.17	0.25
<b>Total</b>	<b>0.86</b>	<b>3.78</b>	<b>4.64</b>

**Table 3 – Overall Expenditure By Care Group in 2014/15**

Care Group	Value £m	%
Acute	79.87	55.9
Mental Health	14.81	10.4
Community	13.15	9.2
Continuing Care	10.90	7.6
Primary Care (including Prescribing)	22.50	15.8
Other Programme	1.57	1.1
<b>Total</b>	<b>142.80</b>	<b>100.0</b>

### The Efficiency Challenge

In common with the remainder of the public sector the health service faces a substantial efficiency challenge over the forthcoming years. NHS England’s paper “A Call to Action” indicates that “...continuing with the current model of care will result in the NHS facing a funding gap between projected spending requirements and resources available of around £30bn between 2013/14 and 2020/21” . Whilst organisations are not given specific targets an estimate of the impact on Bassetlaw CCG is around £45m.

There are two major components of this efficiency challenge, which in other documents is often referred to as QIPP (Quality, Innovation, Productivity and Prevention). They are:

**Provider Efficiency:** These are efficiencies passed on to service providers. For a number of years and for the foreseeable future, providers have been/will be required to provide the same services with less funding. The efficiency value is highlighted within changes to the national tariff, where both the inflationary uplift and the efficiency element for the year are confirmed. The efficiency value has been at 4% for a number of years, and whilst finding that level of savings in the early years was relatively easy for providers, this becomes increasingly difficult to sustain at such a level. A summary of the provider challenge by year is shown below:

Scheme (£m)	2014/15	2015/16	2016/17	2017/18	2018/19
Efficiency	4.21	4.76	4.29	4.34	4.40

**System Wide Efficiency:** These are efficiencies that are the direct responsibility of the CCG. NHS financial allocations are expected to rise by around 1-2% each year for the next five years. This is significantly below the levels of growth recently seen and predicted in NHS activity and costs, through a combination of a growing and ageing population, new medical technologies and drugs and

rising expectations. System wide transformation will be required to cover the gap, and the efficiency savings required will be a by-product of our strategic programmes outlined earlier in this document.

NHS England has suggested that service transformation (big change) requires a number of characteristics. These include:

- A new approach to ensuring citizens are included in service design and change, and are empowered in their own care;
- Wider primary care provided at scale;
- A modern model of integrated care;
- Access to the highest quality urgent and emergency care;
- A step change in the productivity of elective care;
- Specialised services concentrated in centres of excellence.

We have considered our local approach to service transformation, and we are confident that what we are doing meets these national aspirations. One of the issues that we would like to change is the commissioning of primary care. We plan for our general practices to play an even greater role in co-ordinating care for local people. To help us do this we would like to take more responsibility for the commissioning of primary care. A summary of the system wide challenge by year is shown below:

Scheme (£m)	2014/15	2015/16	2016/17	2017/18	2018/19
Efficiency	2.35	3.00	3.00	3.00	3.00

An example of how we are managing efficiency with an emphasis on quality is demonstrated below through the theme of Efficiency in Elective Care:

We will continue to work with our main provider to maintain a balanced position between demand and capacity particularly at the Bassetlaw site. The CCG has made inroads over the past year into the size of the waiting list particularly in orthopaedics and general surgery which we will seek to maintain. A full demand and capacity review has been completed by the local Acute Trust in conjunction with the national Intensive Support Team and our commissioning plans underpin the output of this. We will support the Trust in procuring additional capacity for orthopaedics and elective surgery in private providers to drive down waiting times. We will continue to monitor the quality of this outsourced work. In addition the Trust will maximise their new day surgery facilities offering 7 day lists.

In order to support additional capacity and achieve improved waiting times we will work with clinical leaders in our providers to agree pathways which allow appropriate follow up in primary care. In addition through our GP led service development committee we will further develop GP direct access pathways for diagnostics. This supports timely access and can also reduce the need for onward referral helping to balance demand and capacity. In particular to support capacity issues within

urology we will review the opportunity for primary care to monitor PSA's in patients who are managed through a cancer pathway and risk assessed in secondary care.

For elective surgery we will seek improvements in cancelled operation rates which causes stress and inconvenience to patients and families. Good planned care also recognises that low waiting times between admission and actual operation helps prevent delays, bed pressures and is a better experience for patients. We will seek to better understand elective processes and patient experiences by pathway and benchmark against the NHS IMS Elective Care Guide.

We will support our provider's aspiration to be in the top decile nationally for day case rates and lengths of stay for elective in patients by reducing variations. In particular our focus will be on both ENT and urology where optimum day case rates are still to be achieved. Children's surgical procedure reviews are part of the Working Together programme between commissioners and providers across South Yorkshire and Bassetlaw. To assist in the achievement of this aim this we will continue to promote best practice referral in primary care including optimisation for surgery within orthopaedics and ensure we can demonstrate a reduction in unplanned overnight stays following a planned day surgery procedure.

Quality and safety outcomes are best assured through reductions in variances of practice and as such programmes supporting productive operating theatres and wards are key areas we would wish to see continued. In addition Enhanced Recovery programmes have been trialled in many areas and research has shown there is a reduction in length of stay, morbidity and complication rates. The programme has implications for primary and community care, ensuring that patients are in the best condition for surgery, for the acute provider in ensuring the optimal management of patients pre and during surgery and for the whole health system in enabling the best management post operatively including rehabilitation. The CCG will work with the Trust to expand this approach beyond colorectal surgery.

### **Benchmarked Opportunities and Further Modelling**

The delivery of the programme outlined above will be supported by appropriate benchmarking. The main two elements being considered to date are the use of the national tools "Commissioning for Value" and the "Anytown Health System". The work is at yet still in its infancy, and will be expanded on in more detail in the final iteration of this plan. The early findings from the Commissioning for Value pack are, however, included within Appendix 1.

It is proposed to carry out further activity modelling during 2014/15. This is to ensure the alignment of provider and commissioner plans, and to specifically accommodate the local impact of Nottinghamshire County Council budget cut proposals that are to be developed further during the summer of 2014.

### **Efficiency Governance**

Governance of the Efficiency Programme will be through the Integrated Care Board (ICB), which includes (alongside senior CCG membership) our main acute, mental health, community and primary care providers, NHS England and representatives of both the County and District Council. The governance arrangements of the ICB include a responsibility to set a financial framework and principles to share resources and incentivise change and share and manage financial risk. Progress on

the individual schemes will be monitored through the CCG Performance and Assurance Group, with exceptional issues reported to the Governing Body.

## 14. Organisational Development

### Where we have come from

Our local commissioning organisation was established in 2011, and so is relatively mature in the context of the wider commissioning system that currently operates across the NHS and social care. We have already absorbed a number of changes to our clinical leadership. This has helped us to introduce new perspectives and retain momentum.

During this period the local commissioning organisation has always been progressive, and at the forefront of the development of commissioning. Therefore, the ongoing development of the organisation is framed in this context, and in the context of the position the CCG has within the local community where we act as a collaborative partner encouraging organisations to work together for the benefit of local people.

In the autumn of 2013 the CCG carried out a voluntary survey of local stakeholders inviting them to comment on our approach, leadership style, and impact. This ran ahead of the mandated national survey, and had greater breadth and depth than the exercise carried out during the national process involved with the 'authorisation' of CCG's. We believe we were the first CCG in the Country to do this voluntarily.

The full detail of the survey results can be found here;

The key messages for the CCG were very positive. As with all feedback there is always scope for learning and improvement. The areas that we are considering as part of our ongoing development include:

- How to keep engagement with local people meaningful and worthwhile (from both perspectives).
- How to ensure our leadership can stimulate continuous improvement within the wider health and social care community.
- How to ensure there is a continued confidence in transparency with regard to our actions and decisions.

The Governing Body will help us to develop a plan to ensure our ongoing individual and collective development is aligned with this feedback.

### Our Staff

Our commissioning team is relatively small, a chart summarising this can be accessed here: <http://www.bassetlawccg.nhs.uk/about-us/more-about-us/ccg-organisational-structure>. The team is high quality, and is made up of staff who are dedicated, hard-working and talented.

Our local team is employed by a number of organisations. These include the CCG itself, West & South Yorkshire Commissioning Support Unit, Nottinghamshire County Council, and NHS Property Services. Although the staff have different employers we are 'one team'.

We have developed a Staff Charter ([http://www.bassetlawccg.nhs.uk/news\\_items/7015-locality-staff-charter](http://www.bassetlawccg.nhs.uk/news_items/7015-locality-staff-charter)). This charter was co-created by the staff, it captures what they expect from their employer when they work in Bassetlaw, and it captures what we can expect from them. We believe we are the only CCG in the Country to have developed this sort of collaborative 'one team' approach. The charter has been signed by all of the staff to signal their commitment to local people and our 'one team'.

### **Ongoing Development**

Our ongoing development will always be a priority for us. Over the next two years the main strands of our development will include:

- Support to member GP's who take on new roles to help deliver our strategic programmes.
- Ongoing succession planning for the clinical roles on the Governing Body.
- Support to all clinicians and managers to help them to take on any new responsibilities, and/or to manage change (for example the future commissioning of primary care).
- The continued promotion of our philosophy and approach through the involvement of our clinicians, managers, and lay representatives at a regional and national level.
- Continued support for the personal development of all of our staff.

We also want to develop with our partners. So we will actively seek opportunities for joint development to enhance our understanding of all parts of our local community.

## Map of Bassetlaw

