Clinicians commissioning
healthcare for the people
of North Tyneside

NHS North Tyneside
Clinical Commissioning Group

# North Tyneside CCG Commissioning Plan

**2013/14 - 2015/16**

# Contents

# Foreword

We have pleasure in sharing our 2013/14-2015/16 Commissioning Plan which sets out the healthcare priorities for the first year of NHS North Tyneside Clinical Commissioning Group functioning as a statutory body. Our Clinical Commissioning Group has been fully authorised to operate from 1 April 2013 without conditions which is a major achievement.

However, there are challenging times ahead, in the context of an increasing elderly population, health inequalities both compared to the rest of England and within local geographies, and a tight financial environment.

The NHS England (NHSE) in the NHS Mandate, NHS Constitution and NHS Outcomes Framework has set out the standards required from health commissioners nationally. We will be working with the Cumbria, Northumberland, Tyne and Wear Area Team, the local NHSE presence, to provide assurance that these standards are being met whilst also ensuring alignment between local CCG commissioning responsibilities and those of the NHSE, including primary care and specialised commissioning. We will also continue to work with the North Tyneside Health and Wellbeing Board to ensure all health and social care partners are working effectively together to improve the health and wellbeing of the local population.

The Plan has been developed in collaboration with a wide range of stakeholders, including our patients, 29 member GP practices, hospital and community providers, North Tyneside Council and the voluntary sector.

We have been successful in our journey so far, and look forward to continuing to work with our health and social care partners in delivering this plan throughout 2013/14. You can contact us by email (contactnorthtynesideccg@northoftyne.nhs.uk) or website (www.northtynesideccg.nhs.uk)

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# Executive Summary

Our commissioning intentions are summarised on a 'plan on a page' which explains the why things need to change, our vision and purpose, our principles that guide the plan, how they link to the national policy, and what we are doing to improve outcomes for North Tyneside communities.

**North Tyneside 'Plan on a Page'**

| Context | Vision | Principles | Domain | Initiatives |
|---|---|---|---|---|
| • Locally, high rates of unplanned hospital admission<br>• Continuing gap in life expectancy and healthy life expectancy between most affluent and least affluent populations<br>• High variability in prescribing<br>• Access to local integrated services<br>• Increasing prevalence of mental ill health<br>• Increasing prevalence of dementia<br>• Managing Demand within a Financial Budget<br>• Improving the quality of Services | Working together to maximise the health and wellbeing of North Tyneside communities by making the best use of NHS resources | Promoting wellbeing through preventative healthcare | 3 | Commission a Social Prescribing service |
| | | | 4 | Developing a Sick & Injured Child 'whole system' pathway |
| | | | 4 | Support to Carers - delivery of Carers Strategy Action Plan |
| | | Delivering care locally in primary, community and home settings by improving pathways for planned and unplanned care | 3 | Extend Referral Refinement |
| | | | 3,4 | Improve Access to Primary Care |
| | | | 2,3,5 | Develop a single point of access and structured pathways for older people |
| | | | 1,2,4,5 | Deliver a new Community Nursing specification |
| | | | 4,5 | Implement the 111 service |
| | | | 4 | Improve transition from Children's to Adult Mental Health Services |
| | | | 3,4 | Medicines optimisation – improving use of medicines |
| | | Promoting self-care and care planning | 2,4,5 | Introduce Advanced Care Planning at end of life in nursing homes |
| | | | 2,4 | Develop a work programme to support patients with Long Term Conditions and their carers. The programme will encompass prevention, self-care, improvements in health literacy, and facilitate integration of health and social care. |
| | | | 1,5 | Develop an action plan with the Local Authority for high quality care and support services for people who have a learning disability, autism or have a condition or behaviour that challenges NHS funded care; incorporating key recommendations from the Winterbourne View Concordat. |
| | | | 3 | Develop Falls Strategy |
| | | | 2,3 | Deliver an improved Psychological Therapies service for patients |
| | | | 1,2,4,5 | Improve care for people with Dementia |
| | | | 5 | Secure compliance with the NCB CCG Safeguarding Assurance Framework |

## Vision and purpose

Our vision is:

**"Working together to maximise the health and wellbeing of North Tyneside communities by making the best use of NHS resources"**

This single sentence incorporates several important elements described in chapter 1, and has built on, rather than directly replacing, the vision and purpose of North Tyneside PCT. This acknowledges the progress made by the PCT in relation to the effective commissioning for the health of our communities, whilst also recognising that CCGs are different to PCTs and that we must not just replicate what has been before if the reforms are to be effective.

The vision and our three commissioning principles (which underpin all commissioning activity) have been developed with our stakeholders, including service users and community representatives as part of the commissioning intentions engagement process and have been supported without exception.

## The case for change

Working in conjunction with the North Tyneside Public Health Team and North Tyneside Council, a Joint Strategic Needs Assessment (JSNA) has been developed which identifies health needs across the borough. Moving forward, North Tyneside Health and Wellbeing Board is required to develop a joint Health & Wellbeing Strategy, which sets out how the health and wellbeing of the local population will be improved by working together.

The CCG has engaged with the public and stakeholders across North Tyneside on an annual basis to develop a direct understanding of patient issues and health requirements. During our engagement with the public in October, local people informed us that value for money from investment in health services is of high importance, alongside access to services and service quality is important to patients. There is also support for prevention and wellbeing programmes and for promotion of self-care, care planning and independence.

Chapter 2 sets out the context for change, and includes a review of our past financial and health performance.

## Commissioning improvement areas

Chapter 3 describes our three strategic principles which guide our commissioning plan:

- Preventative healthcare and promoting wellbeing;
- Delivering care locally in primary, community and home settings;
- Promoting self care and care planning.

In addition, delivering the NHS Outcomes Framework will be core to the CCG's business, requiring resources at all levels of the organisation to deliver service quality improvements. This will be driven by the requirements of the NHS Constitution, NHS Mandate, and the NHS England planning guidance for 2013/14.

## Financial challenge and delivering QIPP

In developing our commissioning plan we have remained cognisant of the economic challenges that we face across both health and social care as we move from a position of significant growth to one of more marginal growth. As such, our intention has been to produce a plan which demonstrates a comprehensive approach to commissioning for Quality, Innovation, Productivity and Prevention. Therefore the productivity challenge is not seen in isolation, rather it is integral to the approach in meeting the health needs of our population. Chapter 4 identifies those commissioning initiatives where it is anticipated resources can be released.

## Delivery enablers

There are a number of key enablers to delivering our strategic and operational plans and we continue to identify and consider how these can be used to help deliver the

productivity and efficiency challenges within the local NHS. Our approach to this is described in chapter 5 and includes:

- workforce planning to ensure the right staff are in place to deliver quality and safe services,
- integrated IT systems to improve efficiency within the whole health market,
- the use of contract levers such as incentives and penalties to drive up quality and provide value for money, and
- working with the North of England Commissioning Support service to help us to achieve our goals, freeing time for clinical decision making and commissioning better patient outcomes.

## Governance

As a statutory organisation, we are required to be able to demonstrate that we have the right processes in place to deliver our statutory duties. Within chapter 6 we provide an overview of our structures and reference to our constitution and schemes of delegation.

## Risk Management

The CCG has a risk management strategy which sets out how the CCG brings together the assessment and management of clinical, financial and corporate risks. It refers to the lead roles within the CCG, the mechanism for preparing and maintaining risk registers and the proposed arrangements for risk scoring. Our key risks and the mitigation are explained in chapter 7.

# 1. Vision / Purpose

North Tyneside Clinical Commissioning Group (NTCCG) views the development of this, our first commissioning plan as a statutory NHS body, as a valuable opportunity to work with our key stakeholders including our patients and communities to produce a plan that informs our entire decision making.

Our objective is to produce a 'clear and credible' plan. Having a 'clear' plan means that our member practices, stakeholders, patients and public understand what we are trying to achieve, why we are wanting to achieve this, how we intend to do it and by when.

Developing a 'credible' plan enables us to provide assurances to our member practices, our stakeholders and communities that our plan is feasible, realistic and achievable within existing resource constraints.

## Our vision for NHS North Tyneside CCG

Our vision is:

**"Working together to maximise the health and wellbeing of North Tyneside communities by making the best use of NHS resources"**

This single sentence incorporates several important elements:

- 'Working together' is an acknowledgement that maximising health and wellbeing cannot be achieved by health services alone. Partnership working with North Tyneside Council, Healthwatch, our local provider Foundation Trusts, voluntary and community groups, as well as our communities is critical.
- Maximising health and wellbeing is our desired future state but we have acknowledged that we need to work within increasingly constrained NHS budgets, which will mean that we need to prioritise our investments in order to achieve best value for money.
- We have used the term 'North Tyneside communities' rather than 'North Tyneside residents' in recognition that for several practices in the North West area of North Tyneside, the majority of registered patients live in Newcastle rather than North Tyneside. This presents us with commissioning challenges in relation to equality and equity but it is imperative that we do not just focus on North Tyneside based health services which may not be the most appropriate for Newcastle residents. We will also be responsible for commissioning health services for all people in North Tyneside, although not all will be registered with a North Tyneside GP. This includes holiday makers, some students, travellers, the homeless, asylum seekers etc. Some of these people have very complex health needs so it is very important that we include them in our commissioning plans.

Our vision statement has built on, rather than directly replacing, the vision and purpose of North Tyneside PCT. This acknowledges the progress made by the PCT in relation to the effective commissioning for the health of our communities, whilst also recognising that

CCGs are different to PCTs and that we must not just replicate what has been before if the reforms are to be effective.

Commissioning, led by primary care clinicians (in partnership with their secondary care colleagues), supported by managers; enables commissioning decisions to be made on the basis of local clinical knowledge of registered populations. This in turn leads to more efficient ways of working and the commissioning of health services that are timely, more locally owned and implemented, and have a greater impact.

## Our principles

The vision and our three commissioning principles (which underpin all commissioning activity) have been developed with our stakeholders, including service users and community representatives as part of the commissioning intentions engagement process and have been supported without exception.

Our commissioning principles are as follows:

- Preventative healthcare and promoting wellbeing;
- Delivering care locally in primary, community and home settings;
- Promoting self care and care planning.

# 2. Context – the case for change

## Population demographics and health profile

Working in conjunction with the North Tyneside Public Health team and North Tyneside Council, a Joint Strategic Needs Assessment (JSNA) has been developed which identifies health needs across the borough. More details can be found at www.northtynesidejsna.org.uk.

A Health and Wellbeing Strategy is a new requirement. North Tyneside Health and Wellbeing Board is required to develop a joint Health & Wellbeing Strategy, which sets out how the health and wellbeing of the local population will be improved by working together. More details can be found at: http://www.northtyneside.gov.uk/ntsp/browse-display.shtml?p_ID=25324&p_subjectCategory=900

The CCG has engaged with the public and stakeholders across North Tyneside on an annual basis to develop a direct understanding of patient issues and health requirements. Our most recent engagement was carried out in October to discuss how we plan to invest in health during 2013/14. Key messages from the engagement are shown below.

### Key Messages from public engagement:

- Improving the quality of services is important, including access to information and receiving better support after discharge from hospital.
- Managing demand and value for money are of high importance, with more simplistic prescribing processes to benefit patients.
- Improving access to services and appointments for all people is crucial to patient satisfaction, enabled by the use of technology.
- There is support for promotion of self-care, care planning and independence; support for carers is important and education can help.
- Prevention and wellbeing programmes are positively received, with social activity being seen as an important element.

Our JSNA makes it clear that our local population is projected to rise with an increasingly ageing population. Long term conditions and dementia will be among our biggest challenges ahead, smoking and alcohol remain major local issues, and major causes of poor health and poor mental health and wellbeing are linked to socio-economic deprivation and vulnerability.

### Key Messages from the Joint Strategic Needs Assessment:

- The population of North Tyneside is projected to grow by 9.8% by 2030 with an increasingly ageing population. The number of people aged 85 and over is projected to increase in North Tyneside by 46% by the year 2030 creating additional demand for social care, housing, support, and health services.

- The principle cause of premature death in North Tyneside is cancer, followed by cardiovascular disease.
- People are living longer with the average life expectancy for North Tyneside being 79 years (77 years for males and 81 for females).
- Long term conditions and dementia will be among our biggest challenges going forward.
- At 65 years the disability free life expectancy (DFLE) in North Tyneside is significantly lower compared to England, and in addition the DFLE is significantly lower in the most deprived populations of North Tyneside.
- Smoking is the major contributor to cancer and cardiovascular disease mortality and morbidity and accounts for half the gap in life expectancy between the most and least affluent groups.
- Poor mental health and wellbeing in some parts of the borough are inextricably linked to socio economic deprivation and vulnerability.
- Alcohol is the second biggest lifestyle health risk factor after tobacco use. Alcohol misuse is a major problem within North Tyneside in terms of the health, social and economic consequences which affect a wide cross section of the borough at a considerable cost.
- 1 in 5 children and young people live in poverty in North Tyneside.
- Vulnerable children and young people in the borough suffer from poorer outcomes socially, educationally, economically and educationally.

Our draft Health & Wellbeing Strategy sets out how we will work together with our local partners to address issues of health and wellbeing, the key themes are:

- Reducing avoidable hospital admissions
- Improving the health and wellbeing of families
- Improving mental health and emotional wellbeing
- Addressing premature mortality to reduce the life expectancy gap
- Improving healthy life expectancy.

## Other issues

We have one of the highest rates of hospital admission in England and Wales and are aiming to reduce unnecessary admissions by providing alternatives to hospital within the community.

Our local providers are all in the process of transforming their services in response to reductions in tariff payments over a period of 4 years, we are currently in year 3 of this tariff reduction programme. Maintaining service quality is critical during this time, and we expect each provider to assure the CCG that there will only be a positive impact on service quality associated with their transformation plans.

In addition, our main acute provider, Northumbria Healthcare NHS Foundation Trust, is in the process of merging with Cumbria Hospitals, which could place additional challenges on its resources.

# Financial Performance

In 2013/14 the NHS will move into the third year of reduced growth following the 2007 Comprehensive Spending Review (CSR) which provided increased funding of 4% per year in real terms, taking total NHS funding from £35 billion in 1997/98 to £110 billion in 2010/11.

In 2013/14 CCGs are receiving growth of 2.3% in their recurrent allocations, plus the impact of a 1.3% tariff deflator. Taken together this is a 3.6% opportunity for CCGs. The weighted capitation formula and pace of change have been frozen in 2013/14 and all CCGs will receive the same rate of growth.

In May 2009 it was signalled that that the NHS will be required to deliver between 15-20% efficiency over the life of this strategy. Significant progress was made towards achieving this during 2012/13, but plans for driving out further efficiency savings during 2013/14 are included within this document.

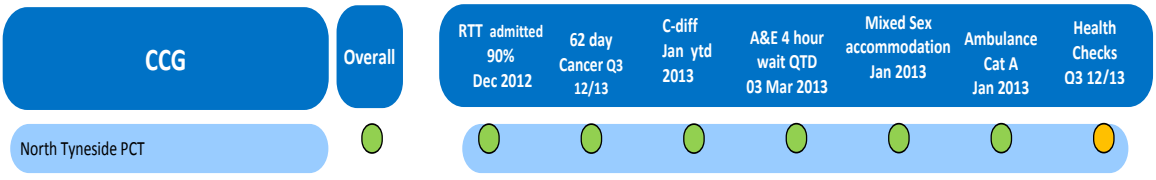
## Past performance

North Tyneside CCG takes over responsibility for commissioning services which were previously commissioned by North Tyneside PCT. In 2012/13 the PCT is forecast to achieve a surplus of £250k against a budget of £400m and is on target to deliver its statutory financial targets.

# Health Performance

North Tyneside CCG and formerly the PCT have demonstrated in recent years that they have worked effectively with their partners to commission services that have a positive impact on the local health economy. North Tyneside generally performs well regionally and nationally, as indicated in the latest performance figures table produced by the North of England Region.

North Tyneside is one of five organisations assessed as 'green' and is ranked joint second in its performance across seven key performance indicators, compared to 51 PCTs in the North of England.




Altogether at the end of the 2012/13, of the 42 key national Integrated Performance Measures, North Tyneside has achieved 71% of indicators, with 19% rated as red (failing by more than 5%). Areas of underperformance are addressed through agreeing corrective action, which in many cases is through our contractual arrangements with provider trusts.

## Past performance

To ensure commissioning and contractual objectives are fully delivered, we identify and report on areas of poor performance and implement action plans to resolve any issues. We also identify areas of good performance in order to share good practice in other areas.

The areas where North Tyneside is performing well include the following:

- **Cancer** - the PCT continues to meet all the access and waiting time targets relating to cancer.
- **Ambulance response times** - the PCT is achieving the range of response times set for the ambulance service in relation to urgent calls across the year, although there were issues in December due to hospital turnaround delays, largely at non-local hospitals.
- **Referral to Treatment times** – all the national thresholds are being achieved for waiting times in relation to admitted and non-admitted patients. In addition, patients are receiving diagnostic tests within the 6 weeks target.
- **Healthcare associated infection** - there were two reported cases of MRSA within 2012/13 compared to a final year maximum target of 4, and 83 Clostridium Difficile cases against a maximum annual target of 94.

Areas of underperformance during 2012/13 included:

- **NHS Healthchecks** – performance to the end of December was 12.2% offered and 5.2% received against trajectories of 15% and 8.3% respectively. Underperforming practices are being supported and data quality issues addressed.
- **Smoking cessation** – forecast end of year performance (based upon data to the end of February) was 88.8% of the target. An internal improvement review of the Stop Smoking Service has been undertaken in order to increase performance.
- **Access: Choose and Book utilisation** – this will be increasingly important as we move towards paperless referrals by 2015 and will require system-wide working with our providers.

Performance is reported to the NHS North Tyneside CCG Governing Body on a bi-monthly basis and papers are available on our website www.northtynesideccg.nhs.uk

It should be noted that within the new organisational arrangements, responsibility for commissioning public health priority areas has transferred to the Local Authority, together with the Public Health Team.

## Future performance

The NHS Outcomes Framework will be used by the Secretary of State for Health 'to hold the new NHS England to account for improving quality and delivering better outcomes for people using health services'. In the context of five domains of the NHS Outcomes Framework, a CCG outcomes dataset has been developed nationally against which the performance of CCGs will be measured by NHS England its Area Team. The CCG outcomes dataset will be incorporated into NTCCG's performance assurance framework for the Governing Body and Clinical Executive, highlighting action being taken to address underperformance.

## Key areas of Improvement and Success in 2012/13

- North Tyneside Clinical Commissioning Group has been developed and authorised without any conditions to begin commissioning as a statutory body from 1st April 2013;
- A social prescribing pilot has been undertaken, which has informed the development of a service specification for competitive procurement of a service, joint with the local authority;
- Referral refinement has been developed in a number of specialities with a reduction in secondary care cost or activity as a result of better primary care;
- Enhanced assessment of intra-ocular pressure is in place, resulting in a reduced need for patient referral to secondary care;
- IV Antibiotics at home service has been implemented, resulting in a reduced length of patient stay in hospital;
- A service has been put in place to support people and implement 'Deciding Right' which includes advanced care planning at end of life in nursing homes, resulting in an increased percentage of people dying in their place of choice;
- A local service, integrated with primary care, has been developed to support people with a long term condition;
- A new memory support service for people with dementia has been commissioned jointly with the Local Authority;
- The North Tyneside Carers' Strategy has been agreed and partners have commenced implementation through the launch of the Carers' Charter and champions;
- A pathway for older people that provides an early response to urgent care need has been established;
- A new action plan has been developed to support the delivery of the National Dementia Strategy;
- The health visitor expansion programme has progressed through its second year;
- The 111 service has been developed ready for implementation in April 2013;
- Three AQP initiatives have been established which will increase the choice of provider in 2013/14 for community dermatology, direct access ultrasound, and anti-coagulation therapy;
- An action plan has been developed in response to the Winterbourne View review;
- Education sessions have been held for the following areas:
    - End of life
    - Cardiology
    - Mental health
    - Diabetes
    - Urology
    - Sick child pathway
    - Gynaecology
    - Diabetes.

# 3. Strategy – Commissioning Improvement Areas

North Tyneside CCG's plan on a page summarises our commissioning intentions for 2013/14. Our vision makes it clear that we aim to work together with partners to maximise the health and wellbeing of North Tyneside communities, making the best use of NHS resources.

## Strategic Principles

We have three strategic principles which guide our commissioning plan:

### 1. Promoting wellbeing through preventative healthcare

We aim to increasingly drive the prevention and wellbeing agenda, working with public health and the local authority, to maximise health and wellbeing of local people. During 2013/14 we will continue to improve support for carers by implementing our carers strategy; develop a strategy to provide North Tyneside children, young people and their families with access to the 'right services', at the 'right time' and in the 'right place' by developing a Sick & Injured Child whole system pathway; and reduce non elective care by commissioning a social prescribing service.

### 2. Delivering care locally in primary, community and home settings by improving pathways for planned and unplanned care

We will commission care that is local to people by providing more community and home based care, reducing unnecessary hospital admissions. We will improve access to primary care; and expand referral refinement making it possible to improve the breadth and quality of primary care. We will improve access to health advice and information by overseeing implementation of a new '111' service; and improve care pathways for older people. We will optimise use of medicines to maximise health outcomes and reduce waste; and we will implement an improved community nursing specification to achieve better community care. We will also improve support for those patients in transition from children's to adult services.

### 3. Promoting self-care and care planning

We will promote self care and care planning to help improve people's lives. We will develop a programme of support for people with long term conditions; and work closely with the local authority to improve quality of care and support services for people who have a learning disability. We will develop a strategy to reduce the risk of falls and the impact on people's health; and improve diagnosis rates and the quality of care for people with dementia. We will work with providers of care to improve psychological therapies services across North Tyneside; and work with the local authority to evidence adoption of NHS England mandated Safeguarding, Looked After Children governance and payment by results guidance to ensure that the quality and safety of care commissioned into these

vulnerable cohorts of children and young people meets national standards. We will improve care planning for people at the end of their life and increase the number of people who die in their place of choice.

By delivering each initiative, we plan to achieve the outcome described in the plan on a page; each outcome is linked to the national NHS Outcomes Framework, which is summarised below.

# Delivery of NHS Outcomes Framework

This national Framework sets out 5 domains within which the NHS aims to achieve improvements. Each domain has a number of outcome indicators, which have been linked to North Tyneside CCG's outcomes; a summary of the domains is shown in the table below:

| | |
|---|---|
| **Domain 1** | **Preventing people from dying prematurely** |
| **Domain 2** | **Enhancing quality of life for people with long-term conditions** |
| **Domain 3** | **Helping people to recover from episodes of ill health or following injury** |
| **Domain 4** | **Ensuring that people have a positive experience of care** |
| **Domain 5** | **Treating and caring for people in a safe environment; and protecting them from avoidable harm** |

Delivering the NHS Outcome Framework will be core to the CCG's business, requiring resource at all levels of the organisation to deliver service quality improvements. The Governing Body will receive regular assurance that the CCG is achieving improvements against the NHS Outcomes Framework. The CCG's approach within each domain is described below together with the outcome measures to be used to assess progress.

## Domain 1 - Preventing people from dying prematurely

The CCG will work with the Providers, the Health and Wellbeing Board, North Tyneside Local Authority, Direct Commissioners and Public Health England to:

- develop and provide integrated health and social care approaches through better use of health checks to ensure earlier diagnosis;
- improve early management in community settings;
- improve acute services and treatment; and
- prevent recurrence after an acute event.

People are living longer in North Tyneside with the average life expectancy for North Tyneside being 79 years (77 years for males and 81 for females), however there is a significant difference in life expectancy between the most affluent and most deprived wards of the borough and this has not changed for the past 20 years.

The JSNA has outlined the key causes of premature mortality in North Tyneside as:

- Cardiovascular Disease
- Cancer
- Chronic Obstructive Pulmonary Disease
- Digestive Disease (including liver disease).

Locally the emphasis needs to be placed on increasing the life expectancy of individuals in the most deprived and vulnerable groups.

In terms of the evidence base key themes emerging include awareness of symptoms in the public and early identification and treatment in primary care settings. Targeting of individuals and groups most at risk will be key to 'finding' people with undiagnosed disease. In terms of suicide, public awareness and training and education for front line staff in relation to vulnerable groups is important. Vulnerable groups in terms of premature mortality generally include people with mental illness, people with learning disabilities, asylum seekers and refugees and homeless people.

The CCG has worked with the Health and Wellbeing Board to agree quality outcomes which include a measure in relation to reducing premature mortality – see appendix A regarding health checks for people with a learning disability.

With regard to 'Under 75 mortality rate from CVD, respiratory and liver disease and cancer the CCG is working with the Director of Public Health to support the commissioning of programmes to reduce premature mortality including the NHS Health Checks Programme, stop smoking services, alcohol treatment services (including community support for people frequently admitted to hospital) and weight management services. Also specifically in relation to cancer, the focus is on raising awareness of cancer symptoms and uptake of screening in the public, in addition to working with GP practices to ensure cancer symptoms are identified early.

With regard to 'Potential years of life lost from causes amenable to healthcare' the CCG is working with GP practices to reduce the variation in outcomes for patients with CVD risk factors and other key conditions including high blood pressure, diabetes and COPD.

National measures to assess delivery:

- Potential years of life lost from causes amendable to healthcare
- Under 75 mortality rate from CVD; Respiratory and liver disease and cancer

## Domain 2 - Enhancing quality of life for people with long-term conditions

North Tyneside CCG has been working with key stakeholders to take an overview of the present provision of services for long term conditions (LTCs) in North Tyneside. We are now in the process of developing a strategy and model of care that is much broader across LTCs to provide the CCG with a vision for development over the next 3-5 years. We have established a Long Term Conditions Partnership which includes representation

from primary care, the local foundation trust, commissioners from both health and social care and a patient voice through representation from LINK and age concern UK.

Our vision for the future is to integrate health and social care services to support patients with LTCs and their carers to optimise their quality of life and support their ability to self-manage their condition(s) through person-centred care and a partnership approach with providers of care. To achieve this, North Tyneside CCG has commenced a number of work programmes overseen by the Long Term Conditions Partnership Board some of which are condition specific but strive towards achieving a generic model of care through the following initiatives:

- Introduction of a LTC dashboard across health, which will shortly include social care with outcomes that matter to those living with LTCs (inclusive of assessment of personalised care, shared decision making and confidence in managing their condition). This will also provide the opportunity to track data across health and social care to inform the community of the big picture and the current variation that exists across care provision.
- Development of a work programme with GPs, health and social care, clinical networks and user forums focussing on prevention, self-care and improvements in health literacy and facilitate integration of health and social care. This has already begun through the local integrated networks programme, the COPD care pathway programme and through the Diabetes Network.
- Designing a specification and market testing the potential for a lead provider for non-traditional services to ensure the wider access of support for patients with long term conditions from organisations within their locality and encourage a whole community approach to supporting patients. Commissioning of this specification is a crucial element toward more personalised patient pathways and follows the main principles as outlined in the 'Thanks for the Petunias' document.
- Continuing the on-going development of locally integrated network for those patients with LTCs with the most complex needs.
- Working with a local provider to establish an extensive range of active support for self- care and improved health literacy including patient information services and education programmes for patients.
- Improving quality in practice disease registers to identify more people with LTCs and help the patient to optimise the level of care they need. This should reduce the risk of a hospital admission for people with a long term condition and instigate early interventions with a focus on asthma, COPD, diabetes and epilepsy in the under 19s.
- Reviewing the current model/pathway for diagnosis with both Northumbria and Northumberland Tyne and Wear NHS Foundation Trusts and development of a North Tyneside model which delivers to NICE guidelines involving commissioners, providers, GPs and people with dementia and their carers.
- Reviewing autistic spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD) commissioning and provision arrangements across 'all age ranges' in response to: i) the findings of the High Profile Mayoral Case Review 2012; ii) the newly published ASD/ADHD NICE Guidance 2012; iii) the national autism strategy.

- Improving transition from children's to adult mental health services through implementation of the Transition Protocol and working with children and adult services commissioners and providers to secure a well- managed, integrated package of care.
- Assessing health commissioning responsibility and requirements expected as a result of the emerging Special Educational Needs legislation including the need to work in partnership with the Local Authority Children's Services.
- Reviewing the current commissioning arrangements for psychological therapies to improve access and recovery rates.
- Reviewing local procedural and system arrangements to optimise support for people requiring continuing healthcare, and facilitating ownership of care through personalised care plans and budgets across Adult and Children's Continuing Healthcare by March 2014.

Clear objectives will be based on local need identified through the JSNA and will be fully integrated with the CCG Commissioning plan. North Tyneside CCG will work through the Long Term Conditions Partnership Board to embed a clear governance structure, a robust reporting mechanism and productive relationship management arrangements through the development of Networks around a range of service areas.

National measures to assess delivery:

- Health-related quality of life for people with LTC
- Proportion of people feeling supported to manage their condition
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
- Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19's
- Estimated diagnosis rate for people with dementia

## Domain 3 - Helping people to recover from episodes of ill health or following injury

Overall in this domain the CCG aims to:

- reduce avoidable admissions to hospitals;
- keep people out of hospitals if better care can be delivered in a different setting;
- ensure effective joined-up working between primary and secondary care;
- deliver high quality and efficient hospital care and coordinate care and support post discharge;
- work with providers to invest savings in better reablement and post-discharge support.

North Tyneside has the fourth highest rate of emergency admissions in England. The Office of National Statistics predicts that the population of across the North Tyneside population will increase by 8% by 2025. This projected increase is not uniform across all age bands with persons aged 60+ increasing by 40%. Presently, patients aged 65+ account for 18% of the population but around 40% of emergency hospital admissions;

hence an increase in the elderly proportion of the population has a significant impact on the number of emergency admissions.

In response to the continued increase in unplanned admissions, North Tyneside CCG set out to commission an effective health and care pathway, delivered in a proactive, integrated way and designed to improve the coordination and cohesion of service provision between primary care, secondary care and adult social care. This will include delivery of the national 111 system across North Tyneside from April 2013 and improvement of access to services in primary care, for example, though GP led telephone triage of requests for GP appointments in order to reduce A&E attendances.

We have already taken steps to commission an urgent care pathway for older people that will ensure patients can be maintained in their usual place of residence with an integrated package of care. A core requirement of the new pathway design will be alignment between the current local community based admission avoidance team and the development of an Elderly Resource Centre. This alignment will provide a dual function of delivering a step up facility for those patients being referred through a primary and social care system and will aid early assessment, diagnosis and management of patients identified as having an urgent care need and a step down facility with the aim of ensuring the majority of elderly patients with an urgent care need can be supported at home without an admission. The review of intermediate care will aim to optimise appropriate use of step up and step down facilities, whilst also streamlining exiting commissioning arrangements on block purchasing and introducing an element of spot purchasing.

Within this development, we will continue to support the on-going development of the social care reablement service which will be fully aligned to the older people's urgent care pathway.

As part of the 30 day readmission priority, we have worked collaboratively with our local acute provider and have developed a 'High Risk Patient Programme' for those elderly patients with the most complex range of long term conditions. Early indications from a 'spearheaded' project around case management for complex COPD suggest reductions in readmissions for this group of patients. The 30 day readmissions measure has been selected to form part of the local Quality Premium – see appendix A.

North Tyneside CCG has recently gathered learning from work undertaken during 2011/12 on a sick and injured child urgent care pathway. The pilot adopted a whole systems approach to providing care closer to home and in doing so ensure paediatric hospital attendances are minimised. Particular emphasis for the pathway focussed on the top ten paediatric emergency admissions which included lower urinary tract infections. We will continue to monitor and build upon the learning from the pilot and identify ways to improve generic GP compliance with the Royal College of General Practice best practice 'spotting the sick child'.

North Tyneside CCG has identified two areas which are impacting upon current service delivery in secondary care. First is the increase in demand in high cost specialties such as orthopaedics and ophthalmology, and second is the variation in referral rates across GP practices. Resolving these related challenges requires a shift in the balance of care, moving from disjointed and fragmented patient pathways towards care that is evidence based, integrated, and locally responsive. We will continue to build upon the referral

refinement system approach across primary and secondary care in 10 specialties to reduce inappropriate referrals to secondary care.

We will work with Northumbria Healthcare NHS Foundation Trust to develop services to be provided from the new Emergency Care Centre at Cramlington from 2015. There will be a need to implement strategies for assessment and evaluation to inform longer term commission intentions for children's services. Also, we will be undertaking a review of maternity services with partner CCGs to ensure maternity services are commissioned to meet the needs of North Tyneside people and to offer greater choice to women for the safe provision of maternity services in accordance with Maternity Matters and recognised best practice.

We have summarised our ideas within the Plan on a Page for improving how we approach elective care over the next three years and have outlined the governance structure we are putting in place to ensure patients who require planned clinical interventions receive the most appropriate care in the most appropriate place by the most appropriate person.

National measures to assess delivery:

- Emergency admissions for acute conditions that should not usually require hospital admission
- Emergency readmissions within 30 days of discharge from hospitalisation
- Total health gain assessed by patients – Hip replacement; Knee replacement; Groin hernia and Varicose veins.
- Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)

## Domain 4 - Ensuring that people have a positive experience of care

The CCG aims to:

- deliver rapid comparable feedback on the experience of patients and carers;
- build capacity and capability in providers and commissioners to act on patient feedback;
- assess the experience of people who receive care and treatment from a range of providers in a coordinated package.

Patient feedback is received from a variety of sources including:

- National patient experience surveys, covering hospital care, primary care (GP and out of hours), and the Friends and Family Test from April 2013;
- CQUIN – real-time patient surveys undertaken by provider trusts and independent sector organisations;
- Engagement and consultation with patients, individuals and groups, LINks, the community and voluntary sector, councillors and MPs;

- Other hard and soft intelligence – complaints, comments, incidents and critical events, and patient stories.

The CCG Quality and Safety Committee will review such patient feedback alongside other indicators of quality to provide assurance regarding the standards of care provided and also to inform service improvement areas as part of the commissioning process. The CCG will further develop systems to ensure that action taken in response to comments from patients is fed back through representative groups.

All initiatives included in the 'Plan on a Page' are designed to improve the experience of patients, carers and families. Specific areas include:

- **care closer to home** - for example through the Any Qualified Provider initiative, and review of minor surgery to ensure the incentives are aligned appropriately to offer choice, care closer to home and maximise value;
- **end of life care** - development of a rapid response team and a strengthening of relationships with palliative care teams and Locally Integrated Networks to ensure people are able to die in the place of their choice;
- **veterans' health care** - evaluation of the pilot Veterans Wellbeing Assessment and Liaison Service provided by the Northumberland Tyne and Wear NHS Foundation Trust to ensure the mental health and wider needs of veterans are being met and to inform the commissioning of future services from 2014/15 onwards.

National measures to assess delivery:

- Patient experience of primary care – GP services and GP Out of Hours services
- Patient experience of hospital care
- Friends and Family test

## Domain 5 - Treating and caring for people in a safe environment; and protecting them from avoidable harm

Our highest priority is to ensure the safety of people who use the health services we commission - it underpins everything we do. As a new statutory organisation we will continue development of our quality assurance processes and early alert systems to identify potential safety failures in providers, informed by national, regional and local quality dashboards. As part of the wider health system, we will work as part of the local Quality Surveillance Group to share information and intelligence. The key aims will be to:

- significantly reduce C-Difficile in all providers in the health economy
- deliver zero tolerance to MRSA infection and conduct Post Infection Review
- implement the findings of the Winterbourne View review and Robert Francis QC following the Mid Staffordshire Inquiry
- secure compliance with the NHSE safeguarding assurance framework, working with local authority partners and community groups to safeguard and address the

needs of vulnerable groups, such as the housebound, frail elderly and looked after children

- improve safety measures and outcomes across all of our providers using contractual leverage and CQUIN (Contracting for Quality and Innovation) to reduce incidence of venous thromboembolism, pressure ulcers, falls and urinary tract infections in patients with a catheter
- continue to work with providers to ensure that any proposed efficiency measures and transformational change will not have a detrimental impact upon their ability to deliver clinically effective, high quality and safe care.

Measures to assess delivery:

- Incidence of healthcare associated infection (HCAI) – MRSA and C-Difficile
- Delivery of contractual quality and safety requirements by providers, including CQUIN
- Quality dashboard performance across a wide range of measures including mortality rates

### Summary

Our 'plan on a page' on page 24 summarises the change initiatives planned over the next 3 years. The CCG will work closely with adult social care commissioners and public health to deliver aligned improvement in outcomes for North Tyneside, using our local integrated commissioning boards.

## National Requirements

### NHS Constitution

As custodians of public money we accept responsibility for ensuring that the NHS is able to support and improve our population's mental and physical health and wellbeing, to assist recovery from illness and to stay as well as we can to the end of our lives. We are resolute in our ambition to utilise human expertise and compassion as well as advancing technologies to save lives and improve health. We will ensure that the rights and pledges of patients are upheld. See appendix B for further details.

### NHS Mandate

We will preserve and defend the principles of the NHS as a comprehensive, universal, relevant and trusted institution. We will play our part to the full in delivering the strategic goals set out in the first NHS mandate.

## NHS England Planning Guidance for 2013/14

The NHS England has set out key areas of responsibility and action for CCGs, which are summarised in the table below. These areas of responsibility will be actioned together with our local initiatives.

- Work with providers to capture real time patient and carer feedback, e.g. Friends and Family Test.
- Develop local metrics for evaluating the social and economic return on investment.
- Promote benefits of technology in improving outcomes, with emphasis on more rapid uptake of telehealth and telecare in line with patient need.
- Improve data quality.
- Work with providers to ensure recommendations in the following reports are being addressed:
    - Transforming Care: A National Response to Winterbourne View Hospital
    - Francis Report into Mid Staffordshire NHS Foundation Trust.
- Commission services to provide access to psychological therapies, with the recovery rate to reach 50%.
- Providers and commissioners must work together to ensure cost improvement programmes are clinically safe.
- Maintain close oversight of patient activity and include in local plans trajectories of how activity will change over the next year.
- Set three local quality premium priorities and associated trajectories to drive local improvements. See appendix A for more details.
- Work with partners and key stakeholders to deliver the five offers of the NHS England, which are:
    - Offer 1: NHS services, 7 days a week
    - Offer 2: More transparency, more choice
    - Offer 3: Listening to patients and increasing their participation
    - Offer 4: Better data, informed commissioning, driving improved outcomes
    - Offer 5: Higher standards, safer care.

## National Planning Offers

**Offer 1: NHS services, 7 days a week**

- North Tyneside CCG will work towards primary and community services delivering high quality, responsive service in / out of hours, and offering better access to routine services 7 days a week in urgent and emergency care and diagnostic services.

**Offer 2: More transparency, more choice**

- We will ensure each of our providers for the relevant commissioned services publishes consultant level information on their website in 2013/14 as required by the Healthcare Improvement Partnership, for:
    - Upper gastro-intestinal surgery
    - Colorectal surgery
    - Orthopaedic surgery

    - Urological surgery
    - Head and neck surgery.
- As part of 2013/14 contract negotiations, the CCG will work with providers and local providers to agree a set of actions that sets out the approaches to be taken to improve patient outcomes and choice across a wide range of medical, surgical and mental health conditions. This will be supported by initiatives on Deciding Right and Shared Decision Making by improving access to information and giving people more control over their care.
- In 2012/13, Any Qualified Providers (AQP) were qualified and are currently mobilising in the following services: non-obstetric ultrasound, anti-coagulation therapy and dermatology. The CCG also continued the offer of choice through the AQP for elective surgery and intends to continue this offer in 2013/14. All services where choice has been extended have been published on the national map (Supply 2 Health website) and commissioners will keep this map updated to reflect extended choice plans and implementation through the Commissioning Support Unit.
- The quality and financial impact of AQP services for commissioners and providers will be assessed in 2013/14. This review will enable an understanding of the effectiveness of AQP to date with particular focus on the patient experience and clinical outcomes, and inform the development of future AQP service lines.

**Offer 3: Listening to Patients and Increasing Their Participation**

- We are working with providers to establish processes to gather public insight into local health services.
- We are considering how all NHS funded patients will be able to leave feedback in real time on any service by 2015 through the use of tools such as the Friends and Family test for acute inpatients and A&E patients from April 2013 and maternity services from October 2013.
- We will demonstrate the action taken as a consequence of feedback from Friends and Family test and plans to work with providers on further roll out from 2014/15.
- We will work with our Health &Wellbeing Board to assess population need and work with HealthWatch to ensure public involvement plans match local expectations for engagement at individual and collective level. We will also develop metrics to evaluate socio economic return on investment and other impacts of patient and public involvement activities.

**Offer 4: Better data, informed commissioning, driving improved outcomes**

- We will deliver the universal adoption of the NHS number as the primary identifier by all providers in 2013/14 by:
    - The NHS number will be a required field in all local and national data flows between providers and commissioners thus encouraging providers to capture it at source. Standard contracts with providers will mandate the use of NHS numbers and all payments for services will be made only where NHS numbers are present (within an agreed tolerance to reflect sensitive anonymised activity, foreign nationals, etc.).
    - CCGs may undertake audits of patient records to ensure the NHS number is included on all patient documentation and correspondence.
- We will use NHS Standard Contract sanctions in 2013/14 if not satisfied with completeness and quality of provider data on SUS

- We will, via our contracts, ensure outcomes information such as the Cancer Outcomes dataset is collected and submitted in line with ISN publications. In additions current provider contracts detail a wide range of outcome measures with a change in focus to commission based on outcomes rather than activity. Contract sanctions can be applied if providers fail to meet expected outcome levels.
- We will ensure secondary care providers comply with data collections based on Information Standards Board and NCB advice by 30/09/13 through:
    - The Data Management and Integration Centre [DMIC] will build relationships with providers across the health economy and work collaboratively to minimise flows of information between providers, CCGs/CSU, Area Teams and other partner agencies (i.e. Public Health).
    - Providers signed up to the NHS standard contract are obliged to demonstrate compliance with Information Standards Notices [ISNs] on a regular basis. This will be monitored via routine contract management arrangements and challenged where appropriate.
- We will move to a paperless referral system by 2015 to enable easy access to appointments in primary and secondary care.
    - We will commission the appropriate GP information services to provide clinical assurance and safety and ensure all systems are accredited and compatible with national applications.

**Offer 5: Higher standards, safer care**

We will work together with North Tyneside Health & Wellbeing Board, and providers to ensure the recommendations in 'Transforming Care: A National response to Winterbourne View Hospital' and the 'Francis Report' are implemented and ensure a dramatic reduction in hospital placements for people with learning disabilities or autism in NHS funded care who have a mental health condition or challenging behaviour.

- **Winterbourne View Hospital Review -** The main actions will be:
    - Create and maintain a register of all fully or partially funded (NHS) patients who have LD or autism combined with mental health disorder and or challenging behaviour
    - Review the care plans and discharge plans of all patients in hospital-based assessment and treatment units by June of this year
    - Provide evidence that there has been thorough discussion regarding the feasibility of pooled LD budgets
    - Work with existing independent sector LD providers to ensure that they are safe to support people coming out of hospital and have sufficient capacity
    - Service redesign of mental health home treatment and crisis teams to ensure that they are able to support people with learning disability
    - Health and care commissioners to ensure everyone inappropriately placed in hospital will move to community-based support by June 2014.

## North Tyneside CCG Change Initiatives for 2013/14

| Context | Vision | Principles | Domain | Initiatives | Outcomes |
|---|---|---|---|---|---|
| • Locally, high rates of unplanned hospital admission<br>• Continuing gap in life expectancy and healthy life expectancy between most affluent and least affluent populations<br>• High variability in prescribing<br>• Access to local integrated services<br>• Increasing prevalence of mental ill health<br>• Increasing prevalence of dementia<br>• Managing Demand within a Financial Budget<br>• Improving the quality of Services | **Working together to maximise the health and wellbeing of North Tyneside communities by making the best use of NHS resources** | Promoting wellbeing through preventative healthcare | 3 | Commission a social prescribing service | • Reduction in non-elective care for participants. |
| | | | 4 | Developing a sick & injured child 'whole system' pathway | • Evidence that a high quality, best practice Sick and Injured Child Urgent Care Pathway is in place that provides North Tyneside children, young people and their families with access to the 'right services', at the 'right time' and in the 'right place'. |
| | | | 4 | Support to carers - delivery of Carers Strategy Action Plan | • Carers strategy action plan is delivered - carers feel more supported as a result. |
| | | Delivering care locally in primary, community and home settings by improving pathways for planned and unplanned care | 3 | Extend referral refinement | • Reduction in the following planned care specialties: orthopaedics, ENT, cardiology, neurology, ophthalmology, urology, gynaecology, dermatology new outpatient attendances.<br>• Publication of named consultants on the directory of services, and increased numbers of GP advice and guidance requests.<br>• Increased capacity of community based vasectomy services. |
| | | | 3,4 | Improve access to primary care | • Increased availability of appointments in primary care. |
| | | | 2,3,5 | Develop a single point of access and structured pathways for older people | • Reduction in unnecessary emergency admissions that should not usually require hospitalisation.<br>• Increased response rate for those most at risk of an A&E admission.<br>• Reduction in emergency readmissions within 30 days of discharge - **Local Quality Premium measure** |
| | | | 1,2,4,5 | Deliver a new community nursing specification | • Community nursing specification in place that meets the needs of patients and primary care; reducing reliance on hospital attendance. |
| | | | 4,5 | Implement the 111 service | • Reduction in hospital attendance/admissions and or primary care visits. |
| | | | 4 | Improve transition from children's to adult mental health services | • Increase the number of young people securing a well-managed, integrated package of care as they enter adulthood. |
| | | | 3,4 | Medicines optimisation – improving use of medicines | • Improve health outcome and well-being through medicine optimisation.<br>• Ensure best value for money to support delivery of financial balance.<br>• Minimise avoidable waste in medicine supply system. |
| | | Promoting self-care and care planning | 2,4,5 | Introduce advanced care planning at end of life in nursing homes | • Increased number of people who die in a setting of their choice – increase in the percentage of people who die in their usual place of residence rather than an acute hospital - **Local Quality Premium measure** |
| | | | 2,4 | Develop a work programme to support patients with Long Term Conditions and their carers. The programme will encompass prevention, self-care, improvements in health literacy, and facilitate integration of health and social care. | • Increased number of people who have a care plan in diabetes and COPD.<br>• Increased access to psychological interventions for stroke.<br>• Improved level of correct diagnoses for COPD through early access spirometry.<br>• Increased uptake of educational programmes for patients with long term conditions.<br>• Development of Locally Integrated Networks in place to target and deliver proactive case/care management for those patients with complex or rapidly changing needs.<br>• Development of a service specification and local guidelines for a 24 hour blood pressure service.<br>• Improve disease registers in primary care. |
| | | | 1,5 | Develop an action plan with the Local Authority for high quality care and support services for people who have a learning disability, autism or have a condition or behaviour that challenges NHS funded care; incorporating key recommendations from the Winterbourne View Concordat. | • Increased number of health checks and health action plans for people with a learning disability - **Local Quality Premium measure**<br>• Improved access to diagnostic pathways for autism spectrum disorder.<br>• Co-ordinated approach to commissioning of services for people with the most complex needs.<br>• Oversee expensive packages of care from a clinical and social perspective.<br>• Improved transitional pathways from paediatrician to primary care and adult health and social care. |
| | | | 3 | Develop falls strategy | • Reduction in unplanned/emergency admissions. |
| | | | 2,3 | Deliver an improved psychological therapies service for patients | • Significantly improve performance against agreed action plan to meet commissioner requirements. |
| | | | 1,2,4,5 | Improve care for people with dementia | • Improved diagnosis rates and reduce the use of antipsychotic medicines.<br>• Structure in place to develop the role of dementia champions in care homes to work with the challenging behaviour teams to reduce the use of antipsychotics.<br>• Improved quality of old age psychiatry services in North Tyneside. |
| | | | 5 | Secure compliance with the NCB CCG safeguarding assurance framework | • Evidenced adoption of NCB mandated safeguarding, LAC governance and payment by results guidance to ensure that the quality and safety of care commissioned into these vulnerable cohorts of children and young people meets national standards. |

# Maintaining and Improving Quality

## Quality Assurance Processes

In addition to the contractual and operating performance related standards, there has been an ongoing focus on ensuring that providers of services to North Tyneside CCG communities are delivering quality services. Quality is assured through a wide range of metrics, indicators, dashboards, information and intelligence gathered nationally, regionally and locally. The NHS Outcomes Framework has provided a structure and focus for the assessment of standards of quality across the five domains. A priority will be the development of a timely and comprehensive quality assurance system to prevent, identify and respond to quality failures, taking on board the recommendations of the Francis Report. The CCG will link to the local Quality Surveillance Group to share information and intelligence and receive assurance through its Quality and Safety Sub-Committee and Governing Body.

## Francis Report

The CCG will work with all of our providers to ensure that the patient remains at the centre and that a culture of openness, transparency and candour is promoted throughout the system. We accept responsibility and accountability for implementation of the recommendations made by Robert Francis QC following the Mid-Staffordshire Inquiry. We will develop a cross system action plan to ensure required changes are implemented and embedded as the common practice and culture within our provider and commissioner organisations.

## Winterbourne View Hospital Review

In the light of 'Transforming Care: A National response to Winterbourne View Hospital', the aim will be to ensure a dramatic reduction in hospital placements for people with learning disabilities or autism in NHS funded care who have a mental health condition or challenging behaviour.

## Compassion in Practice

We embrace the values and behaviours outlines within the vision and strategy for nurses, midwives and care staff. We will ensure that all of our providers focus on the 'Six C's' (care, compassion, competence, communication, courage and commitment) putting the person being cared for at the heart of the care they are being given.

## Quality incentives – CQUIN, pre-requirement, quality premium

The CCG continues to work with providers to ensure that the CQUIN schemes both in the current and future contracts are stretching and delivering quality services for the population within the resident population. In 2013/14 CQUIN remains at 2.5% of the total contract value. The providers' performance will also be reviewed to ensure that they have met the pre-requirement criteria for CQUIN in order to be eligible for future schemes:

CQUIN Pre-Qualification Criteria

- accelerated use of assistive technologies in the NHS, aiming to improve at least 3 million lives nationally over the next five years;
- full implementation of oesophageal doppler monitoring (ODM), or similar fluid management monitoring technology, into practice across the NHS;
- a 'child in a chair in a day' programme to transform the delivery of wheelchair services throughout the NHS;
- opportunities explored to increase national and international healthcare activity;
- reduced inappropriate face-to-face contacts and a switch to higher quality, more convenient, lower cost alternatives;
- services to be commissioned in line with National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) guidance on supporting people with dementia.

The Quality Premium has been introduced by the NHSE in 2013/14 to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities. The reward is anticipated to be up to £5 per head of the population served and is awarded according to delivery against seven measures.

Four elements of the Quality Premium are set nationally:

- reducing potential years of lives lost through amenable mortality (Domain 1 of the NHS Outcomes Framework);
- reducing avoidable emergency admissions (Domains 2 and 3);
- ensuring roll-out of the Friends and Family Test and improving patient experience of hospital services (Domain 4);
- preventing healthcare associated infections (Domain 5).

Three local measures have been identified based on local need, areas of poor performance and alignment with priorities within the commissioning plan shaped through public consultation, and have been considered by the local Health and Wellbeing Board.

Three Local Quality Premium Measures are set locally:

- 70% of people with a learning disability receiving a health check (Domain 1);
- 5% reduction in the number of emergency readmissions within 30 days of discharge from hospital (Domains 2 and 3);
- 51.5% of people dying in their place of choice (Domain 4).

(See appendix A for further information).

# 4. Financial Challenge/QIPP

## Financial performance 2012/13

The table below shows the outturn for North Tyneside PCT:

| | North Tyneside PCT (£000s) |
|---|---|
| Revenue Resource Limit | 406,475 |
| Outturn | 406,209 |
| Underspend | 266 |

The positive out-turn forecast is despite significant over performance in the acute sector due to higher than contracted levels of activity. It is essential that we set a realistic baseline for next year; however we must acknowledge that in the current financial climate significant increases are not sustainable. This highlights the imperative in getting to grips with ever increasing levels of secondary care activity whilst ensuring appropriate levels of care within primary and community care settings.

## Financial challenge in 2013/14 onwards

The Commissioning Plan has been developed in the context of a challenging financial and economic position for health and social care. Delivery of the Department of Health's £20bn efficiency saving in the NHS is a continuing requirement through application of the commissioning principles of Quality, Innovation, Productivity and Prevention (QIPP). The planning assumptions for 2013/14 are detailed below and are in accordance with national financial planning guidance.

| Financial Assumptions (% change) | 13/14 |
|---|---|
| Pay and Price Inflation | 2.7 |
| Efficiency | -4.0 |
| **Net Tariff Adjustment** | **-1.3** |
| CQUIN | 2.5 |
| Recurrent funding for non-recurrent expenditure | 2.0 |
| Revenue contingency | 0.5 |
| Revenue surplus | 1.0 |

## Application of funds in 2013/14

Allocations to Clinical Commissioning Groups for their first year of authorisation were published in December 2012 and were based on a budget and expenditure mapping exercise carried out by the Department of Health in July 2012. This aimed to establish the level of resource currently committed to commissioning responsibilities within PCTs and track these to the appropriate new organisation. Further adjustments were then applied, in particular an estimate of the cost of the additional specialised services transferring to the NHSE, resulting in an allocation to the CCG of £281.3m in 2013/14. The CCG has

also been allocated a running cost budget equivalent to £25 per head of population of £5.3m.

The application of new funds in 2013/14 is based on the Financial Information Management System (FIMS) analysis which is one of the required elements of the financial plan submitted, and is summarised below:

| | North Tyneside CCG (£000s) |
|---|---|
| Acute Contracts | 164,518 |
| Mental Health & Learning Disabilities Contracts | 22,915 |
| Community Contracts | 27,989 |
| Ambulance Contracts | 7,132 |
| Non-NHS Healthcare Contracts | 2,928 |
| Continuing Healthcare | 18,981 |
| Primary Care Prescribing | 35,351 |
| Other | 1,499 |
| **Total** | **281,313** |

# Resource Releasing Initiatives (QIPP)

"Everyone Counts – Planning for Patients" highlights that from 2013/14 a step change in the approach to QIPP with full local ownership of the clinical changes is needed to ensure that this is supported by transformational change through clinical service redesign. The QIPP delivery continues to be demonstrated both via "technical" changes i.e. the efficiency assumptions built into national assumptions and tariffs, and "allocative" changes which relate more closely to the initiatives put in place at a local level.

The planned savings for North Tyneside CCG in 2013/14 are as follows:

| Savings | £000's |
|---|---|
| Efficiency savings (4% on tariff etc) i.e. technical QIPP | 9,838 |
| Resource releasing initiatives i.e. allocative QIPP | 3,027 |

An analysis of the £3m CCG initiatives is shown overleaf.

| Resource Releasing Programme | Action | £000 |
|---|---|---|
| Urgent care pathway | Integrated pathways across primary and secondary care, including 111 | -1,081 |
| Referral refinement | More appropriate referral to secondary care | -450 |
| End of life programme | Advanced care planning at the end of life | -678 |
| Community nursing | Comprehensive community nursing service | -108 |
| Medicine management | More efficient and effective use of medicines | -710 |
| | **Total** | **-3,027** |

These programmes represent an integral part of the commissioning plans of the CCG and are supported by a number of new and ongoing workstreams.

# Activity

The activity plans for 2013/14 onwards have been produced as follows:

- Development of a base case using forecast outturn from the latest available reference period;
- Understanding the impact on activity of the achievement of waiting times targets across all providers;
- Modelling the impact of demand management initiatives implemented across North of Tyne or by individual CCGs;
- Anticipating the impact of demographic change on activity;
- Building in the effect of any significant service changes, for example, the transfer of specialised services commissioning to NHS England.

| Activity Assumptions | | | |
|---|---|---|---|
| | **2012/13 Forecast Outturn** | **2013/14 Plan** | **Forecast growth 2013/14** |
| **Elective FFCEs** | 39,946 | 40,347 | 1.0% |
| **Non-Elective FFCEs** | 28,706 | 28,702 | 0.0% |
| **First Outpatient Attendance** | 84,780 | 85,625 | 1.0% |
| **A&E Attendance** | 73,802 | 73,802 | 0.0% |

# 5. Delivery Enablers

## Workforce

Workforce is a key enabler to delivering our strategic and operational plans and we continue to identify and consider the workforce implications of the productivity and efficiency challenges within the local NHS:

- Workforce assurance is integral to the development of a system which assures patient safety and quality of care. Alignment of all elements of the strategic and operational planning processes to develop a cohesive and whole system strategy remains a challenge, but is key to understanding the full implications of operating framework efficiencies and ensuring quality of care.
- The Local Education and Training Board (LETB) is now operational and is providing a framework for dialogue across the economy about the local workforce needs in the short and medium term.
- Workforce planning will continue to support the safety and quality agenda and we envisage that the new architecture both in commissioning and in education and training commissioning will support and embed this going forward.

## Informatics

The delivery and development of the service areas highlighted in the commissioning plan will require effective integrated IT systems infrastructure. In particular we will:

- Deliver the universal adoption of the NHS number as the primary identifier by all providers in 2013/14.
- Ensure secondary care providers account for patient outcomes and the adoption of safe, modern standards of electronic record keeping by 2014/15.
- Ensure secondary care providers comply with data collections based on Information Standards Board and NCB advice by 30/09/13.
- Plan to move to a paperless referral system by 2015 to enable easy access to appointments in primary and secondary care.
- Commission the appropriate GP information services to provide clinical assurance and safety.

## Medicines Optimisation

We will seek to ensure efficient use of allocated prescribing budgets within all of our service transformation proposals, enabling people to manage their health, reduce the need for acute intervention and maintain independence. In particular we will:

- Implement interventions to deliver the four behavioural influencers to support optimal medicine taking through behavioural change to enhance the quality of life and experience of care for people with LTCs;
- Reduce waste within the overall system through modernisation of repeat dispensing; adopting electronic prescribing; redesign of the repeat prescribing

pathway, including third party ordering; developing an approach to medicine reconciliation, for example, through domiciliary visits; and reviewing practice procedures for the issue of medicines for patients in care homes;

- Ensure local implementation of NICE clinical and technical guidance supporting the development of local integrated pathways and guidance, allied to effective horizon scanning;
- Work with Public Health, Local Authorities and the Local Prescribing Committee to support the development of pharmacies with Healthy Living Centre accreditation to support the promotion of wellbeing through preventative healthcare;
- Promote self-care and care planning using 'Think Pharmacy First' as an alternative source of support for minor self-limiting ailments.

## Contractual Levers

Our aim is to further develop joint working relationships with the full range of providers we have contracts with. In some areas this will be in collaboration with the local authority and/or other clinical commissioning groups as joint commissioners moving forward. A range of areas have been identified for more robust contractual arrangements such as the management of consultant to consultant referrals, the implementation of the Individual Funding Requests system and the application of new tariff guidance.

New Payment by Results (PbR) guidance will be implemented for maternity services. This will require collaboration between commissioners across PCT clusters and the clinical commissioning groups to manage the financial impact.

The Commissioning for Quality and Innovation (CQUIN) framework enables commissioners to reward excellence by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals. The framework aims to embed quality within commissioner-provider discussions and to create a culture of continuous quality improvement with stretching goals agreed in contracts on an annual basis. The available CQUIN reward for providers in 2013/14 is 2.5% of the total contract value.

In addition to service changes under the five domain headings, we will work to secure the best from our existing service contracts and aim to develop mature relationships with providers to achieve our collective aims of better patient health outcomes.

To enable us to achieve improvements in healthcare, it may be necessary to de-commission services, where greater benefit for patients may be secured elsewhere.

The performance schedules in the contracts are developed to ensure that we deliver the range of targets and trajectories within the planning framework. The penalties set for under-performance within each of the provider contracts are set to reflect the level of risk associated with the provider's ability to deliver the levels of achievement set in the contract.

# Commissioning Support

North of England Commissioning Support (NECS) is a business focused primarily on serving the needs of CCGs in the North of England.  Initially hosted by NHS England as a Commissioning Support Unit, NECS will provide North Tyneside CCG with high quality support services, enabling us to achieve our goals, whilst freeing us for clinical decision making and commissioning better patient outcomes.

We will gain assurance from NECS through a performance framework for delivery of delegated functions agreed in the service level agreement.

# 6. Governance

## Constitution

The draft constitution for the CCG has been prepared in conjunction with the member practices and has been signed by all the member practice representatives. It covers the key issues of membership, functions, individual roles and responsibilities and CCG decision making arrangements. It includes as appendices the standing orders, scheme of reservations and delegation and the prime financial policies.

## Governing Body

NHS North Tyneside CCG Governing Body has been meeting in shadow form since June 2012. As set out in the constitution, Governing Body members have been appointed as follows:

| Role | Name |
|---|---|
| Chair | Dr John Matthews |
| Chief Officer | Maurya Cushlow |
| Deputy Lay Chair | Mary Coyle |
| Lay member (lead on audit, remuneration and conflict of interest matters audit official) | David Willis |
| Lay member (lead on patient and public participation matters) | Eleanor Hayward |
| Secondary care doctor | Mr Kyee Han |
| Registered Nurse | Lesley Young Murphy |
| Medical Director | Dr Martin Wright |
| Chief Finance Officer | Alison Thompson |

The Governing Body has three sub committees – the Audit Committee, the Remuneration Committee and the Quality and Safety Committee. The committee terms of reference are included as an annex to the constitution. The CCG has two other key committees.

## Council of Practices

The Council of Practices comprises a clinical representative of each member practice. It will make those decisions reserved to it as set out in the scheme of delegation. It will hold the Governing Body and the clinical executive to account and it will enable Practices to influence the strategic direction and priorities of the CCG.

## Clinical Executive

The Clinical Executive has been established to implement and deliver the strategic priorities of the CCG, working with the Council of Practices, the Governing Body and the accountable officer. Its remit includes development and implementation of strategy, monitoring and delivery of statutory duties, operational, financial, contractual and clinical performance as well as ensuring the coordination and monitoring of risks and internal controls. It is responsible for ensuring effective clinical engagement and promoting the involvement of all member practices in the work of the CCG in securing improvements in commissioning of care.

## Other governance

In addition, the patient forum is integral to the work of the CCG. It builds on the Patient Participation Groups in each Practice. It is being actively developed as the CCG develops.

The CCG has a clear 'standards of business conduct' policy which includes the need to adhere to declarations of interest. The CCG has a register of interests; a copy is available on request.

The CCG works closely with the North Tyneside Health and Wellbeing Board. This will continue and progress as the CCG and the Health and Wellbeing Board develop as statutory bodies. This will ensure better joint working to deliver integrated care across health and social care.

## Further development and consolidation

The CCG underwent a rigorous authorisation process in 2012/13. As a statutory body, the CCG will carry out in full its wide range of duties and functions and account to the public and to stakeholders and partners for how it discharges its responsibilities.

2013/14 will be a year of development and consolidation. The Governing Body and other committees will jointly develop their ways of working; this will be supported by individual and team development programmes. The CCG Governing Body will meet in public, except when matters of a confidential nature are being discussed, and its decisions will be subject to public scrutiny.

# 7. Risk Management

The CCG has a Risk Management and Assurance Strategy that was approved by the interim Governing Body in September 2012 which draws on existing policy and practice from NHS North of Tyne, good practice from elsewhere in the region and nationally, and the advice and expertise of Internal Audit. The strategy sets out how the CCG brings together the assessment and management of clinical, financial and corporate risks. It refers to the lead roles within the CCG, the mechanism for preparing and maintaining risk registers and the proposed arrangements for risk scoring.

The policy sets out the definition of a moderate, high or very high risk and this will inform the risks to be reported to the Governing Body and its committees.

The risk management strategy will be reviewed annually by the Quality and Safety Committee and/or the Audit Committee on behalf of the Governing Body. The strategy would then be subject to annual approval by the Governing Body.

## Assurance Framework

The assurance framework assists the Governing Body in considering the risk to the achievement of the corporate objectives, how those risks can be mitigated and what controls and assurances are in place. The NTCCG assurance framework will be considered by the CCG Governing Body in 2013 and remain under review.

## Key Risks

The main risks to delivery of the commissioning plan are detailed below.

### Financial Risk

- Contract over-performance - over activity on acute /secondary contracts or against continuing healthcare budgets;
- Local Authority Funding – significant reductions in local authority funding, which may impact upon reablement, public health and social care support.

**Mitigation**: An agreed memorandum of understanding; close working with health partners; regular focused events to understand the shared risks, health economy projects on the cross cutting risk areas; ongoing discussions with the NHS England Area Team (NHSEAT) regarding the specialised commissioning risks; financial planning contingency.

### Business Risk

- Clinical involvement – continuing to secure sufficient clinical involvement in commissioning;
- Capacity to deliver – establishing the CCG and North of England Commissioning Support Unit, and developing the model of operational delivery;
- Operational support arrangements, such as accommodation and IT systems.

**Mitigation**: The organisational structure is almost fully populated, and there will be some degree of continuity of staff roles, which will enable a smooth transfer to the new organisations. Transition and handover arrangements from PCT to CCG are in place. Service level agreements are in place with NECS, supported by detailed process discussions.

## Stakeholder Risk

- Increasing patient expectations and the potential for adverse reaction from local interest groups, politicians and the public to a commissioning decision;
- System alignment – potential for a lack of alignment between the plans of individual organisations in addressing efficiency requirements;
- Maintaining quality and safety in provider services whilst delivering efficiency improvements;
- Continued integrated working with health commissioners and providers regarding delivery of public health targets, such as healthchecks and smoking cessation, given the transfer of public health responsibilities to local authorities.

**Mitigation**: Communication and Involvement Plan, close working with partners and Healthwatch, quality and safety governance and assurance arrangements.

# 8. Appendices

## Appendix A – 3 local quality premium priorities

Three local measures have been identified based on local need, areas of poor performance, and alignment with priorities within the commissioning plan that have been shaped through public consultation. The agreed local measures and the rationale for selection are as follows:

1. **Number of emergency readmissions within 30 days of discharge from hospital**
   North Tyneside CCG is ranked 204 out of 212 CCGs nationally for the percentage of readmissions within 30 days of discharge from hospital. The CCG aims to reduce readmissions by working with partners to invest in system improvements such as the 30 day readmission programme with the local Foundation Trust. The measure is included in the CCG Outcomes Dataset (C3.2). A local target of a 5% reduction in the number of readmissions is proposed. Based upon the latest full year data for 2011/12 of 4853 this effectively would be a reduction of 243 readmissions in 2013/14 to 4610.

2. **Percentage of people dying in their place of choice**
   In North Tyneside 48.6% of people are recorded as dying in their place of choice, either in their own home or in a care home. The CCG is increasing investment and changing systems through an end of life care initiative, and implementing 'Deciding Right'. The aim is to increase the number of advanced care plans for people in nursing homes and through GP practices, to give people choice, and achieve a reduction in inappropriate hospital admissions at the end of life. There is an underlying increasing trend for this measure which will be influenced by the initiatives in place. It is proposed that as a stretch to the existing performance that the 2014/15 predicted level of performance of 51.5% is delivered one year earlier in 2013/14.

3. **Percentage of people with a learning disability receiving a health check**
   This is a local, regional and national priority and is an area of performance requiring improvement. People with a learning disability have poorer health than the general population and yet are less likely to access healthcare. These health inequalities result in a lower life expectancy and greater presence of chronic health problems which could benefit from earlier identification and intervention. In 2011/12, 61% of people with a learning disability received a health check and although above average nationally (ranked 58 of 151 PCTs), it is well below performance in the better performing areas at the 90th percentile of 73%. The 2013/14 target will be 70%, requiring 845 assessments to be undertaken out of the number of people eligible of 1207 (as at January 2013).

# Appendix B – Rights and Pledges from the NHS Constitution

| **Referral To treatment waiting times for non-urgent consultant-led treatment** |
|---|
| Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% |
| Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% |
| Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% |
| **Diagnostic test waiting times** |
| Patients waiting for a diagnostic test should have been waiting no more than 6 weeks from referral – 99% |
| **A&E waits** |
| Patients should be admitted, transferred or discharged within 4hours of their arrival at an A&E department – 95% |
| **Cancer waits – 2 week wait** |
| Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% |
| Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% |
| **Cancer waits – 31 days** |
| Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% |
| Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% |
| Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% |
| Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% |
| **Cancer waits – 62 days** |
| Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% |
| Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% |
| Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set |
| **Category A ambulance calls** |
| Category A calls resulting in an emergency response arriving within 8 minutes – 75% (standard to be met for both Red 1 and Red 2 calls separately) |
| Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95% |
| **Mixed sex accommodation breaches** |
| Minimise breaches |
| **Cancelled operations** |
| All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice. |
| **Mental health** |
| Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95% |

NHS North Tyneside
Clinical Commissioning Group

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