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</tbody>
</table>

### Introduction

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   - Strategic Aims
   - Plan on a Page

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   - Everyone Counts
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   - Review of Delivery and Lessons Learnt
   - Remedial Actions and Lessons Learnt
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8. Risks
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We are pleased to present our delivery plan for 2013/14 which sets out what we will achieve in our first year as a statutory body. Our plan responds to the challenges in our local health economy and is true to our vision to help the people of Northamptonshire to lead the best possible life from beginning to end.

During 2012/13 we have been preparing to take on our statutory role. We have gone through a rigorous authorisation process, which highlighted many strengths of our Clinical Commissioning Group (CCG), but also identified a number of areas where we need to improve, most notably in relation to our QIPP delivery and the management of our Commissioning Support Services, currently provided by the NHS Greater East Midlands Commissioning Support Unit (GEM). Improvements are well underway, and we will be relentless in our drive to improve performance in all areas.

We recognise that our health system is extremely challenged and we need to be a strong and effective commissioner in order to drive improvement in system performance and deliver the efficiency savings required for the future. Nowhere is this more apparent than in our acute hospitals, where despite continuing to spend more money year on year, we have not secured the urgent care system that any of us want to see for the future. This has to change and our plans aim to address this issue head on through immediate action plans, medium term plans for frail, elderly care, and through a longer term sustainability plan, delivered through a locally driven Healthier Together Programme.

During 2012, we undertook an extensive public engagement programme, culminating in the development of our 3 year strategy. This work and the strategic priorities we agreed last year endures. For 2013/14 we have refreshed the areas of transformation that will deliver our strategic priorities to reflect our local context through an improved understanding of what needs to change.
The cornerstone of our organisation is our eight localities. It is here that our member practices come together to discuss what needs to change in our health system, and subsequently shape our commissioning intentions for the year ahead. Our intentions for 2013/14 have been developed and tested with localities and each locality has a delivery plan for 2013/14 that sees them taking delegated responsibility for its delivery.

Collaboration is key for future success. We will work with our providers to help them to plan sustainable high quality services for the future. We will work with our partner CCG in Corby to share functions and collaborate where it is appropriate on a countywide basis. We also recognise the importance of our relationship with Northamptonshire County Council, together we have established a joint commissioning team and we will align and pool budgets where this is in the best interests of our patients.

2013/14 is an exciting and challenging year for Nene CCG, as we bring about the changes we need to see in our health system and deliver the best possible care for the people we serve.

Dr Darin Seiger
GP Chair
Ben Gowland
Chief Executive
Our plan for 2013/14 has been developed with, and through, our localities and member practices. Active engagement of member practices and the delivery of plans through our localities is key to our future success. Each locality has a plan for 2013/14 which is owned by them, and for which their leadership team are accountable.

The plan takes the work we did in the Autumn of 2012 to develop our strategic direction and priorities and updates this to reflect our context today, and to drive our plans for 2013/14. Ours plans reflect the context within which we operate; a challenged health economy, with a need to reshape the provider landscape and ensure delivery of sustainable, high quality services for the future, with less reliance on hospital care, particularly for our aging population.

Our plan is shaped around our revised vision “To help people lead the best possible life from beginning to end”. The plan has four strategic aims, that will be delivered through five areas of transformation, each of which has multiple initiatives within it. This will provide the focus for our work in 2013/14.

As a full and active member of the Northamptonshire Health & Wellbeing Board, we have ensured alignment of our strategy with that of the Board. We have influenced the development of Health & Wellbeing strategy and are leading implementation of one key work stream within the strategy – “Vulnerable adults and elderly living as independently as possible”.

Delivering better value and higher quality services for patients is at the heart of our plan. Key elements of our plan in this regard are strengthening contracting and contract compliance, tackling variation in the use of health services at practice level, reducing spend on low value interventions and delivering better value from our programme spend in mental health.
Any plan that is not fully grounded in its local context is doomed to failure, as is an organisation that does not learn from its past. Our plan for 2013/14 responds to both the financial challenge facing our health system, with plans to save £32 Million from our QIPP programme, and with improved programme and performance management arrangements in place to ensure savings are delivered.

To be successful as commissioners, we need successful and sustainable providers. As well as building on the work of the Healthier Together programme to develop a local solution for the long term, we will put in place more partnership arrangements within which providers are incentivised to support and drive the delivery of our plans, as well as strengthening our contracting function and capability to drive the changes we need to happen.

We will continue to engage with our patients and public with regard to our plans. We have some significant challenges ahead as commissioners and as a local NHS. Being open and transparent will characterise how we work in responding to these challenges and taking on the difficult decisions that this demands.
Our Vision, Strategic Aims and Plan Summary (“The Plan on a Page”)
Our Vision

“To help people lead the best possible life from beginning to end”

Our vision has been reviewed and amended in order to:

✓ Establish an ambitious long term aim for the CCG

✓ Create a collective identity and sense of direction for our member practices and workforce

✓ Provide a touch point for all of our planning, ensuring that our plans are aligned to this vision
Our Vision and Strategic Aims

Tackling the top killers – Cancer, Heart Disease and Stroke

Strengthening long term conditions management

“To help people lead the best possible life from beginning to end”

Improving prevention

Delivering system redesign

“Foreword and Introduction”

“Vision”

“Context”

“Quality and Safeguarding”

“Outcome Measures”

“Engagement”

“Financial Plan and QIPP”

“Risks”
Our “Plan on a Page”

The Nene Vision

“Help People Lead the Best Possible Life from Beginning to End”

We will do this by

- Tackle the big killers: heart disease, stroke and cancer
- Improve how we manage longer term (“chronic”) conditions e.g., diabetes and asthma
- Reduce the number of people who are obese, smoke and drink too much alcohol so as to improve health
- Radically change the way we deliver services to improve the quality of patient care and release money for investment in new treatments

We will measure this by

- Reducing potential years of life lost through avoidable mortality by at least 3.2% in 2013/14
- Reducing the percentage of avoidable emergency admissions for local population between 2013/14 and 2014/15
- Increasing the number of people with chronic lung disease referred to a pulmonary rehabilitation programme to 600 in 2013/14
- Preventing healthcare associated infections so there are no cases of MRSA and less than 153 cases of C.difficile in 2013/14
- Ensuring local providers are using the Friends and Family Test and that there has been improvement in average scores for inpatient care and A&E services between 2013/14 and 2014/15

Through 5 Areas of Transformation

1. Vulnerable Adults and Elderly Living as Independently as Possible
   - Improving provider emergency care performance
   - Trail Elderly programme implementation
   - Direct support to care homes
   - Reducing admissions for illnesses that can be managed at home

2. Sustainable High Quality Services
   - Local “Healthier Together” programme
   - Strengthening management of longer term (“chronic”) conditions
   - Innovation in the way we contract to promote better care
   - Developing our operating model

3. Locality Led Commissioning
   - Better value, choice and quality in mental health services
   - Better value, choice and quality in out of hospital and community care
   - Locality partnerships through Health and Wellbeing Forums
   - Developing locality specific schemes

4. Better Commissioning of Elective Care
   - Tackling variation in the use of health services
   - Locality specific schemes
   - Better value and quality in children’s and maternity services
   - “Rightscore” value based commissioning

5. Building the Capability to Deliver
   - Learning from authorisation
   - Collaboration with other CCGs
   - Strengthening commissioning support
   - Better contracting
Local Context
In developing our plan for 2013/14 and beyond we have taken into account a range of relevant factors which influence our thinking and planning:

Health Needs and Inequalities
The health needs of our population, inequalities and priorities for action identified in the Joint Strategic Needs Assessment (JSNA) for Northamptonshire and how we are responding

Benchmarking of Historic Performance & Spending
Examining where we spend our resources and where we should look for efficiency and investment opportunities

Performance and Delivery Targets
This includes identified problems within the local health system which prevent the delivery of local or national priorities and infrastructural issues within the provider landscape

Review of Delivery and Lessons Learnt
Learning the lessons from 2012/13

Remedial Actions on Critical Issues
Actions implemented in 2012/13 to remedy critical issues during 2013/14

Provider Landscape
An understanding of the major providers of acute community and mental health services commissioned to deliver healthcare to our local population.
Detailed information on Northamptonshire’s demographics and health needs can be found in the Joint Strategic Health Needs Assessment for Northamptonshire County Council and in Public Health England’s health profiles. This information has formed the basis of NHS Nene’s 3 Year Strategy and for this Delivery Plan.

NHS Nene CCG catchment area covers most of Northamptonshire’s districts, excluding Corby and some of East Northants (Wansford and Oundle).

The registered population for the CCG is 634,452 with these patients registered with 70 Nene Practices. Around 6,000 patients are unregistered, taking the total resident population to 640,500. This population is expected to rise to 710,400 by 2019.

The population has a lower than average proportion of older people and people in their twenties but a higher proportion of children. Currently 16% of the resident population is aged 65+; this is expected to increase to 19% by 2020.
Overall, the resident population within the NHS Nene CCG area is ethnically less diverse than England or the East Midlands. 91% of the population is estimated to be white; this is even higher in the older age groups. The 2010 annual population survey estimates the non UK born population served by NHS Nene CCG is 60,200. The majority (42,000) are white, non-UK born residents. The biggest proportion of the white, non UK born resident are residing in the Northampton and Wellingborough locality areas.

The estimate obtained from the latest school census shows that 82% of children pre reception class were white and 83.5% of school age pupils were white British.
The geographical area that is covered by Nene CCG has an average deprivation score of 17.5 which is lower than the England average.

The two key components of the IMD score: the income deprivation affecting children (16.2) and income deprivation affecting older people (16.9) are also lower than the England average.

While less of the population as a whole is living in deprivation across Nene, deprivation in children and/or older people is not being hidden by a more affluent working population.

Average life expectancy is 78 years for men and 82.3 years for women which are both higher than the England average.

Across Northamptonshire there is significant variation in life expectancy. The life expectancy gap between the most and least deprived areas in the county is 9.4 years for men and 4.8 for women.
In establishing our plans for 2013/14, we have looked at historical activity and spending patterns. This has shown us that:

- We have been comparatively successful in managing both the level of emergency admissions and their growth in recent years
- Despite managing first out-patient appointments well, more of our patients undergo elective procedures than expected
- Historically, we have managed prescribing costs well, but growth in recent times has been higher than average, suggesting a need to redouble our efforts
- We spend more than expected on our mental health programmes.
## An Understanding of Our Current Performance (1)

**Patient Care Dashboard – Northamptonshire 2012/13 to March 2013**

### Foreword and Introduction

### Vision

### Context

### Quality and Safeguarding

### Outcome Measures

### Delivery Plan

### Engagement

### Financial Plan and QIPP

### Risks

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<th>Issue</th>
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<td>RTT - non-admitted % within 18 weeks</td>
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<td>RTT - incomplete % within 18 weeks</td>
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<td>Diagnostic waits - % waiting 6 weeks or more</td>
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<td>Incidence of C. difficile</td>
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<td>12</td>
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<td>54</td>
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<td>12</td>
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<td>MSA Breaches (mixed sex)</td>
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| Period to date 'ceiling' for C.difficile | 17 | 53 | 52 | 51 | 17 | 173 |

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<th>New cases of psychosis served by EITs (plan for year)</th>
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<th>27</th>
<th>49</th>
<th>73</th>
<th>73</th>
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| Crisis Resolution Home Treatment episodes (Comm.) | 1,052 | 268 | 99.5% | 98.9% | 98.7% | 98.7%
| Acute admissions gatekept by the CRHT teams (NHFT) | 95% | 95.7% | 97.2% | 97.3%
| CPA follow ups 7 days after discharge | 95% | 44.8% | 50.3% |
| IAPT - Treatment against need in population (Q on Q improve) | 15% | 2.9% | 3.1% |
| IAPT - People treated that are moving to recovery (by 2014/15) | 50% | 3.1% | 50.3%

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<td>Healthchecks delivered plan (originally submitted)</td>
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<td>Cumulative Healthchecks delivered Year To Date</td>
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### An Understanding of Our Current Performance (2)

**Patient Care Dashboard – Acute Providers 2012/13 to March 2013**

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<th>Issue</th>
<th>Indicator</th>
<th>Plan</th>
<th>Period</th>
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<td>Cancer - 31 day subsequent treatment-surgery</td>
<td>94%</td>
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<td>95.6%</td>
<td>96.2%</td>
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<td>95.7%</td>
<td>95.4%</td>
<td>96.0%</td>
<td>95.6%</td>
</tr>
<tr>
<td>Cancer - 2 week wait (Breast symptoms)</td>
<td>93%</td>
<td>Dec-12</td>
<td>100.0%</td>
<td>96.8%</td>
<td>96.6%</td>
<td>96.1%</td>
<td>95.9%</td>
<td>96.4%</td>
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<td>95.7%</td>
<td>95.7%</td>
<td>95.4%</td>
<td>96.0%</td>
<td>95.6%</td>
<td></td>
</tr>
<tr>
<td>RTT - admitted % within 18 weeks</td>
<td>90%</td>
<td>Jan-13</td>
<td>95.9%</td>
<td>100.0%</td>
<td>99.5%</td>
<td>98.3%</td>
<td>99.2%</td>
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<td>97.6%</td>
<td>97.8%</td>
<td>98.9%</td>
<td>98.1%</td>
<td>98.1%</td>
<td></td>
</tr>
<tr>
<td>RTT - admitted % below admitted standard</td>
<td>0</td>
<td>Jan-13</td>
<td>96.6%</td>
<td>98.3%</td>
<td>98.5%</td>
<td>98.5%</td>
<td>98.6%</td>
<td>98.4%</td>
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<td>99.6%</td>
<td>97.1%</td>
<td>97.3%</td>
<td>98.0%</td>
<td>97.2%</td>
<td></td>
</tr>
<tr>
<td>RTT - non-admitted % within 18 weeks</td>
<td>95%</td>
<td>Jan-13</td>
<td>98.6%</td>
<td>98.3%</td>
<td>98.5%</td>
<td>98.5%</td>
<td>98.6%</td>
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<td>98.0%</td>
<td>97.1%</td>
<td>97.3%</td>
<td>98.0%</td>
<td>97.2%</td>
<td></td>
</tr>
<tr>
<td>RTT - non-admitted % below non-admitted standard</td>
<td>0</td>
<td>Jan-13</td>
<td>96.6%</td>
<td>98.3%</td>
<td>98.5%</td>
<td>98.5%</td>
<td>98.6%</td>
<td>98.4%</td>
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<td>98.0%</td>
<td>97.1%</td>
<td>97.3%</td>
<td>98.0%</td>
<td>97.2%</td>
<td></td>
</tr>
<tr>
<td>RTT - incomplete % within 18 weeks</td>
<td>92%</td>
<td>Jan-13</td>
<td>95.4%</td>
<td>97.7%</td>
<td>97.3%</td>
<td>96.7%</td>
<td>95.4%</td>
<td>97.1%</td>
<td></td>
<td>96.1%</td>
<td>97.0%</td>
<td>97.9%</td>
<td>96.4%</td>
<td>96.9%</td>
<td></td>
</tr>
<tr>
<td>RTT - number of specialties below incomplete standard</td>
<td>0</td>
<td>Jan-13</td>
<td>95.4%</td>
<td>97.7%</td>
<td>97.3%</td>
<td>96.7%</td>
<td>95.4%</td>
<td>97.1%</td>
<td></td>
<td>96.1%</td>
<td>97.0%</td>
<td>97.9%</td>
<td>96.4%</td>
<td>96.9%</td>
<td></td>
</tr>
<tr>
<td>Diagnostics waits - % waiting 6 weeks or more</td>
<td>1%</td>
<td>Jan-13</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td></td>
<td>0.6%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.2%</td>
<td></td>
</tr>
<tr>
<td>A&amp;E 4 hour waiting time</td>
<td>95%</td>
<td>Jan-13</td>
<td>87.9%</td>
<td>93.7%</td>
<td>93.9%</td>
<td>91.4%</td>
<td>87.5%</td>
<td>92.5%</td>
<td></td>
<td>94.4%</td>
<td>95.9%</td>
<td>90.1%</td>
<td>83.9%</td>
<td>92.4%</td>
<td></td>
</tr>
</tbody>
</table>

| Period to date 'ceiling' for MRSA | 0 | Jan-13 | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 1 |
| MRSA bacteraemia | 0 | Jan-13 | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 1 |
| MRSA breaches (mixed sex) | 0 | Jan-13 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SHMI breaches (mixed sex) | 1/WCL | Jan-13 | 1.09 | 1.06 | 1.05 | 1.08 | 2 | 14 | 9 | 8 | 6 | 37 |
| Incidence of C. difficile all trusts infections | 2 | Jan-13 | 8 | 5 | 7 | 2 | 22 | 6 | 14 | 9 | 8 | 6 | 37 |
| MRSA breaches (mixed sex) | 0 | Jan-13 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Serious incidents | n/a | Jan-13 | 10 | 16 | 13 | 13 | 10 | 52 | 12 | 18 | 16 | 12 | 48 |
| Never Events | 0 | Jan-13 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Harm free care (local standard) | 95% | Jan-13 | 90.8% | 83.8% | 89.7% | 92.6% | 90.8% | 88.9% | 89.3% | | 88.6% | 86.1% | 89.5% | 89.3% | 88.3% |
| VTE risk assessment | 90% | Dec-12 | 93.0% | 91.0% | 92.3% | 93.0% | 91.9% | 92.8% | 91.1% | | 92.5% | 91.3% | 93.3% | 91.3% | 89.8% |
| New pressure ulcers (prevalence) | <0.9 | Jan-13 | 0.7 | 1 | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 1 |
Progress continues to be made in controlling high cost mental health expenditure. Working with our partners in Northamptonshire Healthcare Foundation Trust (NHFT) to manage individual package costs down and exceeding target performance. This collaborative approach will be spread to other client groups in 2013/14, such as those with learning disabilities, and the learning taken into our commissioning in other sectors. However, our programme spend in relation to Mental Health remains above the national average and we will strive for better value, choice and quality in the future.

Performance against our prescribing budget continues to be strong. For the future, we need to influence / control drug initiation in secondary care, ensuring that patients get the medication they need, but that this is done in the most cost effective way.

2012/13 has seen a significant increase in demand for Continuing Healthcare and as a result expenditure has increased. We need to put in place more capacity to undertake assessment and review of patients and increase the uptake of personal health budgets in 2013/14. These measures, together with better procurement will enable cost savings in 2013/14.

Our Urgent Care system continues to underperform as reflected in the failure to meet the related A&E performance target during 2012/13. This has created both financial and service delivery pressures during the year. We will oversee a programme of work to ensure sustained performance improvement and delivery of the 95% national standard in 2013/14 working closely with acute providers. Drawing on national best practice, the Urgent Care Group is tasked with delivering significant improvement for 2013/14, including the development of a new service model for the frail, elderly as well as the effective deployment of social care resources to support effective discharge.
Nene CCG is committed to this constitution pledge relating to ambulance standards and reflects this in the commissioning of this in contracts, however EMAS are currently not performing at the required constitution standards (Red 1 and 2 combined 73.62 YTD, A19 93.61% YTD). This has led to significant performance measures being put in place including contract query, remedial action plan and daily conference calls to support an improvement in the performance position. Penalties will be applied for non-performance, as per the contract in 2012/13. The CCGs have also further supported EMAS during 2012/13 with a further circa £4m to support the delivery of targets, winter pressures and transformation. Performance delivery remains an area of concern for CCGs going into 2013/14 across all the standards.

Nene CCG is committed to support the reduction of ambulance turnaround times, with EMAS currently performing at less than 15 minutes on post handover. The CCG contract leads, EMAS and ambulance commissioners are working with Acute Trusts to support the turnaround pathway to reduce the pre-handover delays but these still stand at well over 20 minutes on average with pockets higher than this. Clauses within Trust contracts are being included for 2013/14 to support the achievement of pre-handover times, including penalty markers. In addition, the CCGs have funded an electronic data capture system for all major Trusts in the East Midlands to support accurate data recording, which supports the highlighting and targeting of bottlenecks to meet this standard (fully in place by June 2013).
There have been no prominent themes arising from the four cases of MRSA bacteraemia identified to date in 2012-13, although asepsis and urinary catheter management have been noted. It is intended that learning instigated to address the issues identified continue to be applied. This includes education in procedures requiring aseptic technique and taking of blood cultures, particularly for medical staff and response to early recognition of symptoms of sepsis. Additionally, there is work undertaken in community health services to provide education for the correct identification of urinary tract infections and management of catheters. We plan to cascade this to care home staff and domiciliary care agencies.

It is recognised that this is a challenge for the whole health economy relating to the prevalence of Clostridium Difficile and a systematic review of cases to date is in progress. Antimicrobial prescribing audits are carried out in acute trusts on a regular basis and learning from these is implemented. The health economy will be exploring how adherence to antimicrobial guidelines can be monitored in the community for both medical and non-medical prescribers. Schemes to incentivise good antimicrobial stewardship will be in place. Additionally, education will be made available to community based health workers for appropriate and timely sampling of people presenting with diarrhoea.

Although improved on previous years, our Right Care Programme for 2012/13 did not deliver the financial savings expected. For 2013/14 we will broaden the prior approval system and contract differently in order to see the reductions we need to see in areas of lower clinical value.
The availability of information to support the commissioning and contract management of services continued to be a problem for the CCG in 2012/13. A task force was established in Q3 to bring about improvement and this has had success in delivering short term improvements. The taskforce is now planning the deployment of the GEM Data Management Information Centre (DMIC) product GEMIMA early in 2013/14.

The CCG will exert further control on provider performance in 2013/14. We will develop our own “in house” contracting function, and cease to obtain this mission critical service from GEM. Through this we will transform our approach across all sectors, ensuring tighter control on contract compliance with all our service providers.

Our ambition to develop empowered localities with delegated budgets is critical to future success. In 2012/13 the tackling of variation in referral and admission rates between practices provided differential results. However, with improved information, enhanced locality management arrangements and properly aligned incentives we believe that our localities will be successful in tackling variation and reducing overall demand for hospital based care in 2013/14.
In 2012/13 NHS Nene CCG, operating in “shadow form” achieved a great deal. However, our achievements were overshadowed by two things; firstly the continuing failure of our local health system to meet the 4 hour A&E standard, and secondly the increase in acute service activity and expenditure above that planned for the year. 2012/13 has also seen the CCG go through the authorisation process, and this has enabled the CCG to identify a number of important developmental areas, where we must improve.

In summary:

- We have built a strong foundation but we will improve the pace and implementation of agreed changes and ensure that these happen consistently across all our localities
- Clinical engagement and leadership is key to future success. We will ensure that our localities are equipped to lead and are accountable for delivery. We will ensure that all member practices associate themselves with NHS Nene CCG and engage to play an active role within their locality
- We will establish a process that can hold individuals to account for the delivery of priorities assigned to them and we will embed our Programme Management Office approach and use it to track and drive change
- We will strengthen contracting capacity and capability and manage provider performance robustly
- We will ensure that provider reimbursement systems deliver the benefits expected, and do not create perverse incentives or unintended consequences. We will consider the “Principal Provider” model, where one provider co-ordinates care and delivers the outcomes specified within the pathway
- We will control acute service activity and expenditure to deliver within plan
- We will find sustainable solutions across the health system that will enable effective patient flow through our hospitals, enabling consistent delivery of the 4 hour standard
- We will develop an effective partnership with our commissioning support provider, GEM, where they are delivering high quality support to us, under a contractual framework with clear performance standards.
The CCG and Urgent Care partners are aware of the need to:

- Focus on discharge processes and avoidable admissions especially for those patients who have 0-1 Length of Stay
- Ensure the community and specialist care centre model is appropriate for local needs and have the flexibility to support the urgent care demands
- Review and refine the CHC process and discharge process from community hospital
- Availability of packages of care.

For 2013/2014 we are moving from unplanned urgent care to planned avoidance through a suite of new services.

Integration of health and social care services is critical in this area to ensure smooth transition of patients between services delivering quality and apportioned cost to the correct services, rather than incurring excess bed days.
In 2013-14, NHS Nene CCG will invest its commissioning resources in a range of NHS, independent sector and voluntary/charitable agencies. The appropriate use of mechanisms such as ‘Any Qualified Provider’ are being used to encourage competition for and within markets of healthcare, and result in the introduction of new healthcare providers to a local health economy, driving improvements and innovation. Alongside service reconfiguration, existing local providers will face increasing challenges to ensure excellence in quality service provision and value for money.

Characteristics of our main local providers are summarised below.

**Acute Care Provision**

Northamptonshire contains two local district general hospitals. These are Northampton General Hospital NHS Trust (2012-13 contract outturn £194.8M) and Kettering General Hospital NHS Foundation Trust (2012-13 contract outturn £146.3M). In addition to this, Nene patients around the county boundaries routinely use a number of hospitals, these being:

- BMI Woodlands (£7.5M)
- BMI Three Shires (£4.3M)
- Oxford University Hospitals NHS Trust (£18.6M)
- Milton Keynes General Hospital NHS Foundation Trust (£2.6M)
- University Hospitals of Coventry and Warwickshire NHS Trust (£6.6M)
- University Hospitals of Leicester NHS Trust (£8M)

Other smaller scale patient flows also take place to Peterborough, Bedford, Hinchingbrooke, Addenbrookes and London.
Northampton General Hospital NHS Trust

Northampton General Hospital has experienced significant challenges over the last two years, with significant financial pressures arising, coupled with poor performance on some key national performance targets, most notably A&E transit times. The trust has received financial support for the past two years from commissioners, above the level of contract funding due. In contrast, it has made improvements in some critical areas of quality, such as infection control and the Standardised Hospital Mortality Indicator (SHMI).

The trust has been delayed in its Foundation Trust application several times due to its financial standing, and its Board has recognised the need for service reconfiguration via the Healthier Together programme to ensure clinical and financial viability. This review is based upon finding the optimal clinical models and services for the population of this area. However, public consultation on the service options arising from Healthier Together, will not include proposals about the organisational form of the providers such as Northampton General Hospital and so the trust has recently begun partnership talks with Kettering General Hospital NHS Foundation Trust, with a view to moving up to and including a merger within 12-18 months, subject to the production of an appropriately robust business case. A partner is currently being sought to progress this work, with funding for a local Programme Director and Programme Office to be made available by the two CCGs through the application of the 2% transformational funding.

The trust faces some significant leadership challenges; it currently has no substantive Chief Executive or Director of Finance, and the Director of Operations/Deputy Chief Executive will leave the trust in June. In addition, the trust will face a significant financial challenge in the year 2013/14.
Kettering General Hospital NHS Foundation Trust

Kettering General Hospital has been a Foundation Trust since November 2008, and whilst it has historically been financially sound, the trust is currently in breach of the terms of its authorisation, due to financial performance, A&E transit times and governance concerns. In 2012-13, it received financial support above contract sums, and faces significant financial challenges in 2013-14. The trust has demonstrated poor performance against the A&E transit times target for over 18 months, and in 2012-13 a significant penalty was levied for non-delivery of this indicator.

As with NGH, the trust is engaged in the Healthier Together programme, although there is significant concern from local people and politicians around the future of the Kettering General site and its services, particularly in relation to A&E and maternity services.

The trust does not currently have a substantive Director of Finance, although an appointment has recently been made to the post. Once this individual is in post, the trust will have a full leadership team in place. As with NGH, the trust will face a significant financial challenge in the year 2013/14.
Community Services

Northamptonshire Healthcare Foundation Trust (NHFT) provides the majority of adult and children’s community health services on behalf of NHS Nene CCG. In 2012/13 NHFT delivered a range of community services including Community Nursing, Specialist Palliative Care, SALT, Physiotherapy, Podiatry Rehabilitation through a contract valued at £52m (excluding public health and sexual health services).

The provision of Community Hospital Beds is included within the contract for services with the Northampton General Hospital Trust. Community Beds are located in Daventry, Corby, Wellingborough, and Kettering.

Community Equipment and Wheelchair services are provided by Millbrook, an independent sector provider, with community equipment commissioned under a Section 75 pooled budget arrangement with Northamptonshire County Council.
Mental Health and Learning Disability Specialist Healthcare

NHFT is the largest provider of mental health and learning disability health care in Northamptonshire with a 2012/13 total contract value of £78.4m. Services cover inpatient and community mental health teams for adults and older people, CAMHS, IAPT and wellbeing service and inpatient, community and specialist services for people with learning disability. A memory assessment service operating in all localities was established as part of the older person’s mental health service during 2013. Commissioners and NHFT are working closely together to integrate the provision of mental health, learning disability and community health services to provide an holistic approach to patient care. This has included initiating the development of multi-disciplinary neighbourhood teams in a number of localities during 2012/13.

There is an extensive independent sector in mental health and learning disability services in Northamptonshire including St Andrews Hospital. Nene CCG commissions services on a case by case basis for people with complex needs and a key element of our market development strategy is to shift activity and resource away from hospital, residential and nursing home case towards supported living and community based pathways. Historically, NHS Northamptonshire Primary Care Trust was a pilot site for personal health budgets (PHB) and expanding the use of PHBs forms an important element of our market development strategy. In addition, Nene CCG commissions mental health services from a range of 3rd sector mental health providers under S75 partnership arrangements with the County Council.
Quality and Safeguarding
Patients and the quality of the care they receive is the focus of everything we do. We will ensure that we commission services based on the quality of care they deliver and ensure that individuals are empowered to choose services on the basis of quality and outcomes. This involves providing clear information to the public about the quality of services which are commissioned on their behalf, including information about poor quality, unexplained variation and differential health outcomes.

As well as promoting ongoing quality improvement, commissioners need to assure themselves that existing services meet acceptable standards. Whilst regulators play a key role in this arena, commissioners must still actively monitor the quality of services delivered by our providers.

Where we are not assured about the quality of any of the services we commission, if we detect early warnings of a potential decline in quality or suspect a breach of unacceptable standards we have a responsibility to intervene.

To deliver this, will to focus on three priorities.

- **Actively manage today**
  - Maintain robust arrangements for quality and safeguarding

- **Manage the transition**
  - Set quality & safeguarding firmly at the core of our new health system

- **Build the future**
  - Take forward priorities & new initiatives for 2012-13
Commissioners have a range of information sources used to triangulate evidence to make judgements about the quality of care provided across commissioned services. This is used to inform the appropriate action to be taken in the event of quality concerns being quantified. This is underpinned by an agreed Quality and Safeguarding Strategy that includes the use of:

- Quality Schedules within contracts to introduce KPIs expected of providers
- National Quality Dashboard
- Serious Incident Management
- Infection Prevention and Control Committee
- Mortality Review Group
- Quality Surveillance Group
- Clinical Quality Visits to providers
- Monthly Clinical Quality Review Meetings with providers.
We have statutory duties relating to safeguarding outlined in Children Act 2004 and the recent publication of Working Together to Safeguard Children, March 2013. Nene CCG are committed to working in partnership with other agencies to ensure that safeguarding is effective across the county for vulnerable adults as well as children. Areas of focus for 2013/14:

- Designated lead professionals in post within CCG
- Safeguarding Strategy agreed in August 2012
- Executive membership of Safeguarding Boards
- Partnership working with children’s social care, police and healthcare providers
- Lead professionals attend provider safeguarding committees
- Providers assessed against agreed practice standards
- Development of Multi-agency Children’s Safeguarding Hub
- Scoping for roll out to Adult Safeguarding Hub
- Future role of Named GP – being developed with LAT.
It is our intention and duty to ensure we reduce health inequalities across our population. We shall consider the impact on all commissioning decisions on various groups within our community including those with protected characteristics highlighted in the Equality Act 2010. Progress to date includes:

- Executive leadership for equality
- Inclusion and Equality Strategy agreed in August 2012
- Adopted PCT Equality Objectives
- Equality Impact Assessments carried out on all QIPP programmes
- Further work to develop new objectives in August 2013 that inform and influence commissioning intentions for 2014/15
- Plan to publish equality information about both staff and our public in August 2013.
Outcome Measures
Outcome Measures

Outcome measures have been developed for Clinical Commissioning Groups to improve both the quality of services they commission and for associated improvements in health outcomes and reducing inequalities. The Quality Premium is awarded based on delivery of these improvements, and is calculated against the achievement of four national measures and three locally defined measures.

National Measures
1. Reducing potential years of life lost from causes considered amendable to healthcare: adults, children and young people
2. Reducing avoidable emergency admission
3. Ensuring roll out of Friend and Family Test
4. Preventing healthcare associated infections

Through engagement, NHS Nene has identified the following as our three local measures:
5. Increasing the number of patients with coronary heart disease who completed cardiac rehabilitation
6. Increasing the number of people with COPD referred to a pulmonary rehabilitation programme
7. Increasing the number of people with diabetes diagnosed less than a year being referred to structured education.

To qualify for the Quality Premium the CCG must manage within its total resource envelope for 2013/14 and not exceed the agreed level of surplus drawdown. In addition, the total payment to the CCG will be reduced if associated providers fail to meet the NHS Constitution rights or pledges for patients in relation to:
• Maximum 18 week RTT
• Maximum 4 hour waits in A&E
• Maximum 2 week wait for urgent GP referral to first treatment for cancer
• Maximum 8 minute response for Cat A red 1 ambulance calls

The following four slides outline the process used to identify the local measures selected by NHS Nene and provides further detail on those measures.
Our Process to Decide on Local Outcome Measures

Mapping
- CCG performance against outcome indicators were mapped against both the performance of other CCGs within the same ONS (Office of National Statistics) Cluster and the England Median (NHS CB Outcomes Indicator Data Set).

RAG Rating & Prioritising
- Health outcomes were RAG Rated: RED = Performing below ONS cluster, AMBER = Performing within ONS Cluster but below England Median and GREEN = Performing within/above ONS Cluster and within England Median
- Outcome indicators already covered by national measures were removed to ensure focused efforts.

Link to local issues
- The remaining Health outcome indicators were cross checked against the outcomes of the Health & Wellbeing Strategy for Northamptonshire 2012-15 for alignment. This exercise left a shortlist of 6 potential measures.

Engagement
- Following consultation with clinical colleagues and the Patient Congress the 3 local measures were selected and agreed.

Agreed Measures
- Increasing the number of patients with coronary heart disease who completed cardiac rehabilitation.
- Increasing the number of people with COPD referred to a pulmonary rehabilitation programme.
- Increasing the number of people with diabetes diagnosed less than a year being referred to structured education.

Rationale
- Through the delivery of our 3 locally selected Quality Premium Measures we shall enable more people to self manage their Long Term Conditions and reduce morbidity and subsequent mortality. This supports our overall strategic priorities.
## Locally Identified Outcome Measure (1)

<table>
<thead>
<tr>
<th>Domain of NHS Outcomes Framework</th>
<th>Domain 2: Enhancing quality of life for people with long term conditions Ensuring people feel supported to manage their condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence</td>
<td>The estimated prevalence of coronary heart disease in Northamptonshire is 5.2%</td>
</tr>
<tr>
<td>Health and Wellbeing Strategy Outcome</td>
<td>People choose healthier lifestyles and exert greater control over their health and wellbeing The numbers of people experiencing emergency, unscheduled care is reduced</td>
</tr>
<tr>
<td>Quality Premium Measure</td>
<td>Number of patients with coronary heart disease who completed cardiac rehabilitation. Completion is defined as the end of the cardiac rehabilitation delivery phase and second assessment, as collected by the national audit of cardiac rehabilitation (NACR)</td>
</tr>
<tr>
<td>Rationale</td>
<td>Participation in rehabilitation for patients with cardiovascular disease and heart failure can significantly improve quality of life, improve functional ability, allow the patient to retain employment, facilitate self-management thus avoiding unnecessary readmissions at 30 day post discharge. Cardiac rehabilitation can also reduce levels of disability and morbidity which has been shown to enable patients to continue to function at home</td>
</tr>
<tr>
<td>Value</td>
<td>12.5% of quality premium</td>
</tr>
<tr>
<td>Threshold</td>
<td>To earn this portion of the quality premium, the number of patients with coronary heart disease who completed cardiac rehabilitation will need to increase from 257 (predicted 2012/13 outturn) to 500 (94.5% increase)</td>
</tr>
</tbody>
</table>
## Locally Identified Outcome Measure (2)

<table>
<thead>
<tr>
<th>Domain of NHS Outcomes Framework</th>
<th>Domain 2: Enhancing quality of life for people with long term conditions Ensuring people feel supported to manage their condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence</td>
<td>Estimated prevalence of COPD in Northamptonshire is 3% of the adult population</td>
</tr>
</tbody>
</table>
| Health and Wellbeing Strategy Outcome | People choose healthier lifestyles and exert greater control over their health and wellbeing  
The numbers of people experiencing emergency, unscheduled care is reduced |
| Quality Premium Measure          | Number of people with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥ 3 referred to a pulmonary rehabilitation programme |
| Rationale                        | This indicator measures a key component of high quality care as defined in the NICE quality standards for COPD: Statement 6, People with COPD meeting appropriate criteria are offered an effective, timely and accessible multidisciplinary pulmonary rehabilitation programme |
| Value                            | 12.5% of quality premium                                                                                                         |
| Threshold                        | To earn this portion of the quality premium, the number of patients with COPD and MRC dyspnoea scale = to > 3 referred to pulmonary rehabilitation will need to increase to 600 during 2013/14  
Lack of available data and KPIs from the PCT has prohibited the development of any accurate baseline available for 2012/13 |
<table>
<thead>
<tr>
<th>Domain of NHS Outcomes Framework</th>
<th>Domain 2: Enhancing quality of life for people with long-term conditions Ensuring people feel supported to manage their condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence</td>
<td>There are around 1000 newly diagnosed patients per annum in Northamptonshire (c.15% of which are type 1). Therefore there are a potential 850 people in Northamptonshire who could complete structured education</td>
</tr>
<tr>
<td>Health and Wellbeing Strategy Outcome</td>
<td>People choose healthier lifestyles and exert greater control over their health and wellbeing The numbers of people experiencing emergency, unscheduled care is reduced</td>
</tr>
<tr>
<td>Quality Premium Measure</td>
<td>Number of people with diabetes diagnosed less than a year are referred to structured education</td>
</tr>
<tr>
<td>Rationale</td>
<td>NICE guidelines state that people with diabetes and/or their carers receive a structured educational programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education</td>
</tr>
<tr>
<td>Value</td>
<td>12.5% of quality premium</td>
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<tr>
<td>Threshold</td>
<td>To earn this portion of the quality premium, the number of people with type 2 diabetes diagnosed less than a year are referred to and complete structured education (DESMOND) will need to increase from 505 (2012/13 contract) to 606 during 2013/14 (20% increase)</td>
</tr>
</tbody>
</table>
Delivery Plan

2013/14
The CCG delivery plan sets out how we will deliver our strategic aims in 2013/14 as well as respond to service and financial pressures within our health system, and nationally determined priorities.

Our strategy aligns with the local Health & Wellbeing Strategy, and the CCG will lead on one of the strategic priorities of the Health & Wellbeing Board (Vulnerable adults and the elderly living as independently as possible).

Our plan is to be delivered through four areas of transformation, underpinned by a fifth area of transformation, aimed at strengthening organisational capacity and capability to deliver.
Aligning Strategies

The CCG plan aligns with the Health & Wellbeing Strategy ...

**The Health & Wellbeing Strategy Priorities**

- Every child is safe and has the best start in life
- Vulnerable adults and elderly people are safe and able to use services and support that helps them to live as independently as possible
- People choose healthier lifestyles and exert greater control over their health and wellbeing

**Alignment to the Nene CCG Strategy**

- Joint commissioning team with NCC
  - Children and Maternity pathway redesign
- Nene CCG Leading the work stream
  - The frail, elderly programme
  - Better LTC management
  - Reducing ACS admissions
  - Care home support
- Locality Health & Wellbeing fora
  - LTC management and education programmes
Our Strategy and Areas of Transformation (1)

AREAS OF TRANSFORMATION

Vulnerable adults and the elderly living as independently as possible

Sustainable high quality services

Locality led development

Better commissioning of elective care

Building organisational capacity and capability

STRATEGIC AIMS

- Tackling the top 3 killers
- Strengthening LTC management
- Improving prevention
- Delivering system redesign

We will achieve our strategic aims...

... by delivering these programmes
Five Programmes have been identified to deliver our strategy ...

<table>
<thead>
<tr>
<th>Strategic Aims</th>
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<th>2</th>
<th>3</th>
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<tbody>
<tr>
<td>Vulnerable adults and elderly living as independently as possible</td>
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<td>Building organisational capacity and capability</td>
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</table>

- Tackling the Top 3 Killers
- Strengthening LTC Management
- Improving Prevention
- Delivering System Redesign
The Five Areas of Transformation

Each of our areas of transformation has a set of commissioning plans ...

1. Vulnerable adults living as independently as possible
   - Improving provider emergency care performance
   - Frail, elderly programme implementation
   - Direct support to care homes
   - Reducing admissions for illnesses that can be managed at home
   - Strengthening management of Long Term (“chronic”) Conditions

2. Sustainable high quality services
   - Local “Healthier Together” programme
   - Better value, choice and quality in mental health services
   - Better value, choice and quality in out of hospital and community care
   - Innovation in the way we contract to promote better care

3. Locality led development
   - Primary Care development
   - Locality specific schemes
   - Locality partnerships through Health and Wellbeing fora
   - Tackling variation in the use of health services

4. Better commissioning of elective care
   - Better contracting
   - “Rightcare” value based commissioning
   - Better value and quality in children’s and maternity services

5. Building organisational capacity and capability
   - Developing our operating model
   - Learning from authorisation
   - Collaboration with other CCGs
   - Strengthening commissioning support
Vulnerable Adults and Elderly living as Independently as Possible

This is a key area of transformation for the CCG.

We need to find better ways to care for vulnerable people in a community setting, reducing the reliance on hospital based care, and helping people to remain healthy at home.

The CCG has identified five specific programmes of change within this area of transformation:

- Improving provider emergency care performance
- Frail, elderly programme implementation
- Direct support to care homes
- Reducing admissions for illnesses that can be managed at home
- Strengthening management of Long Term ("chronic") Conditions

The following pages describe these areas in detail...
Improving Provider Emergency Care Performance

The urgent care system in Northamptonshire needs to significantly improve for the benefit of our patients. Our vision for urgent care is for a system with greater consistency of response in and out of hours, that delivers high quality care and good outcomes and experience for patients, through better integration of care between providers.
Our plans centre around five themes:

1) **Integration at local level** – through our localities bringing forward proposals such as the community hubs, the further development of community services such as CECS, the end of life service, and integrated community nursing we will provide more unscheduled care closer to home for our patients. See primary and community services section of this plan.

2) **Enhanced primary care services** for patients with a long term condition will help more patients to stay healthy and will align resources to care for people at times of exacerbation of their illness. See primary and community services section of this plan.

3) **Improving patient flow** within our system, with acute hospitals delivering significant improvements in internal flow, and ourselves and NCC ensuring patients can be discharged from hospital efficiently at the end of their hospital stay.

4) **The alignment of reimbursement systems**, including CQUIN to deliver the improvements in acute care and A&E quality standards that we want to see.

5) **Longer term structural change** delivered from the Healthier Together programme (see context).
The Urgent Care Team will:

- Work with partners from across the Health and Social Care community to take a ‘whole systems’ approach
- Proactively plan for and manage the demand for emergency and urgent care by simplifying the way in which people access services and improve the quality and responsiveness of Urgent Care services
- Improve knowledge and understanding of demand and access to services in Primary Care and Secondary Care
- Develop and/or reconfigure services to enable more patients to be treated in a Primary or Community care setting, wherever it is clinically appropriate and cost effective to do so, 24 hours a day, 7 days a week
- Support the delivery of the new A&E quality indicators and ambulance service response times
- Commission high quality and cost effective community based services to prevent unnecessary emergency admissions, thereby reducing A&E attendance and emergency in-patient bed days
- Commission and lead on the development of effective systems to reduce delayed transfers of care (DTOCs) in acute hospitals.

Performance Management

Providers performance will be monitored and evaluated against the appropriate targets and locally agreed performance metrics. This will include monitoring of:

- Primary Care access (including out of hours, quality standards and 24/48 access)
- Primary Care engagement in urgent Care agreed pathways/strategies
- Ambulance response times
- Ambulance turnaround times
- Total time in ED
- Delayed transfer of care rates in Acute trusts
- Year on year reduction in emergency bed days
- Year on year reduction in avoidable emergency admissions to hospital.

Performance improvement will be overseen and driven by The Northamptonshire Urgent Care Board, drawing its membership from all commissioner and provider organisations concerned with delivering urgent care to the people of Northamptonshire.
Urgent Care Board Governance Structure

**Urgent Care Board**
- Clinical Network Senior Clinicians and Executive
- Healthier Together
- Frail and Elderly
- Community Capacity Review

**Operational Group: North**
- KGH RAP Board
- Discharge
- Process Information
- System Management
- Reablement System
- Landscape of Care

**Operational Group: South**
- HBSU Process Review
- Surge Planning

**HRP Team**
- NGH IPG Board

**Processes**
- Daily Processes
- Weekly/Weekend Plans
- Holiday/Bank Holiday Plans
- Prescribing
- OOH’s
- Emergency Planning
- Voluntary Sector
- Housing

**Other**
- Daily Bed Meetings x3
- Visual Ward – Daily
- Tracking
- Discharge x2
- Tracker x1
- SCC
- Rehab’s
- Community Hospital Beds

**Urgent Care Board - Membership**
- CCG’s Clinical Chair & Lead
- COO’s
  - NGH
  - KGH
- UC Executive Lead
  - NHFT
  - EMAS
- Executive Lead
  - CHC
  - Primary Care
  - LMC
  - Social Care
- Clinical Reps
  - NGH
  - KGH
  - NHFT
- Co-op
  - OOH: Olympus Care
  - NSL: Prescribing
There are a range of initiatives within our plans for 2013/14 aimed at improving care for patients, reducing flows to hospital and providing care alternatives for patients and referring clinicians ...

Ambulatory Care Clinics/ Pathways
- NGH/Urgent Care team have analysed numbers of patients presenting at A&E with Ambulatory Care Sensitive Conditions (ACSCs) and have identified the top five conditions presenting at A&E that could be treated in an ambulatory care clinic or via an ambulatory care pathway.
- These clinics/pathways would enable A&E and Primary Care clinicians to refer patients directly into these clinics/pathways therefore diverting the patient from A&E and avoiding a non-elective admission.

Wound Management
These Wound Management/Dressing clinics will be open during weekends and bank holidays between 9am and 5pm in three locations across the county. It will enable practices to book ambulatory patients who need routine dressing changes into these clinics rather than them being treated in their homes by Community Nurses. There is also scope to include dermatology patients in this scheme who would normally be treated in A&E. Walk-in patients who would otherwise go to A&E will also be able to attend. An ANP will provide the service.

Urgent Care Clinical Dashboard
- The Urgent Care Clinical Dashboard enables Practices to identify frequent A&E/Urgent Care users and proactively manage those patients to reduce A&E attendance (via MDTs or Neighbourhood teams).
- The savings have been calculated on the basis of 12 avoided admissions per month (across all 21 practices) at a savings of £423.90 per avoided attendance.
- Discussion needs to be had via a UCCD user group to determine methods of reporting and measuring success as this is a pilot scheme.
Crisis Response

- 2 specialist paramedic falls teams who attend to patients who have fallen.
- The falls paramedics are able to see and treat patients at their home and ensure handover to community care where appropriate.
- This will reduce attendance/admission to hospital of the elderly whilst also providing care in their own home.

DECC - Dynamic Emergency Care Centre

A static resource/urgent care centre in the town centres of Northampton and Kettering aimed at managing night time economy at weekends and key dates from 10pm-4am which will direct demand away from the acute hospitals. Staffed by Paramedics and police with scope to treat:
- Sprains and strains
- Wound treatment, cleaning and dressing
- Minor burns and scalds
- Minor head injuries
- Insect and animal bites
- Minor eye injuries
- Injuries to back, shoulder and chest
- Broken bones can be assessed and referred to hospital for X-ray via care pathways.

Actual activity for 2012/13 showed a non-conveyance of 90.0%.

Extended ICT hours and Tracker nurse

These additional ICT hours will be used to base ICT within A&E to assess and facilitate early discharge of patients into community based care.

The full time Tracker Nurse will also be able to assess, track and facilitate timely discharge whilst also maintaining an overall view of the acute bed status.
### Neighbourhood Teams.
- The neighbourhood team looks at new ways of managing high cost patients with complex long term conditions at high risk of emergency admissions, using an MDT approach and developing a personal care plan.
- Patients will be identified using Health Analytics risk stratification tool and intensively case managed.
- The model predicts a 4% reduction in emergency admissions.
- Commencing in two practices in February 2013 with a view to rollout during the year.

### Care Homes Nursing Support
- Care home support provided to reduce emergency admissions to A&E using the 50 bed virtual model scheme with ANP and DN support.
- Currently in seven care homes, using x 50 bed model.
- The scheme includes education and informal training of care home staff.

### Ambulance Handover Delays
- The Urgent Care Team will revise and implement new KPIs with acute services and EMAS contracts to ensure that handover delays are reduced.
- In addition, encouragement for EMAS to consider and use alternative providers where appropriate will ensure patients are treated at the right time and in the right place.
Early in 2013/14 the CCG will complete a business case for the development of a range of services designed to improved care for the frail, elderly. These proposals will be designed by clinicians from across the local care community.

Phase one of our work has identified the opportunity to redesign the way in which care is delivered, as illustrated in the following slides.

From the outline business case developed in late 2012, it is clear that there are some things we can do now to improve services. These “quick wins” are being developed and will be implemented in 2013/14. These are:

- The co ordination and crisis hub
- Improved discharged arrangements.

The Community Care of the Elderly Service (CECS) will continue to be developed in order to provide a full comprehensive geriatric assessment for patients be they in A&E, MAU, hospital wards, special care centre beds, or at home. This assessment is supported by ICT staff that will be able to rapidly implement treatment and care that expedites discharge or prevents acute service admission. The service will:

- Reduce emergency inpatient admissions for elderly, frail patients across the county
- Reduce excess bed days for elderly, frail patients across the county
- Prevent admission of patients requiring hospital admission for IV therapy treatment for cellulitis
- Support patients in the community by increasing case load.
A complex system, with improvements required at several points in a patient’s journey...

- MDTs at practice and neighbourhood level. The MDTs will use risk stratification to actively case manage the frail patients most at risk of being admitted to hospital and provide a care plan to meet their needs.
- Signposting those not at greatest risk to appropriate services that promote independence and wellbeing.

- Discharge to assess through integrated teams into the “hospital at home” environment to enable early discharge before medical recovery.
- Crisis intervention by community geriatrician led ‘Integrated Area Teams’ deployed through a coordination hub to manage frail elderly crises in a hospital at home environment wherever possible; admission would be the exception rather than the norm.
- In reach services by the acute hospital geriatricians to work with the integrated area teams (through the hub) minimising the length of acute hospital stay and enabling early discharge to continue recovery.
- Admissions avoidance at A&E by managing the crisis through a co-ordination hub and admitting by exception only.
“B” & “E” are identified as potential “Quick wins”, for implementation in 2013/14...
It has long been recognised locally that patients in care homes can benefit from more coordinated care.

We will build on the 1:1 relationship that we have developed between GP practices and care homes to enhance support through extended community nursing support.

We will ensure that more patients have end of life plans in place, and that services are better integrated to respond and meet patients wishes at the end of life.

We will ensure that care homes are supported to ensure that they are able to better care for patients during periods of illness that do not require a hospital admission, and are instead able to call on the support of district nursing teams.
Reducing Admissions for Illnesses That Can be Managed at Home

Part of the solution to delivering a first class emergency care service in Northamptonshire is to ensure that only those patients that require a hospital stay are admitted to hospital and more patients that can be treated safely on an ambulatory basis are cared for in this way.

This requires both the availability of community services to deliver care out of hospital and an awareness within our hospitals of the potential to care for people safely outside of hospital.

Therefore we have two work streams specifically designed to reduce ACS

1). Changes within Acute Care Supported with CQUIN Funding

Emergency Ambulatory Care Pathways
1. Low Risk Chest Pain.
2. Supraventricular Tachycardia.
3. Pleural Effusion.
4. Painless Jaundice.
5. Pulmonary Embolism.

Hot Clinics – to Provide Same Day Consultant Opinion
7. Surgery.
8. Paediatrics.

2). Ambulatory Pathways Redesigned

1. Abdominal pain.
2. Low risk cardiac symptoms.
3. COPD / chest symptoms.
5. Paediatric asthma.
The overall vision for managing Long Term Conditions (LTC) across Northamptonshire is for a model of shared care that promotes health and wellbeing and is driven centrally by the individual. It aims to deliver a whole system integrated approach to care, that puts people at the heart of their care. Our commissioning plan for 2013/14, which are derived from our LTC strategy, centre around five key actions:

1. Delivery of a self management training programme in all CCG localities.
2. Risk identification by locality/practice staff of patients with COPD, heart failure.
3. Implementation of a self management programme for COPD and heart failure at locality/practice level.
4. Re-specification of community nursing service to deliver pro-active case management to patients with LTC and reduced hospital admission rates saving £1.6m.
5. Phased implementation of Neighbourhood Team model – linked to Frail, Elderly Strategy development.

We will deliver our plan through:

- Locality training programmes using national tools to support the identification and management of LTC through integrated care teams
- Systematic co management of patients based on outcome measures
- Extending the use of Personal Health Budgets and Continuing Health Care within the management of LTC.
Our key milestones for delivery in 13/14 are:

**RISK PROFILING**
1. By February 2014, 20% of practices covering a minimum of the population within the CCG have committed to implementing a risk profiling tool and have a plan to systematically use the data with the integrated neighbourhood team.
2. By March 2014, all practices that have implemented a risk profiling tool are systematically using the data with the integrated neighbourhood team to pro-actively manage patients identified at risk.

**INTEGRATED CARE TEAMS**
1. By January 2014, the implementation team have identified and engaged all relevant stakeholders/clinicians and developed an action plan to embed the neighbourhood team model in a minimum of 20% of practices covering a minimum of 50% of the population within the CCG.
2. By March 2014 all integrated neighbourhood teams attached to every practice / locality are using risk profiling data to case manage identified people ‘at risk’.
3. Reduction in unscheduled admissions and length of stay for ambulatory sensitive LTC.
Our second area of transformation seeks to address a number of long standing infrastructural issues that affect the county, in terms of service reconfiguration and / or historical spending patterns.

Our aim is to deliver the highest quality of care for patients, within the resources available, through promoting partnership and integration in the way in which our providers work together and with us to deliver joined up, integrated care.

Our themes within this area of transformation are:

- The Local “Healthier Together” programme
- Better value, choice and quality in mental health services
- Better value, choice and quality in out of hospital and community care
- Innovation in the way we contract to promote better care.

Each of these themes is considered on the following pages ...
High quality providers of care are critical to the delivery of quality outcomes. A key priority for us to strengthen the providers across Nene. We are therefore committed to reviewing and strengthening the delivery of acute services in Northamptonshire, working in partnership with our main providers, Kettering General Hospital and Northampton General Hospital.

This review starts with the ‘Healthier Together’ programme that is currently in place. This programme was set up to sustain or improve quality of acute services, building on a well established case for change. Six clinical working groups were set up which have measured effectiveness against safety, sustainability, accessibility, population growth and changing demographics. The reports from these groups outline the changes that are needed. These reports will be the platform for making changes going forward.

**Drivers for Change**
- Improve clinical quality and patient safety
- Ensure sustainability
- A growing and ageing population
- A difficult financial situation
- Improve accessibility

**Approach**
- Review case volume/clinical outcome evidence, Royal College recommendations on catchment population, clinical indicators and interdependencies evidence from previous ASRs
- Learn from best practice
- Development of models of care based on clinical evidence and best practice led by six Clinical Working Groups

**Impact**
- Improved quality of care and patient safety
- Some care transferred to primary, community and social care from secondary care
- Consolidation of some specialist services
- Medium to long term clinical and financial viability of acute providers
We have reviewed the Healthier Together programme and as a result make the following commitments:

**We are committed to ensuring that any changes to acute service provision deliver benefit to the population of Northamptonshire.** We will build on the case for change and the outputs from the Clinical Working Groups of the Healthier Together Programme. But we will change the focus of the Healthier Together programme by setting up a Programme Board and supporting project support to oversee any changes that are needed in Northamptonshire.

**We are committed to ensuring that any changes that are proposed are those that are suggested and supported by local clinicians.** We have put in place and will continue to develop a fora for clinicians from across the county to come together to develop and agree the changes that are required.

**We are committed to involving the whole health and social care economy in any changes to acute provision.** We believe primary care, community care, mental health and social services are key components of any changes, and do not believe changes to acute provision can be made in isolation. We have ensured that all partners are represented on the local steering group.

**We are committed to working with our two local acute providers** to ensure that any changes are made in a way that enables acute services of the highest quality, that are sustainable for the long term, to be delivered in county.

**We are committed to involving the public in the review of acute services.** We will build on the patient and public engagement work of the Healthier Together Programme and link that with our own Patient Congress and patient and public engagement work. We will continue to involve the public as the programme develops and there will be a public consultation on any service changes that are proposed.

**We are committed to working with our CCG and NHS Commissioning Board partners across the South East Midlands** to ensure that specialist services are configured appropriately across the wider area. We have agreed a concordat across the five CCGs to enable this work to progress.
NHS Nene CCG is committed to achieving parity of esteem in its commissioning of services for people with mental health problems or learning disabilities.

In Northamptonshire we spend more than similar CCGs on our mental health services, without seeing markedly better outcomes for the investment we make. The reasons for this are complex and we have worked hard to better understand the pattern of spend and make changes that will reduce overall spending, whilst at the same time improve outcomes through the delivery of more structured, co-ordinated care for patients.

We will continue our work to implement the local mental health strategy, improving services across the whole spectrum of need, but particularly focusing on the provision of mental health care in primary and community settings by enhancing our IAPT and wellbeing services. We will continue our drive to achieve greater value for money and improved performance in our Mental Health services, working closely with our main provider Northamptonshire Healthcare Foundation Trust.

We are committed to improving care for patients with dementia. This includes the continued development of services to detect, diagnose and intervene in dementia early, and better care for patients with dementia who require hospital care.

We will continue to champion the needs of patients with learning disabilities ensuring equity of access and care standards within all healthcare services. We will maintain our focus on people with learning disabilities and complex needs to ensure that wherever possible people are supported in community settings. Where specialist inpatient care is required, we will ensure that people remain in hospital no longer than necessary. We will increase personalisation within learning disability services offering personal health budgets to maximise choice and control for patients, for example as an alternative to traditional building based short break services. We will also strive to ensure that all services that we commission for people with learning disabilities are safe and maximise dignity and respect for the individual.
We plan to tackle high programme spend through alignment of payment and investment to match need and the achievement of quality and outcomes. The joint strategic needs assessment and analysis of mental health spend and outcomes has informed planned improvements in mental health pathways to achieve improved choice, evidence based care and value for money. These include:

- Shift of investment and resources during 2013/14 to enable people with mild to moderate common mental health need to have access to evidence based talking therapy and interventions at NICE steps 1-3, in preparation for AQP procurement exercise in 2014/15.
- Improved delivery of evidence based services and interventions to meet the needs of people with personality disorder and personality difficulties in the community. In particular, focusing on Non-psychotic pathway care clusters 4 – 8 to ensure robust pathway and evidence based interventions are available.
- Routine contractual monitoring of reported improvement in clinical outcomes through the use of HoNOS four factor measures.
- Introduction of routine contractual reporting of patient recorded outcomes measure and improved patient experience measure.
- Building on the personal health budget pilot extend the implementation of personal health budgets in mental health services alongside the introduction of Payment by Results in Mental Health.
- Improving access to mental health services through partnership between primary and secondary care with timely and appropriate referrals and assessments into secondary care.
- Reduce admissions to mental health acute inpatient services through improved community personality disorder services and review of the function and performance of the crisis resolution home treatment team, in particular its capacity to deliver intensive home treatment.
- Continuing the development of local pathways and supported living options to reduce reliance and expenditure on residential/nursing care and out of county placements.
- Clinically led initiative across primary and secondary care to reduce expenditure on mental health prescribing through development of training, advice, clinical protocols and robust review processes which will also contribute to reduction in inappropriate use of anti-psychotic medication.
Dementia

Working with providers we will look to improve performance through redesigning services to help people to live well with dementia. - ensuring quality, efficiency and value for money. We will make the following changes to the way in which care for patients with dementia is organised:

- **Memory Assessment Service**
  - Consolidate memory assessment pathway
  - Training in primary care to improve detection and diagnosis
  - Improve diagnosis rates in the community

- **Review of older people’s mental health services and dementia pathways**
  - Improving community mental health services to ensure effectiveness and efficiency
  - Redesign of community mental health teams for older people, to provide outreach to care homes and acute hospitals
  - Training in care homes to improve capacity to work with presenting needs and reduce admissions to general hospitals and mental health inpatient services

- **Improving acute hospital care and reducing reliance on anti-psychotic medication**
  - We will continue to work with our acute hospitals to improve the care environment and staff competency in the care of people with dementia.
  - Our prescribing teams and commissioners will continue to work with primary care, care homes and our specialist services to reduce reliance on anti-psychotic medication in caring for people with dementia
Learning Disabilities
Our commissioning plan for improving services for patients with learning disabilities and their families are designed to achieve three strategic outcomes:

1. To ensure that people with learning disabilities have the same access to high quality healthcare as the rest of the population.

2. To ensure that when people with learning disabilities need specialist care that this is provided in safe, high quality environments and that people remain in specialist hospital or residential services no longer than is absolutely necessary.

3. To work with social care and other providers to deliver joined up community based and personalised services which offer increased choice and control and an extension of supported living opportunities.
In order to achieve these outcomes our specific learning disabilities commissioning plans include:

- Delivering the 2013/14 priorities in our Better Healthcare Plan
- Compliance with DH standards and post Winterbourne Review requirements for people with complex needs
- Provision of Case Management of CHC packages for people with Learning Disability - keeping people local and bringing people back home
- Provision of supported living options for people with complex needs as default position following AQP procurement exercise and development of increased housing options
- Discharge and pathway planning with outcome monitoring
- Strengthened contracting and quality monitoring processes with providers and involving people with a learning disability in doing this
- Development of Outcome Specification for Specialist Learning Disability Services
- Ensuring the Intensive Support Service provides community based wrap around support and is deployed to support admission avoidance
- Reduction in dependency on inpatient beds and a review of the service provided by our local Assessment and Treatment Unit
- Reduce reliance on long term hospital and institutional care through service development and strengthened case management
- Decommissioning of bed based provision and release of monies to offer Personal Health Budgets to increase choice, control and flexibility
- Support planning for alternative options to those who wish to purchase different short break options
- Stimulate local providers to be responsive to changing need and service choices for short breaks
Community Services

A central facet of our plans to transform our local health system, centre on the development of an expanded and effective primary and community care sector. We will make no apology for investing in primary and community care, in order to create the capacity and systems to care for more people out of hospital and closer to home.

By showing that we are able to manage the resources at our disposal, we will have the flexibility to make the shift in investment that is required. Our localities will lead the development of primary and community care services. During 2013/14 we will:

- Develop **integrated community nursing teams**, designed to meet the needs of individual localities and practices
- Introduce new systems to better support case finding and case management of patients at risk of admission to hospital, which can be used by practices and their nursing team to keep patients well at home
- Embed our successful **Care Home pilot schemes** across all localities through recurrent investment
- Integrate service providers to deliver services through Primary Care Led Integrated Teams.
- Develop the concept of **multi disciplinary neighbourhood teams** to support patients in the community and reduce reliance on hospital care
- Expand and embed the use of **referral peer review** (prospective and retrospective) across all localities in order to reduce variation in referral practice
- Develop **more primary and community care specialist services** in our localities to which GPs can refer, as an alternative to hospital admission
- Redesign care pathways to promote collaborative working between secondary and primary care clinicians, delivered in the community
- Provide **GPs with direct access to more fast turnaround diagnostic services**, enabling them to better manage patients in the community
- Develop robust plans for the **development of community hubs** and so provide the estate that supports care closer to home
- Procure services through the use of the **Any Qualified Provider** to promote quality improvement and choice.
Better Value, Choice and Quality in Out of Hospital and Community Care (5)

The requirement to achieve efficiencies across all areas of commissioning activity has required us to evaluate our expenditure on community health services to identify areas where services are not commissioned to meet healthcare needs or where services are of low clinical priority. As a result of this evaluation two areas of decommissioning have been identified within community health services as follows:

1). Podiatry
The CCGs currently spend over £3m on podiatric services. 14% of the community podiatry service provision has been identified as not being medically required and of low clinical risk. Similar services are available from High St providers and an alternative service has been commissioned with Age UK using volunteers to assist low risk patients. It is proposed to raise the clinical eligibility threshold for community podiatry so that future service provision is limited to moderate/high clinical need patients. This will achieve a saving of £300k in 13/14 with a full year saving of £460k in 14/15. An engagement process will be required to agree the eligibility threshold change.

2). Third Sector Grants
The CCGs continue to fund a number of historic grants to 3rd sector organisations which were originally commitments made by the PCT and even further back in time by the Health Authority. This total grant funding of £637,000 is now inequitably distributed and generally does not appear to either meet specific health needs or provide evidence of effectiveness. Following a commissioner review of historic grant funding arrangements proposals have been made to review and re-commission a number of these arrangements and this will be actioned during 2013/14. In addition it is proposed that funding is withdrawn/reduced from a number of organisations, which are essentially providing social care services, as follows:

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Pravasi Mandal</td>
<td>£13,800</td>
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<tr>
<td>Bangladeshi Association</td>
<td>£14,736</td>
</tr>
<tr>
<td>Sofa Wise</td>
<td>£3,116</td>
</tr>
<tr>
<td>Homestart</td>
<td>£82,549    (Funding withdrawn from Q2)</td>
</tr>
</tbody>
</table>
Better Value, Choice and Quality in Out of Hospital and Community Care (6)

Changing Funding Mechanisms and Sources (1)

We intend to change the way in which some primary and community services are financed:

**Favell House** is a centre providing in-patient respite care for 57 people with degenerative neurological conditions. The service costs £1.66m per annum. We will be engaging with these patients and their carers upon the potential to reprovide this service through personal health budgets with the intention of withdrawing from NHS provision of inpatient respite care and realising efficiencies that will contribute to our QIPP programme. This initiative forms part of a broader shift across health and social care away from bed based short break provision, and will potentially release a high quality in-patient facility for utilisation within our Frail, Elderly / Community Hospital Strategy.

**Hospices** – The CCGs currently provide the majority of the funding (£3.1m) for the Cynthia Spencer Hospice in Northampton and the Cransley Hospice in Kettering. In Northamptonshire NHS funding represents 80% of the total core running costs of the hospices with charitable funds contributing 20%. Nationally NHS Commissioners typically fund 34% of hospice core costs with charitable funds meeting 66% of costs. The CCGs will be engaging with Trustees of the two hospices to agree a phased increase in charitable funding and a reduction of £2m in NHS funding being achieved on a phased basis over 2-3 years, with an initial reduction of £500,000 proposed for 2013/14.
Changing Funding Mechanisms and Sources (2)

**Continuing Health Care Packages** – Building on the successful work previously undertaken in mental health to reduce expenditure on individual packages of care. We will be working with NHFT to develop more community based care pathways and to intensively case manage patients with complex care needs currently receiving traditional continuing health care packages in residential and nursing home care. We will be seeking to improve quality and choice in the services available and reducing costs by £1.1m. Patients with learning disabilities, brain injuries and neurological conditions will benefit from this initiative.

**Personal health budgets** – Building on the PCTs success as a pilot site for personal health budgets (PHBs) we will be seeking to enhance choice and control for patients and realising efficiencies for the CCGs through the extension of personal health budgets. In particular we will be seeking to increase the take up of PHBs by patients eligible for continuing health care. We will also seek to introduce PHBs as an alternative way of meeting continence related needs, as part of a wider programme of redesign of our continence service, which is intended to reduce waiting times, increase the provision of advice and treatment services and offer greater choice to patients about how their needs are meet.
Our approach to medicines management has three principle facets ...

**Primary Care**
- All practices achieving against performance scheme
- Stretch targets
- Rapid implementation of new schemes

**Interface**
- Scope to reduce whole system cost
- Diabetes
- Cardiology
- Respiratory
- Pain
- Sip feeds
- ADHD
- Antipsychotics

**Secondary Care**
- PbR excluded medicines
- Benchmarking costs
- NICE compliance
- Homecare delivery
- Patient Access Schemes
**Better Value, Choice and Quality in Out of Hospital and Community Care (9)**

**Medicines Management (2)**

<table>
<thead>
<tr>
<th>Primary Care Prescribing</th>
<th>Interface Prescribing (including Mental Health)</th>
<th>Secondary Care Medicines Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>- New Performance Framework for 2013/14 developed, including a budgetary performance indicator</td>
<td>- Diabetes – BGTS, GLP-1 agonists, insulin choice</td>
<td>- PbR excluded medicines - Benchmarking / budget setting</td>
</tr>
<tr>
<td>- All practices to achieve against performance framework</td>
<td>- Cardiology – managed entry of new CV drugs</td>
<td>- Audit especially rheumatology</td>
</tr>
<tr>
<td>- All practices to work on areas beyond the framework as necessary</td>
<td>- Respiratory – reduce inappropriate use of high dose ICS</td>
<td>- Care pathways</td>
</tr>
<tr>
<td>- Rapid implementation</td>
<td>- Pain – analgesic patches and pregabalin</td>
<td>- Homecare</td>
</tr>
<tr>
<td>- Savings of approx £1 million</td>
<td>- Sip feeds – reduce inappropriate use</td>
<td>- Patient access schemes</td>
</tr>
<tr>
<td>- Main areas:</td>
<td>- Antipsychotics – review use of atypicals especially aripiprazole, reduce use of low-dose antipsychotics in dementia</td>
<td>Savings of approx £500K (although negated by cost pressures from ranibizumab in diabetic macular oedema)</td>
</tr>
<tr>
<td>- Diabetes</td>
<td>- ADHD – review high use of methylphenidate and atomoxetine; commission a sleep clinic to reduce use of melatonin</td>
<td></td>
</tr>
<tr>
<td>- Respiratory</td>
<td>- Risk / gain share to be introduced</td>
<td></td>
</tr>
<tr>
<td>- Pain</td>
<td>- Savings of approx £400K (some overlap with primary care savings and some savings negated by new CV drugs)</td>
<td></td>
</tr>
<tr>
<td>- Lipid lowering drugs</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>
Integrated Care

Integrated care is critical for the future of the NHS. Nene Commissioning PBC championed integrated care since its inception in 2006. As Nene CCG we will promote the value of integration and seek to enable it to take place through innovation in reimbursement systems and the contracts we let.

Our approach to integrated care will evolve from an approach based wholly on the Northamptonshire Integrated Care Partnership (NICP), to a more sophisticated approach which considers integrated care through a number of lenses.

We will continue to develop the clinical network, but will also develop the concept of the “Principal Provider”, which will for a given care group, or clinical pathway, take the lead for coordinating care. We will develop reimbursement systems and risk / incentive systems which encourage development of better connected providers and less silo working, in line with the diagram to the right.

**The Kings Fund (2011) What is it? Does it work? What does it mean for the NHS?**
Developing The Principal Provider Model

For some care groups or care pathways, we believe that the establishment of a principal provider arrangement, may provide the impetus for integration of care, by changing the reimbursement system and incentivising providers to work effectively together to meet the needs of patients, and deliver better outcomes. We will investigate the potential to develop this type of approach and associated contractual framework in a number of areas.

In addition, where we have agreed the establishment of countywide services, such as Stroke or PPCI, we intend to contract with the principal provider of the service, who will be responsible for ensuring sub-contracting arrangements deliver the best outcomes required for all our patients.

**Mental Health** – for the management of complex cases, sometimes requiring individual packages of care (in place for 2012/13)

**Learning Disability** – for the management of complex cases, requiring individual packages of care (building on the success in mental health)

**Stroke, Vascular and PPCI** – Acute providers working together to deliver high quality, joined up care with agreed outcomes

**End of Life Care** – building on the excellent work done to date in supporting more people to die in their place of choosing

**Unscheduled Care** – maximising the benefits of integrated community nursing, case management, and long term condition care

**Diabetes Care** – recognising that the work done to date to transform the care pathway has been partially successful, but that more can be done to improve outcomes for patients at lower cost

**Orthopaedics** – recognising that orthopaedics is a high cost, complex system involving primary and community services, as well as acute care, and that more needs to be done to manage cost in this area.
Risk and Gain Share Arrangements

Consistent with our wish to partner with providers that share our desire to see care co-ordinated, integrated and delivered more cost effectively we will enter into innovative contractual arrangements that seek to incentivise performance beyond minimum levels, where both parties can benefit from this enhanced performance.

In 2013/14 The CCG will enter into risk and gain share arrangements with one of its main providers, NHFT across a number of service areas, where they are best placed to drive improvements in care / value. These are:

• **Mental Health** – Reducing Individual Packages and keeping more care local
• **Continuing Healthcare** - Reducing Individual Packages and keeping more care local
• **Acquired Brain Injury** – Developing local services to reduce reliance on high cost individual packages, often out of county
• **Prescribing and Dressings Costs** – Reducing unnecessary spending on medication and dressings initiated in secondary care, but prescribed by GPs in the community.
Nene CCG is, as its heart, a locality led organisation. Being locality focused and organised enables us to engage with member practices and local people to shape services around their needs and preferences. Therefore our third area of transformation is concerned with locality led development.

This area of transformation has four themes:

**Primary Care Development** – How can the localities transform the way in which primary care is organised and delivered in their area, by working together and developing new services as an alternative to specialist care. We believe these developments are necessary, and can only be delivered through local partnership.

**Locality Specific Schemes** – Initiatives that are to be introduced at a very local level to improve care for patients, or deliver efficiency savings for reinvestment.

**Locality Partnerships** – Locality leadership teams working with local authorities and other partner agencies to plan and develop services through the Health & Wellbeing Fora.

**Tackling Variation in the Use of Health Services** – Variation exists in every health system. One role of the CCG is to reduce unwarranted variation wherever it exists, and through locality discussion and peer review, plans will be developed to firstly identify variation and then secondly to tackle its causes and reduce it.

Each of our localities plans across these four domains is addressed in the pages that follow ...
In 2013/14 the Daventry North Locality plan to support the development of Primary Care through the following initiatives:

- Promoting collaborative working amongst practices to utilise practitioners with enhanced clinical specialities. This will be done to:
  - explore opportunities to deliver services close to the patients home initially through GP to GP referral.
  - enhance the knowledge and skill base of locality clinicians to support the delivery of healthcare to the registered population within the practice setting.

- Using locality protected learning time for training we will enhance clinical knowledge to support the management of long term conditions within the community setting.

- Through enhanced integration of community and practice nursing we will improve the management of patients with long term conditions.

- Through opening up the local market we will look to improve collaborative service delivery and facilitate care closer to home.

- In the light of forecast population growth and demographic change, we will review the use of the Danetre Community hospital and develop a long term strategy to best meet the health needs of the local population.
<table>
<thead>
<tr>
<th>Scheme Title</th>
<th>Brief Description of Scheme (Aims/ Objectives</th>
<th>Identified Net Saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Home Scheme</td>
<td>To provide Advanced Nurse Practitioner support as an acute response to Locality Care Homes; as well as proactive care planning and advance care planning to reduce numbers of avoidable emergency admissions and A&amp;E attendances</td>
<td>£255,000</td>
</tr>
<tr>
<td>Neighbourhood Team</td>
<td>To provide a multi-disciplinary team approach to intensive case management and personalised care planning of patients with complex long term conditions to reduce reliance on emergency health services specifically emergency admissions and A&amp;E attendances</td>
<td>£169,323</td>
</tr>
<tr>
<td>Dermatology Locality Clinic</td>
<td>To provide enhanced GP dermatology services as an alternative to secondary care referral for those practices without any in house dermatology expertise</td>
<td>£3,837</td>
</tr>
<tr>
<td>Locality Self Management Schemes (COPD, Heart Failure and Paediatric Asthma)</td>
<td>To provide nationally recognised self management materials to support enhanced assessment of patients with these conditions to self manage their own conditions effectively and reduce avoidable emergency admissions and A&amp;E attendances</td>
<td>£37,241</td>
</tr>
</tbody>
</table>
## Locality Specific Schemes (2)

<table>
<thead>
<tr>
<th>Scheme Title</th>
<th>Brief Description of Scheme (Aims/ Objectives)</th>
<th>Identified Net Saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locality D Dimer Testing</td>
<td>To provide a Locality based D Dimer testing service to enable near patient testing to confirm diagnosis and reduce avoidable emergency admissions</td>
<td>£38,464</td>
</tr>
<tr>
<td>Paediatric Activity Reduction</td>
<td>To support practices to review and reduce their unexplained variation in paediatric secondary care activity, to the Locality average</td>
<td>£73,710</td>
</tr>
<tr>
<td>Managing Variation in General Practice</td>
<td>To support practices to review and reduce their unexplained variation in A&amp;E attendances, and GP referred first outpatient attendances, to the Locality average</td>
<td>£77,368</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>£654,943</td>
</tr>
</tbody>
</table>
Locality Partnerships Through Health and Wellbeing Fora

- The Daventry District Local Health and Wellbeing Board will support the development and delivery of the Daventry District Sustainable Community Strategy and the countywide Health and Wellbeing Strategy.
- The Locality is represented at the Board by the GP Chair and Senior Locality Manager and works closely with all partners across the District to deliver the agreed priorities.
- The high level Health and Wellbeing priorities identified by the Sustainable Community Strategy are:
  - Improve health and access to healthy lifestyles
  - Reduce inequalities between our most deprived and better off communities

The Health & Wellbeing Strategic Priorities

- Improve health and access to healthier lifestyles
- Reduce inequalities between our most deprived and better off communities

Alignment to The Daventry North Locality Strategy

- Patient Self Management Programmes in COPD, Heart Failure and Paediatric Asthma
- Neighbourhood Team
- Care Homes
The Daventry North Locality will look to tackle variation in the use of health services through the following:

• Managing variation in General Practice delivery – by focusing on practices over the locality average in GP referred first outpatient attendance and all A&E attendances. Where this cannot be explained we will look to bring the practice back to the locality average.

• Paediatric activity reduction scheme – by focusing on those practices whose referrals into secondary care (all Points of Delivery) is over the locality average and where this cannot be explained we will look to bring them back to the locality average.

• A standing item on the locality meeting agenda will be to review outliers in utilisation and agree actions plans to reduce unexplained variation in clinical behaviour. This may be at practice outlier level or at a locality level where the locality may be deemed an outlier in utilisation as a whole.

• The Locality GP Chair and Senior Locality Manager will with each practice conduct periodic practice review meetings at which specific practice objectives will be agreed, focusing on reducing unexplained variation. The locality support team will monitor progress against these objectives.

• Clinicians will work closely with Locality Medicines Management colleagues to understand and reduce unexplained variation in prescribing behaviour.
The South Northants Locality will support 8 member practices to meet the needs of 78,000 patients by developing Primary Care that is focussed on:

• Integrating the care of frail older people. This includes:
  o GPs linking in with practice nurses, community nurses, mental health teams and 3rd sector organisations and taking an integrated approach to reviewing patients every week. This will delegate care from GPs to nurses and free up GP time to improve primary care access
  o Senior Nursing input and support to patients in care homes for GPs, so improving care and freeing up GP time to improve primary care access
  o Provision of a community paramedic service working with practices to attend older people who have an illness to take prompt action to reverse the decline in health. This will reduce home visits and free up GP time to improve primary care access.

• Timely and appropriate elective referrals to reduce referral rate variability within practices and between practices. A locality support team will work with practices to help analyse and manage referrals safely and effectively and ensure GP time is not taken from patient care.

• Help maintain and improve the quality of primary care through protected learning time programmes, education and support through the locality support team, provision of information and feedback using locality engagement groups and patient participation groups.
• Closer inter-practice working to include:
  - Services to be delivered out of hospital locally with GP to GP referral across several practices. Examples include:
    - Dermatology
    - D Dimer Testing
    - Cardiology Assessment
  - Aural Toilette
  - Vasectomy
  - Gynaecology
  - Joint back-office functions to increase practice efficiency. Areas to be examined include:
    - Telephone systems
    - Appointments
  - Audit and information provision
  - Review of hospital data and charges

To deliver these priorities, the locality will work with member practices to help that practice to thrive by having a plan that meets growing population size, population age and population expectation.

The locality will encourage the sharing of information and experience between practices, and also work through locality support to help manage projects with similar outcomes to a common high standard.
<table>
<thead>
<tr>
<th>Scheme Title</th>
<th>Brief Scheme Description (Aims/Objectives)</th>
<th>Net Saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Home Support</td>
<td>Maintain health of care home residents and so prevent A&amp;E attendance and hospital admission through specialist nursing input and links to practices</td>
<td>£65,000</td>
</tr>
<tr>
<td>Community Nursing</td>
<td>Maintain health of frail older people in their homes and so prevent A&amp;E attendance &amp; hospital admission by working across primary, community and social care</td>
<td>£291,000</td>
</tr>
<tr>
<td>Community Paramedic</td>
<td>Rapid response to ill frail older people by community based paramedic and so prevent A&amp;E attendance and hospital admission</td>
<td>£110,000</td>
</tr>
<tr>
<td>Counting and Coding</td>
<td>Examination of hospital activity and charges to ensure accuracy and reduce over-charging</td>
<td>£271,000</td>
</tr>
<tr>
<td>Elective Referral Quota</td>
<td>Establish expected GP referral levels for first outpatient appointments in six major specialties so that referral is based upon clinical urgency</td>
<td>£93,000</td>
</tr>
<tr>
<td>Local Elective Services</td>
<td>Provision of local outpatient diagnostic and treatment services and so help target referrals to hospitals</td>
<td>£100,000</td>
</tr>
<tr>
<td>Local D Dimer Testing</td>
<td>Local testing to detect deep vein thrombosis and so prevent A&amp;E attendance and hospital admission</td>
<td>£40,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>£970,000</strong></td>
</tr>
</tbody>
</table>
Working in partnership through the South Northants Health & Wellbeing Fora member organisations have agreed local priorities. The South Northants locality are represented by the GP Chair and Senior Locality Manager and through this representation has influenced, and been influenced by, the health and wellbeing forum discussion and this is reflected in priorities set in the South Northants Locality commissioning strategy for 2013/14.

**The Health & Wellbeing Strategy Priorities**

- Local Services Delivery through development of a local hub
- Frail older people supported to live independently through integrated service delivery across health, local authority and 3rd sector organisations
- People choose healthier lifestyles to maintain personal health & wellbeing. e.g. alcohol use

**Alignment to South Northants Locality Strategy**

- Greater delivery of elective services out of hospital
- Integrated approach to care in patient’s homes
- Community Paramedic support
- Care Home support
- Stronger urgent care management
- The Nene frail elderly programme
- Maintaining health for patients with longer term conditions
- Managing elective referral levels
The South Northants Locality has identified the following priority areas in which it will seek to tackle variation in the use of health services:

1. Elective New First Outpatient Appointment
2. Non-Elective Admission

We will take the following actions to address variation:

- Elective Quotas by practice for General Surgery, Urology, Orthopaedics, Ophthalmology, Cardiology and Gynaecology. Quotas based on levelling down rate per 1,000 for higher referring practices
- Work with Northamptonshire Health Care NHS Foundation Trust to equalise community nursing and integrate with primary care, mental health and social care services

The impact of our actions will be:

- Lower elective referrals for new patient follow up appointments
- Lower emergency admissions and A&E attendances
- Priority for elective referrals based upon clinical urgency
- Reduced non-elective admission reduces likelihood of hospital acquired infections
- Waiting times for elective first referral will be maintained/reduce
- Patients prefer to remain at home if safe and appropriate to hospital admission
In 2013/14 East Northants Locality plan to support the development of Primary Care through the following initiatives:

- Evolving business models – the locality has partnered with the Wellingborough Locality to explore provider models that are linked with community provision. The commissioning of service to be delivered from the Isebrook hospital site (due autumn 2013/14) will require providers to engage with localities and play an integral role in the wider demand management agenda.

- Promoting collaborative working amongst practices to utilise practitioners with enhanced clinical specialities. This will be done to:
  
  o Explore opportunities to deliver services close to the patients home initially through GP to GP referral.
  o Enhance the knowledge and skill base of locality clinicians to support the delivery of healthcare to the registered population within the practice setting.

- Improving access models – the locality continues to encourage practices to explore different models of working aimed at improving access to Primary Medical services. This includes appointment management and extended hours of opening. The locality will support the evolution of plans in response to patient feedback gained from A&E attendance audits.
<table>
<thead>
<tr>
<th>Scheme Title</th>
<th>Brief Description of Scheme (Aims/Objectives)</th>
<th>Identified Net Saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locality Clinics</td>
<td>Patients referred to local Dermatology Clinic instead of Secondary Care supporting both care closer to home and reduction in outpatient referrals</td>
<td>TBC (awaiting results of pilot)</td>
</tr>
<tr>
<td></td>
<td>Ophthalmology</td>
<td>£7500</td>
</tr>
<tr>
<td>Care Homes Advanced Nurse Practitioners</td>
<td>Providing care for those most at risk of unplanned admission to hospital, and helping to manage the end of life pathway, at care homes in the locality</td>
<td>£280,000</td>
</tr>
<tr>
<td>Patient Education for A &amp; E Attendances</td>
<td>Educating patients on the appropriate use of health services and surveying where A&amp;E has been inappropriately used</td>
<td>£9,210</td>
</tr>
<tr>
<td>SERVE Pilot</td>
<td>Supporting older people at home during a period of treatment (under case management) who would otherwise be admitted to hospital (April to August 2013)</td>
<td>£17,000</td>
</tr>
<tr>
<td>Scheme Title</td>
<td>Brief Description of Scheme (Aims/Objectives)</td>
<td>Identified Net Saving</td>
</tr>
<tr>
<td>------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Isebrook Urgent Care Centre</td>
<td>Provision of UCC for a range of interventions, linked to primary care demand management in localities (Q4 2013/14)</td>
<td>£92,000</td>
</tr>
<tr>
<td>Isebrook Observation Bays</td>
<td>Observation bays within Howard Johnson Unit – up to 4hr stay</td>
<td>£120,000</td>
</tr>
<tr>
<td>Isebrook Planned Care Endoscopy</td>
<td>Planned care as part of a community pathway (limited procedures)</td>
<td>£127,000</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>£652,710</td>
</tr>
</tbody>
</table>
Locality Partnerships Through Health and Wellbeing Fora

- Local priorities are being defined through a partnership involving public health, neighbouring CCGs, and a core group representing various sectors across the locality
- Core group has been established and a framework for planning agreed

The Health & Wellbeing Strategic Priorities

- Every child is safe and has the best start in life
- Vulnerable adults and elderly people are safe and able to use services and support that helps them to live as independently as possible
- Health, social care and public health services work together in all areas and services are joined up where people have both health and social care needs

Alignment to The East Northants Locality Strategy

- To be developed with partners in Education and East Northants Council
- The frail elderly programme
- Better LTC management
- Reducing ACS admissions
- Care home Nurse Practitioner support

To be developed with partners across the H&WB Forum and Peterborough & Cambridge CCG
Tackling Variation in the Use of Health Services

The East Northants Locality has identified the following priority areas in which it will seek to tackle variation in the use of health services:

1) Elective Care
2) Non-Elective Care
3) Outpatients

We will take the following actions to address variation:

• Utilising Nene CCG dashboard illustrating practices position against plan and average to provide practices with reliable data, and embed a rolling programme of the top three clinical areas of variation reported into the Locality Board
• Hold regular performance meetings with individual practices to discuss progress and where improvement can be made
• All practices continue to conduct prospective review of all referrals to reduce in house variation.

The impact of our actions will be:

• The dashboard allows the practices to monitor their activity and hold practices to account at locality meetings which reduces variation by changing behaviour
• Meeting with practices provides them with the information to understand their position and provides tools for improvement to reduce cost and variation in activity
• Reducing unwarranted variation will allow the population of East Northants to receive the same level of high quality of care throughout the locality.
In 2013/14 the Kettering Locality plans to support the development of Primary Care through the following initiatives:

- Evolve operating models by sharing best practice, exploring federated working, collaborative working, super practice, mergers etc to promote sustainability, support primary care delivering more services
- Improve access to existing services for patients, e.g. doctor first/training to increase uptake of minor surgery procedures in primary care
- Improve clinical quality of services and efficient use of resources through sharing best practice/up skilling of clinicians to support management of care within the GP setting
- Support collaborative working to use clinical specialists within the locality. GP to GP referral/enhancing knowledge of GP to support management of care within the practice/shared services.
- Develop primary care led integrated teams
- Support the delivery of care closer to home
- Working with practices to help deliver a practice strategic plan that supports the locality strategic plan, e.g. what is the practice strategy, how will they accommodate population expansion/service model changes.
<table>
<thead>
<tr>
<th>Scheme Title</th>
<th>Brief Description of Scheme (Aims /Objectives)</th>
<th>Identified Net Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 Hour ECG</td>
<td>Use primary care based service to deliver 320 24hr ECG's in practice, preventing the need for patients to attend hospital twice for each ECG</td>
<td>£27,900</td>
</tr>
<tr>
<td>Best Practice in General Practice</td>
<td>GPs and practices within the locality sharing and using best practice to reduce need for secondary care appointments and planned care. Reducing need for outpatients, surgery and day cases.</td>
<td>£197,389</td>
</tr>
<tr>
<td>Locality Care Homes Nurses</td>
<td>Reduce emergency admissions experienced by residents in care home setting, by ANPs developing advanced care plans, EOL plans, DNAR status and responding to urgent requests for assessment from homes</td>
<td>£334,860</td>
</tr>
<tr>
<td>Community Heart Failure Nursing</td>
<td>Develop and expand existing community heart failure nurse service in the north of the county across Kettering, Corby, Wellingborough and East Northants. Reducing emergency admissions for patients with Heart Failure</td>
<td>£112,060</td>
</tr>
<tr>
<td>Community Dermatology</td>
<td>Commission a community based dermatology service to see and treat 60% of current locality dermatology activity</td>
<td>£60,968</td>
</tr>
</tbody>
</table>
### Locality Specific Schemes (2)

<table>
<thead>
<tr>
<th>Scheme Title</th>
<th>Brief Description of Scheme (Aims /Objectives)</th>
<th>Identified Net Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community EMG</td>
<td>Commission a community based EMG service to diagnose referrals from GPs for Neurophysiological issues in the community</td>
<td>£76,611</td>
</tr>
<tr>
<td>Facilitated Early Discharge</td>
<td>Work with community providers to increase FED activity reducing LoS and EBD expenditure</td>
<td>£22,998</td>
</tr>
<tr>
<td>Community IVs</td>
<td>Develop current community IV pathway that relies on patient admission for first dose of ABX, by developing community clinic for first doses. Supported by existing community nursing and medical staff</td>
<td>£87,395</td>
</tr>
<tr>
<td>&quot;LES SLOTS&quot;</td>
<td>Prevent 1 A&amp;E attendance per day per practice by developing redirection policy and LES to redirect A&amp;E attendances to practices</td>
<td>£53,760</td>
</tr>
<tr>
<td>LUTS</td>
<td>LUTS service is from Corby CCG close to Kettering Locality. The service is for male Urology patients who would previously have gone to KGH for flow studies, urology outpatient first and follow up. These patients can now go to Corby, see a GPwSI supported by a consultant</td>
<td>£47,460</td>
</tr>
</tbody>
</table>
### Locality Specific Schemes (3)

<table>
<thead>
<tr>
<th>Scheme Title</th>
<th>Brief Description of Scheme (Aims /Objectives)</th>
<th>Identified Net Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neighbourhood Teams</td>
<td>Develop a local team to identify, assess, develop care plans and support patients with long term conditions (LTCs) in the Kettering locality.</td>
<td>£250,000</td>
</tr>
<tr>
<td>Community Outpatients Clinics</td>
<td>Continue with the Kettering Locality Wax Clinic. Develop a locality based chronic headache clinic</td>
<td>£31,500</td>
</tr>
<tr>
<td>GP Step Up Beds</td>
<td>Reduce emergency admissions into KGH from Primary Care by commissioning 6 beds for use by GPs to &quot;step up&quot; patients from the community, as opposed to admitting into acute beds at KGH. The beds will also aim to reduce length of stay and expenditure on resultant excess bed days by offering intensive, dynamic nursing and therapy support, alongside local primary care medical support</td>
<td>£245,230</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>£1,548,131</td>
</tr>
</tbody>
</table>
The Kettering District Local Health and Wellbeing Board have developed its key priorities through consideration of both local needs and the countywide Health and Wellbeing Strategy. The locality is represented at the board by the GP Chair and the Senior Locality Manager who work closely with partners to deliver the agreed priorities.

**The Kettering Health & Wellbeing Strategic Priorities**

- Healthy Business
- Healthy Lifestyles
- Healthy Homes
- The Elderly and Vulnerable

**Alignment to the Kettering Locality Strategy**

- Collaborative working with the Voluntary Forum bi-monthly
- Developing a health check ‘fun day’ in partnership with the organisations on the H&WB fora
- Working to develop integrating housing services with health services specifically discharging patients from KGH
- • Working with the voluntary sector developing Neighbourhood Teams for patients with COPD
  • Developing and submitting domestic violence related business case to H&WBB
The Kettering Locality has identified the following priority areas in which it will seek to tackle variation in the use of health services:

1) Elective Care  
2) Non-Elective Care  
3) Outpatients

We will take the following actions to address variation:

- Developed an interactive locality dashboard illustrating practices position against plan and average to provide practices with reliable data
- Hold regular performance meetings with individual practices to discuss progress and where improvement can be made
- All practices continue to conduct forward review of all referrals to reduce in house variation.

The impact of our actions will be:

- The dashboard allows the practices to monitor their activity and hold others to account at locality meetings which reduces variation by changing behaviour  
- Meeting with practices provides them with the information to understand their position and provides tools for improvement to reduce cost and variation in activity  
- Reducing unwarranted variation will allow the population of Kettering to receive the same level of high quality care throughout the locality.
In 2013/14 the Northampton Central Locality plan to support the development of Primary Care through the following initiatives:

- Exploring models of collaborative and federated working amongst practices to utilise practitioners with enhanced clinical specialities. This will be done to:
  - Explore opportunities to deliver services close to the patient’s home initially through GP to GP referral
  - Enhance the knowledge and skill base of locality clinicians to support the delivery of healthcare to the registered population within the practice setting
  - Promote the sustainability of Primary Care within the future market place

- Improving access models – the locality continues to encourage practices to explore different models of working aimed at improving access to Primary Medical Services. This includes Doctor First, appointment management (including open access), extended hours of opening and drop in clinics.

- To support the reduction in utilisation of A&E for conditions that could be treated outside of the hospital setting, through training we will look to enhance the skills and knowledge of primary care clinicians to be competent in the delivery of such services from their community base.
### Locality Specific Schemes (1)

<table>
<thead>
<tr>
<th>Scheme Title</th>
<th>Brief Description of Scheme (Aims/Objectives)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Locality Dermatology Clinic</td>
<td>Patients referred to local Dermatology Clinic instead of Secondary Care supporting both care closer to home and reduction in outpatient referrals</td>
<td>£36,440</td>
</tr>
<tr>
<td>Care Homes</td>
<td>Providing care in the most appropriate setting through the delivery of care home, GP Led ward rounds</td>
<td>£539,821</td>
</tr>
<tr>
<td>Patient Education for A &amp; E Attendances</td>
<td>Educating patients on the appropriate use of health services and surveying where A &amp; E has been inappropriately used</td>
<td>£29,278</td>
</tr>
<tr>
<td>Patient Self Management</td>
<td>Assessing patients with COPD and Heart Failure through pro-active self management plans</td>
<td>£98,983</td>
</tr>
<tr>
<td>Locality Sigmoidoscopy Clinic</td>
<td>Patients referred to local Sigmoidoscopy Clinic instead of Secondary Care supporting both care closer to home and reduction in outpatient referrals</td>
<td>£21,070</td>
</tr>
<tr>
<td>ENT Clinic</td>
<td>Patients referred to local ENT Clinic instead of Secondary Care supporting both care closer to home and reduction in outpatient referrals</td>
<td>£4,754</td>
</tr>
</tbody>
</table>
## Locality Specific Schemes (2)

<table>
<thead>
<tr>
<th>Scheme Title</th>
<th>Brief Description of Scheme (Aims/Objectives)</th>
<th>Identified Net Saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHIADIC</td>
<td>Early discharge of patients from Secondary Care to continue their alcohol detoxification in the community</td>
<td>£140,400</td>
</tr>
<tr>
<td>Paediatric Asthma Self Management</td>
<td>Assessing children with asthma pro-active self management plans</td>
<td>£4,680</td>
</tr>
<tr>
<td>Locality Dietician</td>
<td>Locality led dietician support for patients with Long Term Conditions to help prevent A&amp; E attendances and emergency admissions</td>
<td>£28,584</td>
</tr>
<tr>
<td>Patient Follow Up</td>
<td>Managing follow up of outpatient procedures in Primary Care where appropriate to provide care closer to home</td>
<td>£42,300</td>
</tr>
<tr>
<td>Maple Access</td>
<td>Targeted focus on the most vulnerable patients, including a medical facility in Oasis House</td>
<td>£16,632</td>
</tr>
<tr>
<td>Patient Self Care</td>
<td>To educate patients to self care for targeted age groups including Younger Persons, Children and Older Persons</td>
<td>£143,376</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>£1,106,318</td>
</tr>
</tbody>
</table>
Locality Partnerships Through Health and Wellbeing Fora

The Northampton Central Locality forms part of the wider Northampton Health and Wellbeing Fora. The group meets bi monthly addressing the key variations in health inequalities across Northampton. Key stakeholders include Voluntary Sector, Library Services, Public Health, Northampton Borough Council and Police.

The key priority is the Health and Wellbeing of the population with a strong focus on Mental Health.

The Northampton Health & Wellbeing Strategic Priorities

- Supporting the most vulnerable and hard to reach patients in Northampton
- Working with the key stakeholders to implement the “GREAT DREAM” focusing on the health and wellbeing of Northampton residents.

Alignment to the Northampton Central Locality Strategy

- Development and sharing of Common Childhood Illness Book / App in schools, libraries and healthcare establishments
- Promotion of self care in different languages and in hard to reach areas.
Tackling Variation in the Use of Health Services

The Northampton Central Locality will look to tackle variation in the use of health services through the following:

- **Prospective Reviews (Elective)** - All practices undertake frequent Peer Prospective Reviews to support their peers in the practice as well as other practices in the locality. The different approaches are regularly reviewed and shared across all practices.

- **Practice Performance Meetings** - Each practice undertakes a Performance Review led by the GP Chair and SLM. This review looks at unwarranted variation across the locality practices and in different specialties. An action plan is drawn up and delivery monitored.

- **Hip and Knee Score Audits** - The Locality has been using the Oxford Hip and Knee scores for the last 12 months and implemented it as part of the QP QoF Projects. The Locality will also be managing and monitoring activity from April onwards.
The Northampton East and South “Plan on a Page” displays a working model of how the locality works in terms of operations, delivering change, practice development etc. It also depicts channels of communication between both Practices and the Locality, as well as Nene as an organisational body.
In 2013/14 Northampton East and South Locality plan to support the development of Primary Care through:

- Practices working together and development of Locality Board
  - The new Locality Board where decisions will be taken will replace the Locality meetings from April 2013
  - One GP from each practice will be expected to attend the Locality Board
  - All sub groups and work-streams will include or be led by GPs
  - Representatives from the Central team – planned care, urgent care, finance and mental health) will be co-opted onto the Board when required

- Clustered Practice Approach
  - Practices and locality working together
  - Locality GP specialists leading service changes
  - Prospective review - putting quality and equity at the centre of quality provision
  - Co-opt support from Central teams, GP chair, or other leading clinicians where necessary or appropriate
  - Ensuring Practice and Locality Engagement Groups are intrinsically involved in this, ensuring our patients voice is core to service improvements

- Locality Clinics and GP to GP Prospective Review of Referrals
  - GPs within the Locality are proactively reviewing Locality Clinics to tackle areas of high spend/activity in the Locality, which supports the delivery of Care Closer to Home.

- Neighbourhood Teams
  - The Neighbourhood Team is based on looking at new ways of managing high cost patients with complex long term conditions at high risk of emergency admissions, using an MDT approach to develop a personal care plan. Patients will be identified using Health Analytics risk stratification tool and intensively case managed. Commencing 1 Feb 2013 in two practices, with a view to roll out during the year.
<table>
<thead>
<tr>
<th>Scheme Title</th>
<th>Brief Description of Scheme (Aims/Objectives)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Targeted Care Home Support (ANP)</td>
<td>Care Home support provided to reduce emergency admissions to A&amp;E, using the 50 virtual bed model scheme with ANP and DN support. Currently in 7 care homes, using 3 x 50 bed model. Scheme includes education and informal training of care home staff</td>
<td>£400,000</td>
</tr>
</tbody>
</table>
| Neighbourhood Schemes and Frequent Flyers         | Neighbourhood Teams - The Neighbourhood Team is based on looking at new ways of managing high cost patients with complex long term conditions at high risk of emergency admissions, using an MDT approach to develop a personal care plan. Patients will be identified using Health Analytics risk stratification tool and intensively case managed. The model predicts a 4% reduction in emergency admissions. Commencing 1 Feb 2013 in two practices, with a view to roll out during the year  
  
A&E Frequent Flyers - working with the bed management team at NGH to identify frequent flyers in A&E attendance and hospital admissions. Looking to colour code or 'mark' their notes and work with GPs to address their needs and promote education and self-care where possible. The MDT approach could also be used                                                                                     | £103,000 £ pending    |
| 0-4 Admission Avoidance                          | A range of schemes targeted at 0-4s in the Locality:  
  - Common Childhood Illness Booklets and link to interactive website version  
  - Health Analytics to identify the top ten 0-4 year old patients based on the cost of their emergency admissions and the top ten patients based on the number of A&E attendances. Once identified, practices will review the patients to determine options to educate and support to prevent further admissions  
  - Purchase of children’s thermometers and pulse oximeters for each practice                                                                                   | £5,000                |
<p>| Self Care - Patient education                     | A range of patient education and self-care information Asthma, Elderly Adolescent, Heart Failure - in the form of posters, stickers, booklets, website, 13-18 years mobile phone website                                                                                                                     | £10,000               |</p>
<table>
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<tr>
<th>Scheme Title</th>
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</tr>
</thead>
<tbody>
<tr>
<td>End of Life</td>
<td>Using the Gold Standard Framework to identify patients appropriate to add to Palliative Care Register and to carry out an Advanced Care Plan, allowing patients to die in their place of choice</td>
<td>£10,500</td>
</tr>
<tr>
<td>Dermatology Clinic</td>
<td>GPs refer into a Locality clinic instead of secondary care. Fortnightly clinic with 12 slots running since December 2012</td>
<td>£12,000</td>
</tr>
<tr>
<td>GP to GP prospective review</td>
<td>Mandatory use of the best practice tool, GPs to review peer referrals: urology, ENT, Cardiology, MSK, gynaecology, haemorrhoids, colon cancers. Will reduce referrals and provide equity by reducing variation</td>
<td>£15,000</td>
</tr>
<tr>
<td>Utilisation of Highfield</td>
<td>Looking at community clinics which could provide services currently running in secondary care e.g. dermatology and ophthalmology.</td>
<td>£100,000</td>
</tr>
<tr>
<td>Elderly Males</td>
<td>To establish a community based support network with a focus specifically on elderly men who are locked into a cycle of loneliness, depression, reduced self-care and are therefore at a potential higher risk of falls and therefore hospital admission</td>
<td>£7,000</td>
</tr>
<tr>
<td>Dietician - Sip Feeds</td>
<td>A dietician review of all patients on oral nutrition supplements across the Locality with the aim to reduce prescribing and educate clinicians on appropriate initiation of sip feeds</td>
<td>£13,500</td>
</tr>
<tr>
<td>Care Home Pharmacist/Prescribing Quality Pharmacist Roll-over scheme</td>
<td>A specialist care home pharmacist to carry out medication reviews for all care home patients within the Locality annually. Plus reviewing and changing where appropriate, patients on high risk combinations of medication and those aged 75 taking 4 or more meds which leads to significantly higher emergency admission rates</td>
<td>£25,000</td>
</tr>
</tbody>
</table>
### Locality Specific Schemes (3)

<table>
<thead>
<tr>
<th>Scheme Title</th>
<th>Brief Description of Scheme (Aims/ Objectives</th>
<th>Identified Net Saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Outcomes in Heart Failure Patients</td>
<td>To up-skill one GP per practice to improve Heart Failure diagnosis and management</td>
<td>£14,000 + 8 deaths avoided</td>
</tr>
<tr>
<td>Welcome Home Phone Calls</td>
<td>Age UK will phone patients within 2 weeks of their hospital discharge to check up that their recovery is progressing, to prevent readmission. Will be in 8 practices in the Locality. Will be rolled out across 8 practices as resource is put in place</td>
<td>£5,000</td>
</tr>
<tr>
<td>Stroke Prevention in AF</td>
<td>Avoiding stroke in patients with atrial-fibrillation through better identification of AF and optimising medication. Practices to identify patients through practice QOF AF Registers and implementing GRASP-AF risk stratification tool</td>
<td>£15,000</td>
</tr>
<tr>
<td>Community Clinics</td>
<td>Working with Locality GPs to consider running Locality clinics to tackle areas of high spend/activity in the Locality. Discussions underway, proposed start dates - Spring onwards 2013</td>
<td>£15,000</td>
</tr>
<tr>
<td>Community Nursing</td>
<td>This involves restructuring of the existing community nursing team. Working with NHFCT to make existing contract arrangement efficient and effective for the Locality and its practices</td>
<td>£27,075</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>£777,075</strong></td>
</tr>
</tbody>
</table>
The Northampton East and South Locality forms part of the wider Northampton Health and Wellbeing Fora. The group meets bi monthly addressing the key variations in health inequalities across Northampton. Key stakeholders include Voluntary Sector, Library Services, Public Health, Northampton Borough Council, and Police.

**The Northampton Health & Wellbeing Strategic Priorities**

- We will look to improve the integration of health and social care support to people to live as healthy and independently as possible, recognising the differing needs of our local community
- JSNA – supporting our communities
- GREAT DREAM
- Improved health and emotional wellbeing, improved quality of life, making a positive contribution, increased choice and control, freedom from discrimination, economic wellbeing, maintaining seamless personal support

**Alignment to The Northampton East and South Locality Strategy**

- Seamless services
  - Wellbeing Clinics
  - Supporting troubled families
  - Effective Hospital Discharge
- Emotional Wellbeing
  - GREAT DREAM
  - Wellbeing drop ins
  - Community and Voluntary Sector support
  - Focus in priorities highlighted in Northampton JSNA
  - Seek joint commissioning opportunities
  - Common assessment framework
The Northampton East and South Locality has identified the following priority areas in which it will seek to tackle variation in the use of health services:

- A&E attendances; Paediatrics, 0-24 year olds
- Right Care procedures
- Non-elective; Frail Elderly 75+, 0-4 zero-1 day admissions

We will take the following actions to address variation:

- Manage referrals for Rightcare procedures
- Prospective review for ‘top 3’ referrals (outside of Rightcare)
- Ensure adequate access to Primary Care to decrease A&E and Non-elective

The impact of our actions will be:

- Decrease in unscheduled and urgent care
- Downward trend in referrals for the areas identified by practices (likely to include cardiology, ophthalmology, trauma and orthopaedics).

Through our actions we aim to meet the requirements of the NHS Constitution:

- Quality - Reduced non-elective admissions and unnecessary hospital stays – Timely access for patients
- Equity – Service provision the same no matter where patients live or what practice they are registered with.
- Value for money – Actions to remain within the locality (a QIPP saving of Circa £5.8m)
In 2013/14 the Northampton West Locality plan to support the development of Primary Care through the following initiatives:

• Exploring models of collaborative and federated working amongst practices to utilise practitioners with enhanced clinical specialities. This will be done to:
  
  o Explore opportunities to deliver services close to the patients home initially through GP to GP referral
  o Enhance the knowledge and skill base of locality clinicians to support the delivery of healthcare to the registered population within the practice setting
  o Promote the sustainability of Primary Care within the future market place.

• Improving access models – the locality continues to encourage practices to explore different models of working aimed at improving access to Primary Medical Services. This includes Doctor First, appointment management (including open access), extended hours of opening and drop in clinics

• To support the reduction in utilisation of A&E for conditions that could be treated outside of the hospital setting, through training we will look to enhance the skills and knowledge of primary care clinicians to be competent in the delivery of such services from their community base.
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<td>Locality Dermatology Clinic</td>
<td>Patients referred to local Dermatology Clinic instead of Secondary Care supporting both care closer to home and reduction in outpatient referrals</td>
<td>£36,440</td>
</tr>
<tr>
<td>Care Homes</td>
<td>Providing care in the most appropriate setting through the delivery of care home, GP led ward rounds</td>
<td>£490,520</td>
</tr>
<tr>
<td>Patient Education for A&amp;E Attendances</td>
<td>Educating patients on the appropriate use of health services and surveying where A&amp;E has been inappropriately used</td>
<td>£23,589</td>
</tr>
<tr>
<td>Patient Self Management</td>
<td>Assessing patients with COPD and Heart Failure through pro-active self management plans</td>
<td>£83,516</td>
</tr>
<tr>
<td>Locality Sigmoidoscopy Clinic</td>
<td>Patients referred to local Sigmoidoscopy Clinic instead of Secondary Care supporting both care closer to home and reduction in outpatient referrals</td>
<td>£21,070</td>
</tr>
<tr>
<td>ENT Clinic</td>
<td>Patients referred to local ENT Clinic instead of Secondary Care supporting both care closer to home and reduction in outpatient referrals</td>
<td>£3,734</td>
</tr>
</tbody>
</table>
### Locality Specific Schemes (2)

<table>
<thead>
<tr>
<th>Scheme Title</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Best Practice In Primary Care</td>
<td>Providing directly targeted support in primary care, including prospective reviews, best practice training and BMJ supporting tools</td>
<td>£51,000</td>
</tr>
<tr>
<td>Locality Dietician</td>
<td>Locality led dietician support for patients with Long Term Conditions to help prevent A&amp;E attendances and emergency admissions</td>
<td>£26,700</td>
</tr>
<tr>
<td>Patient Follow Up</td>
<td>Managing follow up of outpatient procedures in Primary Care where appropriate to provide care closer to home</td>
<td>£62,100</td>
</tr>
<tr>
<td>Patient Self Care</td>
<td>To educate patients to self care for targeted age groups including Younger Persons, Children and Older Persons</td>
<td>£136,068</td>
</tr>
<tr>
<td>Paediatric Asthma Self Management</td>
<td>Assessing children with Asthma pro-active self management plans</td>
<td>£4,657</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>£939,394</td>
</tr>
</tbody>
</table>
The Northampton West Locality forms part of the wider Northampton Health and Wellbeing Fora. The group meets bi-monthly addressing the key variations in health inequalities across Northampton. Key stakeholders include Voluntary Sector, Library Services, Public Health, Northampton Borough Council and Police.

The key priority is the Health and Wellbeing of the population with a strong focus on Mental Health.

**The Northampton Health & Wellbeing Strategic Priorities**

- Supporting the most vulnerable and hard to reach patients in Northampton
- Working with the key stakeholders to implement the “GREAT DREAM” focusing on the health and wellbeing of Northampton residents.

**Alignment to the Northampton West Strategy**

- Development and sharing of Common Childhood Illness Book / App in schools, libraries and healthcare establishments
- Promotion of self care in different languages and in hard to reach areas.
The Northampton West Locality will look to tackle variation in the use of health services through the following:

- **Practice Performance Meetings** - Each practice undertakes a Performance Review led by the GP Chair and SLM. This review looks at unwarranted variation across the locality practices and in different specialties. An Action plan is drawn up and delivery monitored.

- **Hip and Knee Score Audits** - The Locality has been using the Oxford Hip and Knee scores for the last 12 months and implemented it as part of the QP QoF Projects. The Locality will also be managing and monitoring activity from April onwards.
In 2013/14 Wellingborough Locality plan to support the development of Primary Care through the following initiatives:

- Evolving business models – the locality has partnered with the East Northants Locality to explore provider models that are linked with community provision. The commissioning of service to be delivered from the Isebrook hospital site (due autumn 2013/14) will require providers to engage with localities and play an integral role in the wider demand management agenda.

- Promoting collaborative working amongst practices, and with secondary care to utilise practitioners with enhanced clinical specialities. This will be done to:
  - explore opportunities to deliver services close to the patients home initially through GP to GP referral
  - enhance the knowledge and skill base of locality clinicians to support the delivery of healthcare to the registered population within the practice setting.

- Through enhanced integration of community and practice clinical staff we will improve the management of patients with long term conditions.
## Locality Specific Schemes (1)

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<tr>
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</thead>
<tbody>
<tr>
<td>Isebrook UCC</td>
<td>Refurbishment of part of existing Isebrook site to develop an urgent care centre to provide a medically led locality based walk-in service, with observation bays. This will support the care of elderly and sub-acutely unwell adults and children where there is a requirement for longer more involved assessment. This scheme is subject to SHA capital approval</td>
<td>£212,000</td>
</tr>
<tr>
<td>Gastroenterology service with Endoscopy</td>
<td>Provision of community based consultant led clinics to manage gastroenterology conditions (except 2 week waits and unplanned care) and provide an endoscopy service as part of Isebrook refurbishment plans</td>
<td>£127,000</td>
</tr>
<tr>
<td>Care Homes</td>
<td>Provision of daily senior nurse support to locality care homes to rapidly manage sub-acute illness through advanced treatment and care plans, medically supported by GPs</td>
<td>£105,504</td>
</tr>
<tr>
<td>SERVE</td>
<td>Provision of short term (up to 10 days) personal care and support for patients being cared for within a case management model (PAC) who experience an exacerbation of a long term condition or acute infection which would otherwise put them at risk of admission to hospital</td>
<td>£44,275</td>
</tr>
</tbody>
</table>
## Locality Specific Schemes (2)

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>Community wax clinic</td>
<td>Practice based service provided on behalf of the locality for suction-based removal of ear wax following unsuccessful standard ear syringing</td>
<td>£8,856</td>
</tr>
<tr>
<td>Welcome Home phone calls</td>
<td>Assertive phone calls to patients over 65 who have experienced a hospital admission. Service provided by Age UK volunteers based within GP practices. Phone conversations identify any ongoing care needs including practice appointments, community nursing visits or sign posting to other agencies</td>
<td>£10,500</td>
</tr>
<tr>
<td>COPD self-management</td>
<td>Education for patients about their COPD condition and how to recognise and manage exacerbations using the COPD Self Management Pack produced by the British Lung Foundation</td>
<td>£15,732</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>£523,867</td>
</tr>
</tbody>
</table>
• Nene CCG are fully engaged with the Wellingborough Health and Wellbeing Forum as part of a broad membership representative of statutory and voluntary sectors.
• Current local priorities reflect the priorities from the previous Healthier Group and will be reviewed in light of the Health and Wellbeing Strategy and emerging priorities.

The Wellingborough Health & Wellbeing Strategic Priorities

Alignment to the Wellingborough Locality Strategy

Overarching theme
*Improve and increase healthy life expectancy and reduce health inequalities*

- Reduce obesity through the promotion of healthy and active lifestyles across all ages and concentrating on preventative action from childhood onwards
- Improvement in mental and emotional wellbeing, including developing support for dementia
- Reduce the prevalence of smoking
- Promote a culture of responsible drinking and action on alcohol and substance misuse

- Isebrook Urgent Care Centre development
- SERVE scheme for short term home support
- Care home nursing support
- Welcome Home phone calls
- COPD self-management scheme
- Childhood asthma self-management scheme
- Alcohol and drug referral service at Isebrook
- Stop Smoking service access through GP practices
- IAPT services available through GP practices
The Wellingborough Locality will look to tackle variation in the use of health services through the following:

• **Locality Audit Cycle** – prospective review and 6 month retrospective review of all T&O referrals – through this work we will reduce referrals through compliance with best practice referral criteria, reduction in GP variation through in practice prospective review.

• **Audit within practices of all referrals for ‘Right Care’ (prior approval) procedures** - we will assure GP compliance with best practice guidance and agreed patient pathways. Through this we will look to manage patient expectation and optimise referral processes

• **Regular practice visits** – we will introduce bi-monthly practice visits by the locality support team to discuss practice activity challenges based on available data and support development of practice-led action planning. Through this we will look to reduce variation and share best practice

• **Prescribing variation** – we will ensure that the Locality prescribing team are working closely with practices to decrease variation in utilisation and implement prescribing changes.
Better Commissioning of Elective Care

Our fourth area of transformation is concerned with the better commissioning of elective care.

As a CCG, we are committed to clinically led redesign of planned care pathways that reflect quality, best practice, effectiveness and affordability. Where we are national and local outliers we will improve performance and ensure our patients receive the very best quality of care to address their needs. In the future, we plan to commission services closer to home to enable patients and their carers to access appropriate treatment in the community as an alternative to hospital based services and where necessary we will stimulate the market to ensure patients have a greater range of services that delivers both quality and choice.

**Better contracting** – enabling the CCG to better manage its contracts and transact its commissioning decisions through the contracts it lets with providers

**Rightcare** – Value Based Commissioning – ensuring that the CCG spends its resources on those interventions that do the most good for patients.

**Better value and quality in Children’s and Maternity Services** – ensuring these services are of high quality and value for money

These themes are described in more detail on the pages that follow . . .
We are making significant changes to contract management, to enable us to extract maximum value, quality and safety from contracts through:

• Tightening up of prior approvals processes to ensure equity of access for patients
• Review and rationalisation of inherited contracts where insufficient value has been obtained, most notably around community services provided by out of county providers
• Closer management of contract clauses and provider performance, to improve delivery of key targets and invoke appropriate levers when this is not done
• Using contracting intelligence to highlight areas of high spend against benchmark to reduce expenditure to expected levels where this is clinically appropriate
• More robust and comprehensive data validation and contract challenge processes
• Investment in the contracting function within Nene, coupled with closer management of GEM CSS contracting support against agreed specification
• Alignment of local CQUIN schemes with key area of concern (urgent care) to incentivise delivery of change and improvements for patients
• Innovating with reimbursement systems to incentivise desired behaviour change and enhance delivery, through for example, alliance contracts, principal provider models and risk and gain share arrangements.
In December 2012, the NHS National Commissioning Board published planning guidance for the coming financial year. The overarching guidance document, ‘Everyone Counts: Planning for Patients 2013/14’ provides clear guidance for both providers and commissioners on expectations relating to all cost improvement programmes.

On 25th January 2013, the Director of Quality wrote to Medical and Nurse Directors to request assurance on appropriate arrangements within provider organisations.

1) Confirmation of timetable for agreement of all cost improvement plans for 2013/14
2) Copy of a ratified policy that outlines the process for quality impact assessments of all cost improvement plans in the organisation
3) An assurance statement to confirm that the Medical and Nurse Directors having assessed the impact on quality; authorise all cost improvement plans as being clinically safe
4) Confirmation that all quality impact assessments for cost improvement plans will be approved by your Board, including the date of that Board meeting. A copy of the minutes relating to this item needs to be submitted as part of the assurance required
5) Confirmation that the organisation has systems in place to monitor the ongoing quality impact of cost improvement plans throughout the year.

By 6th March 2013, all three large providers had submitted their evidence and appropriate levels of assurance were gained from each organisation.
The next stage of assurance will follow the guidance published by the National Quality Board in July 2012, “How to Quality Impact Assess Provider Cost Improvement Plans”. It is intended that this guide is followed during the coming year by commissioners to carry out an impact assessment of provider cost improvement plans.

To facilitate this, a list of all cost improvement plans for 2013/14 have been requested. As soon as they are agreed, we shall organise a series of meetings with Medical and Nurse Directors from all provider organisations to meet with commissioning colleagues to gain assurance about their plans, using other information sources to triangulate and agree an overall level of risk.

To ensure ongoing assurance in year, we also plan to repeat the above meetings with Medical and Nurse Directors at mid and end of year points to reassess risk.

We have also included an indicator within the local quality schedule regarding this process.

The CCG recognises that to be a financially sound commissioner, it needs financially sound providers. As part of its financial strategy, the CCG aims to ensure that it can commission with strong providers, and that all organisations work together to deliver success for the Health Economy.

The impact of Provider CIPs across the Health Economy is forecast as follows: The values attributed to Provider CIP’s are awaiting final authorisation, therefore this page will be populated shortly.
Northamptonshire have seen significant increases in urgent care activity in recent years resulting in a challenged health economy due to the effects this has on other services across the county. It is recognised by both commissioners and providers that we need to radically change how we deliver services if we are to improve the current situation.

Discussions have taken place with the three main providers over recent months about the concept of focussing all our efforts on a single Urgent Care CQUIN across the county. The response has been positive. We are also considering extending this approach to cover more than one year.

There will be a single local scheme with the following overarching aims:

1) To reduce A&E attendances across the county
2) To reduce emergency admissions to acute hospitals, avoiding admission wherever possible and appropriate
3) To ensure those who do need to be admitted, flow through the hospital effectively and are discharged in a timely manner
Northampton General Hospital NHS Trust and Kettering General Hospital NHS Foundation Trust have worked together and developed a joint approach to this work. This has resulted in the development of the following eight schemes, all of which are aimed at reducing emergency admissions.

Emergency Ambulatory Care Pathways

1) Low Risk Chest Pain
2) Supraventricular Tachycardia
3) Pleural Effusion
4) Painless Jaundice
5) Pulmonary Embolism

Hot clinics – to provide same day consultant opinion

6) Medicine
7) Surgery
8) Paediatrics
Our plans are to reduce activity on those interventions of low clinical value through a series of aligned actions...

Right Care

- The continued introduction of value based treatments including Lower GI Bleed and IBS in Primary Care
- Deliver thresholds for hip and knee arthroplasties undertaken in Northamptonshire

Prior Approval Process

- Enhance the local Prior Approval Process (PAP) and Value Based Policies and agree these in contracts with providers
- Ensure all treatments requiring prior approval have appropriate request made via the process
- Influence and strengthen contracting process to ensure delivery in secondary care

Pathway Redesign

To review current pathways and clinically redesign pathways for:

- Orthopaedics – implementation framework for hips and knees
- Ophthalmology – new hub and spoke model to be delivered, working with secondary care, Ophthalmology community clinics
- Cardiology – cardiovascular/pulmonary rehabilitation transformation
- Dermatology – locality/community new service model will be delivered
- Phototherapy – move to year of care tariff (to be approved)
- Cancer Services – reduce emergency admissions for patients with cancer, develop clear pathways as part of survivorship
- Urology – one-stop community clinic for lower urinary tract symptoms (LUTS) – men

Pathfinder (referral support tool)

- Further enhancements to the system to support GP/Clinicians with referrals
- Revision of referral criteria, pathways and policies
Children and young people aged 0-19 make up around 25% of our population and we recognise that the services we commission impact not just on the health of those children but on their future health throughout adulthood and on the health and wellbeing of their parents and carers. What we do to improve the health of children now will significantly impact on the health needs and demand on all public sector services for the future. This is particularly true of the health services we commission during pregnancy and early years, where evidence shows the significant long term impact on mental health, educational attainment, employment, social ability, and communication and life chances.

We will work with NHSCB and the Local Authority to ensure a safe transfer of commissioning responsibilities for Health Visiting, Family Nurse Partnership, Child Health Information Services and Children and Young People’s Public Health Nursing (school nursing). We shall develop effective communication channels to enable continued integration of commissioning plans and service delivery and robust safeguarding arrangements during this period of change and in the future.

To support effective decision making we will continue to develop our evidence base for commissioning through research, evaluation and continued work with partners. We shall continue to develop our joint commissioning team and to work with the multi-agency Children and Young People’s Partnership sub group of the Health and Well Being Board to ensure we have a shared vision for children’s services, integrate our commissioning processes and develop integrated services where families only have to “tell their story once”.

We believe that too many children and young people attend accident and emergency and other hospital settings, including mental health in patient care, who could safely and more appropriately be provided care in community settings or at home. We also believe that when a child has palliative care and end of life care needs, families should have a choice of where their child is cared for during that time and ultimately where that child dies.
Better Value and Quality in Children’s and Maternity Services (2)

Children and Young People’s Services

In 2013/14 we will:

- Pilot and evaluate the extension of the admission avoidance role of the community children’s nursing service
- Evaluate the pilot admission avoidance initiative in health visiting
- Working with Northampton University, deliver a social marketing research project to help us understand the behaviour of patients with sick children
- Develop children’s services within emerging urgent care centres
- Review therapy services and redesign the services to improve access
- Re-commission children’s community nursing services with an equitable county wide flexible and responsive service in place by April 2014
- Work with the Local Authority to implement the Special Educational Needs pre-legislative changes
- Continue to promote the use of personalised budgets for children and young people with special educational needs and continuing care packages
- Implement the paediatric diabetes best practice tariff in our two local providers, monitoring compliance to ensure high quality care
- Review our responsible commissioner arrangements to ensure appropriate funding systems are in place
- Review our Tier 3 Child and Adolescent Mental Health Services to ensure robust community services that provide timely support and reduce the need for hospitalisation
- Develop, with partners, alternative community based support for children with behavioural problems, reducing the need for long term medication and improving quality of life.
Maternity Services

We will implement the new Maternity Pathway and mandatory tariff pricing with both in county providers and out of county providers where they have systems in place. We shall benchmark local activity against national data to monitor local implementation of the pathway.

We recognise NICE guidance regarding a woman’s right to personal choice of method of delivery. However we believe that too many women elect to give birth by caesarean section due to misconceptions and that more support and advice is needed to enable women to make safe and confident choices during pregnancy and the intrapartum period. We will continue to work with local providers to develop consistent evidence based pathways of maternity care that promote the normalising birth agenda to women and their families and professionals and support women to make confident and safe choices for their place and type of birth.

We will continue to engage with Healthier Together and use the outcomes to inform our commissioning intentions for maternity services.
Our fifth and final area of transformation is one that underpins all of the others and is concerned with building the organisational capacity and capability to become a great Clinical Commissioning Group.

During 2013/14 we have learnt a lot, and have needed to adapt our approach significantly as we prepare to become a fully operational statutory organisation from April 2013.

We recognise that as well as developing ourselves, we need to ensure that we have in place really strong partnerships with other CCGs and highly effective commissioning support arrangements that deliver great services into the CCG.

Therefore this area of transformation has four distinct themes:

- **Developing our operating model** – to strengthen and accelerate accountability and delivery
- **Learning from authorisation** – embedding this learning across the organisation
- **Collaborating with other CCGs** – both within Northamptonshire and wider, where we have shared interest
- **Strengthening Commissioning support arrangements** - with our current provider GEM, and later through market testing

Each of these themes is considered on the following pages . . .
**Developing Our Operating Model**

We have made significant changes to our operating model in order to strengthen accountability and delivery ...

**Why Change?**
Accountability needs to be discharged more effectively through the organisation

We need greater clarity on individual personal responsibility and accountability

A standardised delivery mechanism needs to underpin and guide the work of our localities and central teams

We must be able to operate more initiatives across all localities and spread best practice between localities at a faster pace

**What Has Changed?**
Review of financial baseline undertaken and performance managing improvement

New Director of Performance and Chief Finance Officer in place February 2013

Management structures being filled

Greater support for QIPP delivery and planning in place through establishment of internal PMO

New locality performance “dashboards”

Personal accountability frameworks in place for 100% of staff

Monthly Director led QIPP reviews commenced of all localities and central teams

QIPP schemes risk assessed and actively managed

Locality Delivery Teams established with Director input to each Locality

Redefined relationship with Commissioning Support Provider (GEM) based around focused improvement areas.
Learning From Authorisation

Having made our application as part of Wave 2 in the application process, from the 18 January 2013 we became authorised as a CCG subject to 13 conditions and 1 direction of operation. These 13 conditions of operation focus primarily on the following areas:

- The development, management and delivery of QIPP
- The management of Commissioning Support Services
- Information Governance

Our direction of operation is focused on the commissioning of our 2 main providers of Secondary Care Services.

In response we have established a robust action plan aimed at developing our organisation to effectively discharge all its functions. Through the leadership of our Executive Team, our authorisation action plan identifies that we need to focus on in the following areas:

1) Changing our operating model
2) Strengthening internal capacity and capability
3) Strengthening commissioning support
4) Collaborating with others and provide system leadership

This authorisation plan forms the focus of the work we will do within Nene to build organisational capability. Working alongside the Area Team we aim to develop our organisation and provide the necessary assurances to have our conditions and directions as early as possible in 2013.
It is only in the latter part of 2012/13 that the CCG has been fully able to populate its management structures and begin to address key gaps in capacity and capability arising through the transition period:

- Executive team fully in place in early February 2013
- Recruitment underway to other vacant posts in the structure
- All staff have a personal accountability framework in place – build on this as part of appraisal and personal development for 2013/14
- Organisational development focus around “delivering today” and specifically QIPP delivery – partnering with KPMG to drive this forward
- Establishment of our PMO function a key aspect of this work in supporting our staff
- “Making a Difference” Programme – recruiting people from across the organisation to drive a new delivery culture to underpin how we operate in the future
- Locality teams strengthened and more visible to member practices. Directors supporting each locality meeting
- Each locality putting in place refreshed arrangements for mutual accountability between practices and between the CCG and its member practices.
NHS Nene CCG as a larger CCG has greater choice over where it secures commissioning support from, as it has an increased ability to provide services for itself than would be the case for a smaller CCG. However, we have adopted a rigorous approach to the assessment of “build, buy, share” options in order to ensure that we get the best support possible.

**Principles which guide our decision making in relation to commissioning support services**

**Principles which support hosting commissioning support within a CCG (either for itself or on a shared / federated basis)**

- Where integration with partners within the health economy is critical to future success
- Where success will be based on the effectiveness of relationships, particularly clinical ones
- Where functions will benefit from being clinically led or directed
- Where the function is ‘mission critical’
- Where functions can be more effective with increased primary care engagement
- Where there is a fundamental need to change the way the function is provided from the way it is currently discharged within the PCT
- Where there is a need for a Northamptonshire focus, as opposed to a cluster focus
- Where there is an important statutory responsibility.

**Principles which support the provision of services / functions via a non CCG based commissioning support provider**

- Where the function is transactional in nature
- Where the function is routine
- Where the function is scalable to meet the needs of multiple CCGs
- Where the function is non-tailored
- Where the function requires a cluster (or regional) focus
- Where the function requires scarce / very specialist skills
- Where the function has relatively little impact on the organisation
- Where there could be a perceived ‘conflict of interest’ between GPs involved in commissioning and service provision.
We continue to develop more robust partnership arrangements with our commissioning support provider, GEM:

- Specifications agreed for all service areas (Feb 2013)
- Updated SLA with associated performance framework (Feb 2013)
- Issues log established, together with service line leads to manage performance in each area (Nov 2012)
- Escalation process used to drive production of improvement plans in 5 areas (Information, Contracting, Finance, Continuing Healthcare and HR)
- Establishment of taskforces to drive improvements in business critical areas – Information (Nov 2012) Contracting (Jan 2013)
- Integration of GEM senior staff into Nene structures, and establishment of Exec to Exec business meetings (Jan 2013)

We intend to market test our commissioning support arrangements during 2013/14, with new contracts in place during 2014/15.

Our approach and key milestones are set out in more detail in our commissioning support strategy ...
Collaborating With Other CCG’s (1)

Our Partnership with Corby CCG...

Nene CCG and Corby CCG have agreed to share functions and work together, where it makes sense to plan and deliver these on a countywide basis.

The partnership is governed by a Memorandum of Understanding and related to a number of shared functions including:

- Urgent care commissioning and system management
- Planned care commissioning
- Mental health, learning disability and community commissioning
- Medicines management
- Emergency planning and business continuity

By working in this way we will ensure that patients across Northamptonshire benefit from “joined up” planning of services, and taxpayers benefit from the management cost efficiencies that are possible when CCGs share services, and can invest more in frontline services.
We recognise that our future strength comes from collaborating with others and through co-production …

<table>
<thead>
<tr>
<th>The Grafton Group</th>
<th>• 10 CCGs across England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning of Support Services</td>
<td>• 21 CCGs across Greater East Midlands</td>
</tr>
<tr>
<td>The “Healthier Together” Review</td>
<td>• 5 CCGs across the South Midlands</td>
</tr>
<tr>
<td>Quality, Safety &amp; Safeguarding</td>
<td>• Northamptonshire County Council &amp; Corby CCG</td>
</tr>
<tr>
<td>Mental Health, Learning Disability, Children’s Joint Commissioning</td>
<td>• Northamptonshire County Council &amp; Corby CCG</td>
</tr>
<tr>
<td>Commissioning from Main Providers</td>
<td>• Corby CCG (Nene Lead) • Oxford &amp; MK (Active Associate)</td>
</tr>
<tr>
<td>EMAS, Patient Transport, 111, Pathology Services</td>
<td>• Other E. Midlands CCGs</td>
</tr>
</tbody>
</table>

Nene CCG – Leaders AND Collaborators
Engagement
Engagement Work Carried Out in 2012/13

From January to April 2012, just under 13,000 members of the public were contacted:

• More than 10,000 that we already had relationships with (such as Hospital Trust members), were asked about their health priorities. This was mainly through mailings, emails and face-to-face at local forums. 168 of these completed our online survey.

• 1,500 members of the public were approached in the community whom we hadn’t spoken to before and 632 completed public surveys around perceptions of local NHS priorities.

• Using a creative social marketing approach a ‘cool’ wall was created and scratch cards handed out to attract attention and open up dialogue in local settings such as: town centres, shopping centre, supermarkets, churches, sports grounds, university locations and local pubs.

• A launch event was organised in May 2012 where more than 260 members of the public and other stakeholders attended to learn about the results of the surveys, discuss the findings and input further into the creation of locality priorities and engagement groups.

The results of which shaped the CCG priorities for 2012/13.
The commissioning intentions 2013/14 have built upon the 2012/13 priorities and as such now require a different approach to communication and engagement. This will be:

1. A tailored approach to patient engagement that will be implemented throughout the commissioning cycle, specifically to support new commissioning intentions, assessed against the appropriate level of involvement required.

2. All key activity demonstrating patient involvement will be approved via all relevant elements of the CCG patient involvement framework.

3. Publication of a public-facing document outlining the major commissioning intentions ensuring that key stakeholders are kept up to date with developments. The document can be used for consideration by:
   - Governing Body (and relevant CCG meetings)
   - The Overview and Scrutiny Committee
   - The Health and Wellbeing Board
   - Patient Congress
   - Other public meetings
   - General public via CCG website.
Our Patient Involvement Framework ensures patient engagement is embedded in the culture of the organisation.
Each commissioning plan, and indeed all other CCG initiatives, are tested against this matrix to assess the appropriate level of engagement.

This ensures we meet our statutory responsibilities under the law and the NHS Constitution, while at the same time ensuring that engagement with our stakeholders is ongoing.

Those that have the highest level of change in commissioning and the highest potential impact on patients are: Favell House review, Hospice Care Funding and Podiatry.

These will require communication and engagement/consultation plans above and beyond business as usual.

Potential impact upon patients

- Low
  - Small change, low impact
    - Inform and promote decisions already made to existing stakeholders and representative groups
- High
  - Small change, high impact
    - Engage with those who will be most affected via relevant fora
  - Large change, low impact
    - Co-design with patients affected via focus groups, partners e.g. LiNK
  - Large Change, high impact
    - Formal consultation for up to 12 weeks statutory framework
Applying Patient and Stakeholder Requirements
For Residential Respite Care in Northamptonshire

Re-provision of respite care and Health Checks for people with neuro-degenerative conditions. The current service supports 21 people with Parkinson’s, MS or motor-neurone disease, most of whom do not meet the threshold for CHC funding. They receive routine nursing care whilst also receiving respite care. The service also has a day centre attached which supports 42 people, some of whom also use the respite service. The day service is funded by NCC and delivered at Favell House, Northampton.

The proposal is to assess each person and to then offer an appropriate personal health budget to facilitate their continued care. This could be offered on a wider basis to others with the same need thereby reducing inequity across the county.

The use of the building premises would also be reviewed for potential, to promote value for money and quality of care.

**Large change : High level of impact**

**Recommendation for engagement**
Due to the potential for a change in location of service and alternative use of the premises – a formal consultation is recommended.
In Northamptonshire the NHS funding is 80% of the running costs of the two hospices. The national figure is that the NHS typically funds 34% of all hospice services. The hospices are based on two sites and operate independently.

It is planned to work with the hospices to secure alternative means of revenue through fund raising and to reduce the demand on the NHS funds to a figure that is closer to the national average. Initial proposals will seek to reduce by £2m over the period of two years.

**Small change : level of impact from low to high**

**Recommendation for engagement**
High volume engagement to ensure that a collaborative approach to securing alternative funding is sought.
The current community podiatry service was subject to a partial AQP exercise in 2012. This resulted in an increase in the contact price from £42 to £87. It is therefore essential that a clinical evaluation of the service, its pathways and alternative, cost effective solutions are investigated.

While it is not intended for the service to change, a review of the threshold in order to access podiatry services may result in some existing low risk patients having a change in where and how the service is delivered. This would be perceived, by those patients affected, as a service change.

Small change : level of impact from low to high

Recommendation for engagement
While this would not necessarily require a formal consultation on the merit of a small change, it is recommended that a formal consultation is taken forward to ensure that the service takes account of future countywide needs.
Applying Patient and Stakeholder Requirements to Review Adult Short Breaks

A service for adult short breaks is currently commissioned at two facilities in Duston. The service is provided by NHFT and is available for adults with learning difficulties and disabilities and adults with learning difficulties and challenging behaviour.

The proposal is to assess existing individuals, being supported by the service, with a view to offering personal health budgets and providing the choice to receive their short breaks in alternative locations.

In parallel to this, the pathway would be reviewed and a further proposal produced regarding the impact on the block contract – currently valued at £1.5m

**Small change : level of impact from low to high**

**Recommendation for engagement**

The change to individuals currently accessing the service will be minimal as they are still able to receive the service in the existing locations.

The review of the pathway and impact on the reduction in demand on the block contract will require high volume engagement with stakeholders.
Engagement and Consultation Implementation Process

Each of the three programmes will now follow the process below:

1. Identify communications and engagement themes and produce detailed plan
2. Carry out stakeholder analysis and agree key messages
3. Highlight interdependencies with other programmes and formulate consultation programme
4. Analyse feedback, finalise proposals and share results
5. Implement and evaluate

Enablers for successful engagement:

- Inclusion of engagement lead in planning process
- Access to senior decision-makers to enable timely and appropriate interventions
- Individual projects are part of the on-going programme of communications and engagement
Financial Plan and QIPP
We understand the importance of strong and sound financial planning and management, and the need to plan effectively to ensure the CCG is sustainable and ready to take on statutory responsibility for commissioning from 1 April 2013.

The financial plan which underpins this plan has been developed in full consultation with the localities, focusing investment on those areas where we believe we can obtain maximum return in terms of quality, safety, responsiveness, and finance, and which fulfil the vision set out within this document.

The QIPP plan which is integral to this is based around transformation and service redesign, with future service provision being designed to be as efficient and effective as possible, using the principles of ‘right care, right place, right time’. This plan focuses on a number of key work streams which are clinically owned and clinically led. It is only through this route that we believe QIPP and service redesign can be effected, and that the financial stability which arises from this can be fully realised.
Planning Assumptions (1)

These assumptions underpin the NHS Nene CCG financial plan and include the following:

• Inclusion of 2013/14 ‘Everyone Counts’ requirements

• Plan for a 1% surplus in line with the NCB requirements

• 2% Transition Fund top slice built in, to be accessed via LAT

• Tariff deflation at 1.3% for PbR and for Non PbR

• Plans developed built up from a bottom up CCG approach

• 0.5% contingency reserve established

Nene CCG Planning Assumptions

<table>
<thead>
<tr>
<th>Assumption</th>
<th>2013/14</th>
</tr>
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<tbody>
<tr>
<td>CCG Allocation Growth</td>
<td>2.30%</td>
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<tr>
<td>Pay Awards</td>
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<tr>
<td>Demographic Growth</td>
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<td>Primary Care</td>
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<tr>
<td>Gross Tariff uplift</td>
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<td>Efficiency</td>
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<tr>
<td>Net Tariff</td>
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<td>Non Recurrent Transformation Fund</td>
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<tr>
<td>Operating Framework Initiatives</td>
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<tr>
<td>Contingency Reserve</td>
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<tr>
<td>Surplus</td>
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</table>
• 2012/13 Outturn forms baseline for 2013/14

• Growth in activity based on a mix of local population and national growth assumptions

• CCG contract offers to Providers based on financial assumptions

• Growth in CHC calculated over a 2 year trend

• Running Costs within £25 per head of population

Nene CCG Planning Assumptions (Cont)

<table>
<thead>
<tr>
<th>Prescribing Growth</th>
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<tbody>
<tr>
<td>CHC growth rate</td>
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<tr>
<td>Non-elective activity growth - In county acute providers only</td>
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</tr>
<tr>
<td>A &amp; E activity growth – In county acute providers only</td>
<td>5.00%</td>
</tr>
</tbody>
</table>
Use of 2% Non Recurrent Fund in Supporting Change and Transition

- Planned use of the 2% Non Recurrent Funds will focus on organisational and system change for 2013-14, with the need for a return on investment integral to any investments.
- Funding to be used to pump-prime initiatives which will produce recurrent savings for the health system.
- Initial business cases have been agreed for “Healthier Together” and £2M for the health economy that return a recurrent QIPP delivery of £9.2M.
The total budget for NHS Nene CCG for the 2013-14 financial year is £653.814M. This includes a 2.3% growth uplift of £14.310M and the return of the 2012/13 non-recurrent surplus of £2.058M. It also includes the CCG running cost allowance based on £25 per head of population.

This funding covers all areas of commissioning which pass to the CCG from 1 April 2013.

The allocation has been reduced to take account of the expansion of services which are now classified as Specialist Services and also for some Public Health adjustments.
The total running cost allowance for NHS Nene CCG for 2013-14 is **£15,260M**.

The RCA will be used to fund both the internal management structure of Nene and the elements of Commissioning Support purchased from the Greater East Midlands Commissioning Support Services (GEM CSS).

NHS Nene is able to contain all of its running costs within the allocated RCA, as shown in the table.

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Running Cost Allowance</td>
<td>15,260,000</td>
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<tr>
<td>Nene Structures</td>
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<tr>
<td>Pay Costs</td>
<td>8,853,472</td>
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<tr>
<td>Less recharges to other organisations</td>
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<tr>
<td>Less: Non-Running Cost Posts</td>
<td>(412,997)</td>
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<td>Subtotal: Nene Structures</td>
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<td>Nene Non-Pay</td>
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<td>20% of staffing costs</td>
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<td>Subtotal: Nene Non-Pay</td>
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<td>Commissioning Support Organisation</td>
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<td>Total Service level Agreement Value</td>
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<tr>
<td>Less: Non-Running Cost Posts</td>
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<td>Subtotal: CSO Recharge</td>
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<tr>
<td>Enablement funds for strategic priorities</td>
<td>234,115</td>
</tr>
<tr>
<td>Total Running Cost</td>
<td>15,260,000</td>
</tr>
<tr>
<td>(Shortfall)/Surplus</td>
<td>(0)</td>
</tr>
</tbody>
</table>
NHS Nene CCG has set aside a number of reserves within the plan. These include:

- 2% funding set aside for non-recurrent expenditure on transformational/QIPP schemes (£12.730M)
- Reserve funding to cover ‘Everyone Counts’ requirements and new strategic investments (£4.261M)
- 0.5% contingency funding to be used for unexpected expenditure items, e.g. pandemics, major incidents (£3.182M)

In addition, the CCG has planned for a 1% surplus, to be top-sliced from budgets and held in reserves.
Based on the assumptions outlined above, when all known commitments have been accounted for, the financial gap for NHS Nene CCG is a value of £32.130M. This includes the value of any investments which are required to deliver the QIPP agenda, and includes the investments which may be met by the 2% transformational fund, but for the purposes of financial planning, are currently assumed to be funded from baseline funding.

QIPP schemes totalling £32.130M (net) have been identified to be set against this gap. In addition to this, further schemes are being developed to give a total savings plan of £49.0M. These additional schemes will then allow some headroom to increase the level of mitigations to ensure that any slippage can be managed effectively, and mitigate the risk of unexpected financial pressures arising in year.
The Gap is £32.13 Million

Historical delivery of schemes is 60-70%, therefore asking for plans to deliver £40 + million

c.6% of CCG allocation

The Challenge for each area is shown in the table

### Nene CCG - QIPP Challenge 2013/14

<table>
<thead>
<tr>
<th>Programme Area</th>
<th>Assessed Plans £ Million</th>
<th>Additional Requirement £ Million</th>
<th>Total £ Million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuing Healthcare</td>
<td>2.5</td>
<td>0.5</td>
<td>3.0</td>
</tr>
<tr>
<td>Mental Health / LD</td>
<td>5.3</td>
<td>2.7</td>
<td>8.0</td>
</tr>
<tr>
<td>Community &amp; LTC</td>
<td>3.9</td>
<td>2.1</td>
<td>6.0</td>
</tr>
<tr>
<td>Planned Care</td>
<td>4.2</td>
<td>0.8</td>
<td>5.0</td>
</tr>
<tr>
<td>Maternity &amp; Children's</td>
<td>0.0</td>
<td>2.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>3.2</td>
<td>4.6</td>
<td>7.8</td>
</tr>
<tr>
<td>Prescribing</td>
<td>1.9</td>
<td>1.1</td>
<td>3.0</td>
</tr>
<tr>
<td>Contracting Business Rule</td>
<td>2.7</td>
<td>0.0</td>
<td>2.7</td>
</tr>
<tr>
<td>Other</td>
<td>3.0</td>
<td>0.0</td>
<td>3.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>26.7</strong></td>
<td><strong>14.3</strong></td>
<td><strong>41.0</strong></td>
</tr>
</tbody>
</table>

| Localities Plans                | 5.4                      | 2.6                              | 8.0             |

**Total**                        | **32.1**                 | **16.9**                         | **49.0**        |
Commissioning intentions have been developed to deliver the plans outlined below:

<table>
<thead>
<tr>
<th>Scheme Type</th>
<th>Gross Savings (£Ms)</th>
<th>Investment (£Ms)</th>
<th>Net Savings (£Ms)</th>
<th>% By Type (of total schemes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>QIPP</td>
<td>35.859</td>
<td>(6.429)</td>
<td>29.430</td>
<td>92%</td>
</tr>
<tr>
<td>Transactional</td>
<td>2.700</td>
<td>0</td>
<td>2.700</td>
<td>8%</td>
</tr>
<tr>
<td>Total</td>
<td>38.559</td>
<td>(6.429)</td>
<td>32.130</td>
<td>100%</td>
</tr>
</tbody>
</table>

These reflect a mixture of schemes commenced in 2012-13 for which the full year effect has not yet been delivered and new projects developed through the CCG Programme groups to commence in 2013-14. These plans are sufficient to enable financial balance but further schemes are being developed in order to allow further mitigation if required.
# Our Top 10 QIPP Initiatives (by Value)

*Of our total initiatives, our top 10 will deliver £15.297m, 48% of our challenge.*

<table>
<thead>
<tr>
<th>Commissioning Initiative</th>
<th>Value</th>
<th>Lead Clinician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health programme budget CIP</td>
<td>£3,532,000</td>
<td>Tom Houseman</td>
</tr>
<tr>
<td>Rightcare</td>
<td>£3,331,783</td>
<td>Roger Perry</td>
</tr>
<tr>
<td>Integrated teams working with care homes</td>
<td>£2,021,564</td>
<td>Judith Dawson</td>
</tr>
<tr>
<td>Community nurse case management</td>
<td>£1,461,376</td>
<td>Tom Houseman</td>
</tr>
<tr>
<td>Effective Prescribing</td>
<td>£1,887,000</td>
<td>Rick Byrne</td>
</tr>
<tr>
<td>Neighbourhood teams</td>
<td>£801,779</td>
<td>Matthew Davies</td>
</tr>
<tr>
<td>Review of 800 Free Nursing Care and Continuing Healthcare cases.</td>
<td>£700,000</td>
<td>Peter Boylan</td>
</tr>
<tr>
<td>Community Podiatry</td>
<td>£676,000</td>
<td>Roger Perry</td>
</tr>
<tr>
<td>Individual Funding requests</td>
<td>£572,318</td>
<td>Roger Perry</td>
</tr>
<tr>
<td>Community Elderly Care Scheme</td>
<td>£313,087</td>
<td>Judith Dawson</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£15,296,907</strong></td>
<td></td>
</tr>
</tbody>
</table>
### QIPP Schemes by Provider

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In Contract</strong></td>
<td></td>
</tr>
<tr>
<td>NGH</td>
<td>6.569</td>
</tr>
<tr>
<td>KGH</td>
<td>4.385</td>
</tr>
<tr>
<td>NHFT</td>
<td>3.532</td>
</tr>
<tr>
<td>Other</td>
<td>0.308</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>14.794</strong></td>
</tr>
<tr>
<td>Other schemes impacting on contracts</td>
<td>8.924</td>
</tr>
<tr>
<td>Non Contract Schemes</td>
<td>14.841</td>
</tr>
<tr>
<td>Less investment required</td>
<td><strong>(6.429)</strong></td>
</tr>
<tr>
<td><strong>Total net saving</strong></td>
<td><strong>32.130</strong></td>
</tr>
</tbody>
</table>
The Nene Performance Cycle is an important process which has a single aim of ensuring Nene CCG achieves its objectives.

1) Plan
- Develop annual plans and agree contracts based on local and national strategic objectives

2) Deliver
- Implement local plans and manage provider contracts

3) Monitor
- Collate and report appropriate information to enable effective performance management

4) Manage
- Manage performance and oversee improvement to outcomes, financial performance operational performance
The Nene Performance Management team in close collaboration with other Nene teams are responsible for ensuring the Nene Performance Cycle is implemented, utilising the following mechanisms:

<table>
<thead>
<tr>
<th>Step</th>
<th>Commissioner Mechanisms</th>
</tr>
</thead>
</table>
| 1) Confirm what is important | • Annual operating plan  
  • Locality plans and QIPP  
  • Provider contracts |
| 2) Deliver Services and QIPP | • Commissioning support  
  • PMO lifecycle |
| 3) Collate and report the right information | • Specific performance reports |
| 4) Learn and improve | • Performance assurance meetings and reviews  
  • Data analysis tools and expertise  
  • CCG and CSU support  
  • Contractual mechanisms |
A strong performance culture underpins the Nene performance management cycle. There are 7 guiding principles that define the Nene CCG performance driven culture.

- Visible Leadership & Commitment
- Clear Accountability & Expectations
- Delivery focussed
- Open & Explicit Review
- Shared Learning, Understanding & Supportive Mindset
- Success is Celebrated
- Robust Provider Management and Local QIPP Delivery
- Quality and Safeguarding
- Outcome Measures
- Financial Plan and QIPP
- Engagement
- Context
- Vision

Foreword and Introduction
QIPP Assessment

- Each scheme has a supporting CAD document as detailed in the QIPP handbook.
- The individual schemes were designed with clinical involvement and subsequently have been challenged to the validity of the scheme with appropriate clinical challenge.
- CADs are being triangulated to confirm the accuracy of activity and finance
- Clinical leads have been assigned to support the delivery of each scheme
- Non contracted schemes will have KPI’s developed and will be monitored via the Programme Management Office
Management of QIPP Projects

QIPP delivery is incorporated within the Nene performance cycle and performance culture outlined earlier. However, due to the importance of successfully delivering QIPP projects, additional information has been outlined regarding the Nene CCG approach to QIPP project management.

QIPP delivery within Nene CCG is based on the following structure and principles:

**Principles**

- All of Nene’s QIPP challenge is attributable to Locality QIPP plans
- The Locality Chair is responsible for delivery of the Locality QIPP plan and ensuring the identified QIPP gap is met
- QIPP plans are reviewed by the Director of Performance with the Chief Finance Officer and Director of Contracts
- All projects are owned locally, even if they are coordinated centrally
- The Nene Performance Director will oversee all Locality plans
- The PMO will ensure that all projects adhere the Nene project lifecycle and are robustly monitored.
- In the event of project schemes not delivering forecast savings, the Locality will be required to develop additional projects, in collaboration with central teams where appropriate.
Risks
The CCG’s Strategic Approach to Risk Management

There will always be significant risks associated with all health and social care systems and Nene CCG uses a common risk scoring matrix to quantify and prioritise risks identified within the organisation.

In order to mitigate the risks to delivery for Nene CCG, the Audit and Risk Committee has now introduced a process where they will identify, review and reassess the top risks at each of their meetings. These top risks will be presented to Governing Body and Board of Directors meetings to ensure organisational focus on the programme of work that are underway. This will ensure full integration of risk management and mitigation into all aspects of planning and delivery, in particular QIPP.
The top risks identified by the Governing Body are currently:

- The CCG will not achieve financial control and balance in 2012-13, leading to recurrent financial pressures going forward
- Ability to deliver QIPP initiatives to reduce cost and support financial balance. Risk on overspends if controls are not in place
- No clear governance structures and programme management capacity and capabilities in place to support the delivery of QIPP
- CCG has arrangements in place to manage all contracts that will be transferred from PCTs on/ by 31 March 2013, or new contracts from 1 April 2013
- Ability to manage commissioning support arrangements in order to provide quality and value for money

The following slides provides detail on:

1) The internal assurance process and the review mechanism for each of the top risks
2) The governance structure supporting risk management in Nene CCG
3) The reporting of risks across Nene CCG
4) Specific risks relating to the delay of our 2013/14 Plan
# The Top Risks Currently Identified Within the CCG (1)

<table>
<thead>
<tr>
<th>Corporate Objective</th>
<th>Exec Lead</th>
<th>Principal risk</th>
<th>Internal Assurance on Controls</th>
<th>Reviewed</th>
</tr>
</thead>
</table>
| Financial Control    | Finance Director          | The CCG will not achieve financial control and balance in 2012-13, leading to recurrent financial pressures going forward | • Plans in place to monitor financial pressures and to reduce overspend  
• Recovery plan to include contract escalations  
• CSU to understand their role in financial recovery through the information task force  
• Establish clear CSU performance measurement  
• RCA to be commissioned from CSU on acute over performance  
• CSU to highlight areas of over performance other than urgent care  
• Financial modelling to identify the financial gap for the next 3 years  
• Discussions with providers to reduce forecast expenditure. Continuing discussions with LAT re reserve position | Finance Committee monthly  
Monthly Governing Body |
| Financial Balance    | Director of Performance   | Ability to deliver QI/PP initiatives to reduce cost and support financial balance. Risk on overspends if controls are not in place | • Detailed QI/PP plans in place  
• Focus on financial recovery/ resilience  
• Monthly reviews to take place with all localities to understand their financial position and QI/PP performance, to ensure delivery is maximised and, where slippage occurs, mitigations are put in place  
• Development sessions with locality managers to support delivery  
• Reporting to include non-financial indicators  
• Enhance CCG performance reporting to include quality, performance and financial information | Finance Committee monthly  
Monthly Governing Body |
## The Top Risks Currently Identified Within the CCG (2)

<table>
<thead>
<tr>
<th>Corporate Objective</th>
<th>Exec Lead</th>
<th>Principal risk</th>
<th>Internal Assurance on Controls</th>
<th>Reviewed</th>
</tr>
</thead>
</table>
| Financial Balance Organisational Development | Director of Performance               | No clear governance structures and programme management capacity and capabilities in place to support the delivery of QIPP | • PMO in place from November 2012,  
• Support from KPMG to establish systems and processes - now concluded  
• Of the 3 substantive positions, 1.5 vacant  
• Head of Performance is offering support in the interim                                                                                                                                  | Finance Committee  
Governing Body                                                                                                                  |
| Organisational Development           | Director of Contracting and Procurement | CCG has arrangements in place to manage all contracts that will be transferred from PCTs on/ by 31 March 2013, or new contracts from 1 April 2013 | • Appointment of Director of contracting and Procurement  
• Contract transition working group to be established  
• Full list of contracts to be reviewed prior to handover to ensure contract terms and values are confirmed and agreed. Contracting strategy for 2013-16 to be developed to set down key processes, strategies and timelines for contract management  
• MOU with Corby CCG to be amended to reflect lead contracting arrangements. Contracting team to be fully recruited to  
• A detailed specification for contracting and relationship with CSU has been finalised, creating clear lines of management and accountability  
• Collaborative agreements being put in place with all associate CCGs                                                                                                           | Governing Body Finance and Performance Committee                                                                                       |
| Localities fit to lead               | Chief Commissioning Officer            | Ability to manage commissioning support arrangements in order to provide quality and value for money | • A “CSU Issues Log” has been posted on the Nene Shared Drive to support the management of Commissioning Support Services  
• Specifications agreed by 31/01/13. SLA to be agreed by 28/02/13. Commissioning support strategy to be agreed by 28/02/13  
• Use of escalation process by 31/12/12                                                                                                                                 | Contract and Procurement Committee  
Governing Body                                                                                                                  |
**Governance Structure**

- **Corporate Objectives** (set by the Governing Body)
- **Directorate Objectives** (set by the Director to deliver the Corporate Objectives after every refresh of the Corporate Objectives)
- **Department/Team Objectives** (set by operational managers to deliver the directorate objectives)
- **Strategic Risks** (Risks identified by the Governing Body or Board of Directors that affect the delivery of the Corporate Objectives)
- **Directorate Risks** (Risks that affect the delivery of the Directorate Objectives)
- **Operational Risks** (Risks that affect the delivery of the Department/Team Objectives)

**Top 5 Corporate Risks to Board of Directors and Governing Body Monthly**

**Board Assurance Framework (Quarterly)** to Board of Directors and Governing Body

**Audit & Risk Committee to Review Corporate Risks Monthly**

**Risk Register**
Risks with a residual moderate or low rating will be managed and monitored by the risk owner at directorate level. All red/amber rated risks will be presented monthly to Audit & Risk Committee as Corporate Risks.
Top 5 Corporate risks reviewed monthly by Board of Directors and Governing Body

Board Assurance Framework reviewed quarterly by the CCG Governing Body and Board of Directors

All Corporate Risks (amber/red rated) reviewed monthly at Audit and Risk Committee

Risks with a residual moderate or low rating will be managed and monitored by the risk owner at directorate level. All red/amber rated risks will be presented monthly to Audit and Risk Committee as Corporate Risks
The Management and Reporting of Risk

The CCGs risk register uses a common risk scoring matrix to quantify and prioritise risks identified within the organisation.

Escalation of the risk will be by the risk owner reporting it to the appropriate Director. The Director will then ensure that the risk is logged on the risk register. Directors will manage the detail of the risks to ensure that the risks themselves are identified correctly, well controlled and that appropriate assurance can be gained.

The management of risks will include:

- Tracking, monitoring and managing identified risks
- Responding to risks as they occur
- Evaluating Risk Action Plans
- Monitoring risk triggers
- Ensuring risk policies are followed
- Ensuring risk action plans and contingency plans are appropriate and effective.
Risks – Management and Reporting of Risk

Risks with a residual moderate or low rating will be managed and monitored by the risk owner at directorate level. All red/amber rated risks will be presented monthly to Audit and Risk Committee as Corporate Risks.

The Audit and Risk Committee will review the amber/red rated risks, ensuring that they are identified and graded appropriately and that relevant controls, assurances and monitoring arrangements are in place. The top 5 Corporate Risks will be escalated monthly to the Board of Directors and Governing Body.

The Board Assurance Framework (BAF) is a key strategic document which demonstrates how well the organisation is identifying and managing material risks sourced from both its internal and external operating environments, which could significantly impact on its ability to deliver its corporate objectives. The BAF is presented to the Board of Directors and Governing Body once a quarter.

The BAF will provide assurance to a range of stakeholders and other interested parties that Nene CCG operates effectively and takes mitigating actions on risks that may impact on the delivery of its objectives, its decision-making and its reputation.
Specific Risks Associated with our 2013/14 Plan

The CCG has identified the high level risks for the 2013/14 plan and is developing mitigation plans to address these:

1) **Acute contract over performance** – the CCG has built its plan based on 12/13 forecast outturn, increased for anticipated future demand and population growth. Contract levers will be strengthened (e.g. prior approval) through the contract, and a set of contract business rules put in place to manage provider performance more strongly. The CCG is actively managing delivery from its support provider, but importantly at this point has not assumed benefit from this within its QIPP plan. Overall the CCG has taken a prudent approach to its plan, has established a 1% contingency and 1% surplus.

2) **Responsible commissioner** – the CCG is working hard to understand the impact of responsible commissioner shifts, for example in relation to specialised services, and has taken a prudent approach within its plan.

3) **Continuing Healthcare** – the CCG has identified a risk of £9.5M within its plan in respect of retrospective review of CHC cases. This is not provided for financially within the plan, but would be addressed from the upside risks identified above and from contingency.
4) **Provider performance** – The CCG has identified provider performance as a major risk to delivery. As well as using contract levers, the CCG will instigate Board to Board meetings with its major providers, in order to ensure focus and delivery. The refocused Healthier Together programme provides the basis for delivery of sustainable acute services for the long term.

5) **Capacity to deliver** – the CCG has a significant QIPP challenge and needs to ensure that internal capacity and capability, and external support services are aligned to this challenge. The CCGs top 10 QIPP schemes (by financial value) will deliver 48% of the challenge and the CCG has clinical and managerial leadership already aligned to these initiatives. The CCG is filling its internal vacancies (30% of posts were unfilled in original structures in December) and will have the structure fully recruited to by 31/3/13. The CCG has provided £2 per head from management costs to deploy flexibly in year to deliver specific change programmes, and the CCG is strongly performance managing improvements in delivery from its support provider GEM.

6) **Resource assumptions are over optimistic** – it is important that the CCG mitigates financial risk within its strategy. The underlying principle is that the CCG has a minimum of 3% of its resources uncommitted recurrently each year to ensure the statutory duty of breakeven is met (2% non recurrent reserve and 1% contingency reserve).
7) **Tariffs, inflation uplifts and efficiency requirements** – the financial plan assumes that acute and community services will receive a net tariff deflator of 1.5% per annum, including a built in 4% efficiency, with Mental Health receiving a QIPP target to bring the Programme Budgeting spend more in line with peers.

8) **QIPP delivery/transition** - in the context of increasing uncertainty and risk, our ability to develop and deliver sustainable QIPP is crucial. Clearly this task becomes more challenging as we continue to deliver significant change across our commissioning portfolio where opportunities potentially reduce or become more complex to achieve. We have in place a tight governance and monitoring system to ensure 2013/14 delivery, which includes the following:

- A Programme Management Office (PMO), working with finance colleagues, are to track the progress of each initiative against clear milestones. This will be completed on a monthly basis with a clear escalation pathway for non delivery.
- Programme managers to effectively manage contracts, ensuring the delivery of rectification plans where initiatives fail to stay on track.
9) **Process for managing financial risk in year** – the CCG will look to implement a range of actions, should they be necessary to support the delivery of positive year end position. This will include the following:

- Involving partners where necessary, seeking to effectively manage expenditure in overspending areas and bring back in line where possible
- Maximise the use of the 2% non-recurrent investment fund
- For 2012/13, use the £2 per head funding to support delivery through an equivalent value fund within the plan
- Consider the acceleration of QIPP plans where possible
- Further enhancement to claims management and activity validation in relation to acute services
- The ring fencing of unplanned savings to ensure they are retained and not spent
- The potential delaying or reallocation of funding for planned investments that are yet to start and will not deliver necessary returns
- Where appropriate, working with partner organisations agree mitigating actions, demand plans and recovery measures focused on reducing over performance
- Full review of available resource to support flexibility across budgets.