



**Derby and Derbyshire**  
Clinical Commissioning Group

# COMMISSIONING INTENTIONS 2020/21

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## Foreword

I am pleased to introduce the first set of Commissioning Intentions for NHS Derby and Derbyshire Clinical Commissioning Group.

Progress has been made in 2019/20 by all member organisations within Joined up Care Derbyshire (JUCD) to improve the quality of healthcare services for our population and maximise the efficiency of resource. However, there is much more to do, and these Commissioning Intentions build on the work that is happening across the System Delivery Boards and provides focus on the service planning and improvement priorities for 2020/21.

As we move towards becoming an Integrated Care System (ICS), it is vital that we build a strong Strategic Commissioning function as a cornerstone to effective planning, population needs assessment and maintaining clear accountability to the local population. In this context, I welcome the opportunity to build on the strong working relationships with all organisations across the Health and Social Care system to achieve this aim.

I see 2020/21 very much as a transition year towards ICS status and further development of the role of the Strategic Commissioner in the system. During this transition it is important that we retain a firm grip and focus to improve our financial position as a system whilst accelerating the pace and breadth of our transformational change programme to ensure long lasting and sustainable delivery of improved outcomes for the local population we serve.



Dr Chris Clayton

Chief Executive Officer

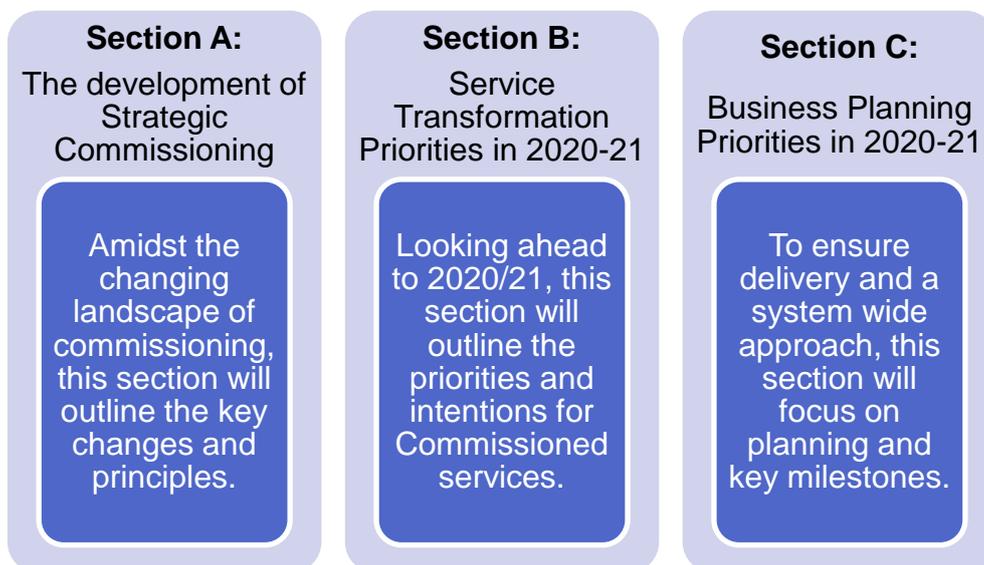
## Executive Summary

During 2020/21 it is important that we retain a firm grip and focus to improve our financial position as a system whilst accelerating the pace and breadth of our transformational change programme. This is vital to ensuring long lasting and sustainable delivery of improved outcomes for the local population we serve.

In this context, these 2020/21 Commissioning and Contracting Intentions detail:

- The need to see sustained improvement against constitutional targets and Long Term Plan outcome measures;
- The key service planning and transformation priorities which are fully aligned with the STP Refresh; and
- The intention to ensure an appropriate mix of transactional and transformational action to secure financial recovery whilst at the same time developing a range of new incentive structures to promote integrated care.

The document is structured in the following way:



# The Development of Strategic Commissioning

## 1. Introduction

NHS Derby and Derbyshire Clinical Commissioning Group (CCG) brings together the combined expertise of 116 local GP practices to commission health services on behalf of over 1,055,000 patients in Derbyshire. Our vision is to continuously improve the health and wellbeing of the people of Derbyshire, using all resources as fairly as possible.

## 2. Evolving context

The future of both the commissioning and provision of healthcare is evolving in a positive way. The development of integrated models of care through provider partnerships, supported by strategic commissioning (working at a larger scale) is being identified as a future model for the NHS. This way of working means that a greater level of care will be provided to patients in their home or within their community, by a multidisciplinary team of professionals. When patients do need hospital treatment they will receive the same seamless care delivered by an integrated team.

Our vision and ambitions set out what we want to achieve across the spectrum of health services and our model of care and planned improvements will be continuously informed by the feedback received from service users.

## 3. Strategic Objectives

Our Clinical Commissioning strategy sets out how NHS Derby and Derbyshire Clinical Commissioning Group aim to develop and improve health services for our population over the next two years. We want to ensure the right help is available to people when they need it, achieving the best health outcomes we can and making the best use of our resources, within a landscape of constrained financial resources, advances in medicine and increasing life expectancy.

Our strategy has been developed in alignment with national and local policy:

- Joined Up Care Derbyshire (our local Sustainability and Transformation Partnership)
- Five Year Forward View
- General Practice Five Year Forward View
- Mental Health Forward View
- Transforming Care Programme
- National Cancer Strategy
- Derby and Derbyshire Health and Wellbeing Strategy
- Derby City Health and Wellbeing Strategy

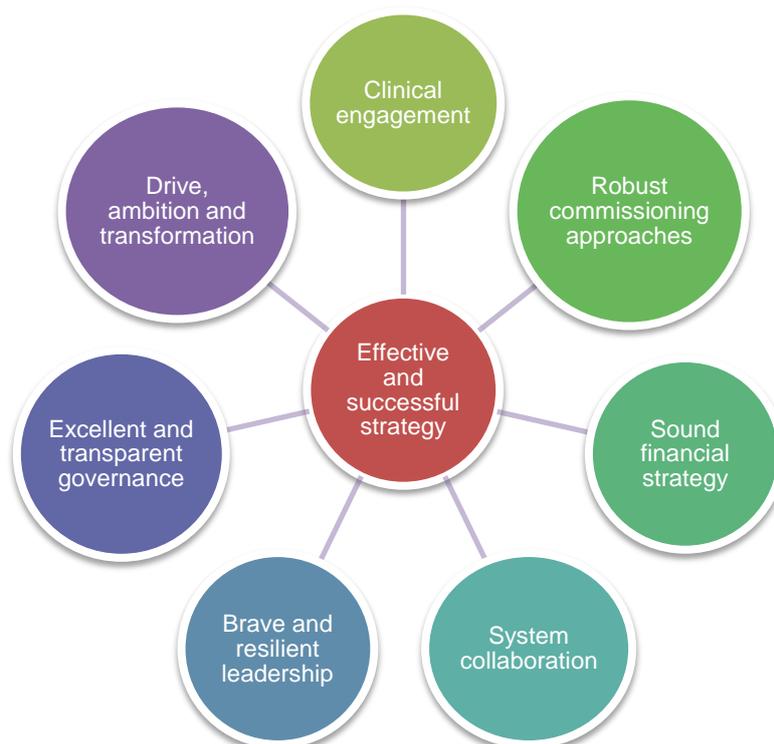
## The CCGs strategic objectives are:

1. To improve the physical and mental health of the people of Derbyshire by commissioning quality, safe and acceptable services to address health inequalities
2. To reduce the variation in the quality of care across Derbyshire
3. To take the lead in planning and commissioning care for the population of Derbyshire by providing a whole system approach and to support the development of general practice
4. To make the best use of resources by bringing together other NHS organisations, local authorities and the third sector to work in partnership on improving health and care
5. To develop alliances of NHS providers that work together to deliver care through collaboration rather than competition
6. To effectively communicate at all levels, encouraging patients and the population to be more engaged with their health outcomes.

Joined Up Care Derbyshire agreed that health and social care delivery needs to change in line with the three key principles that people:

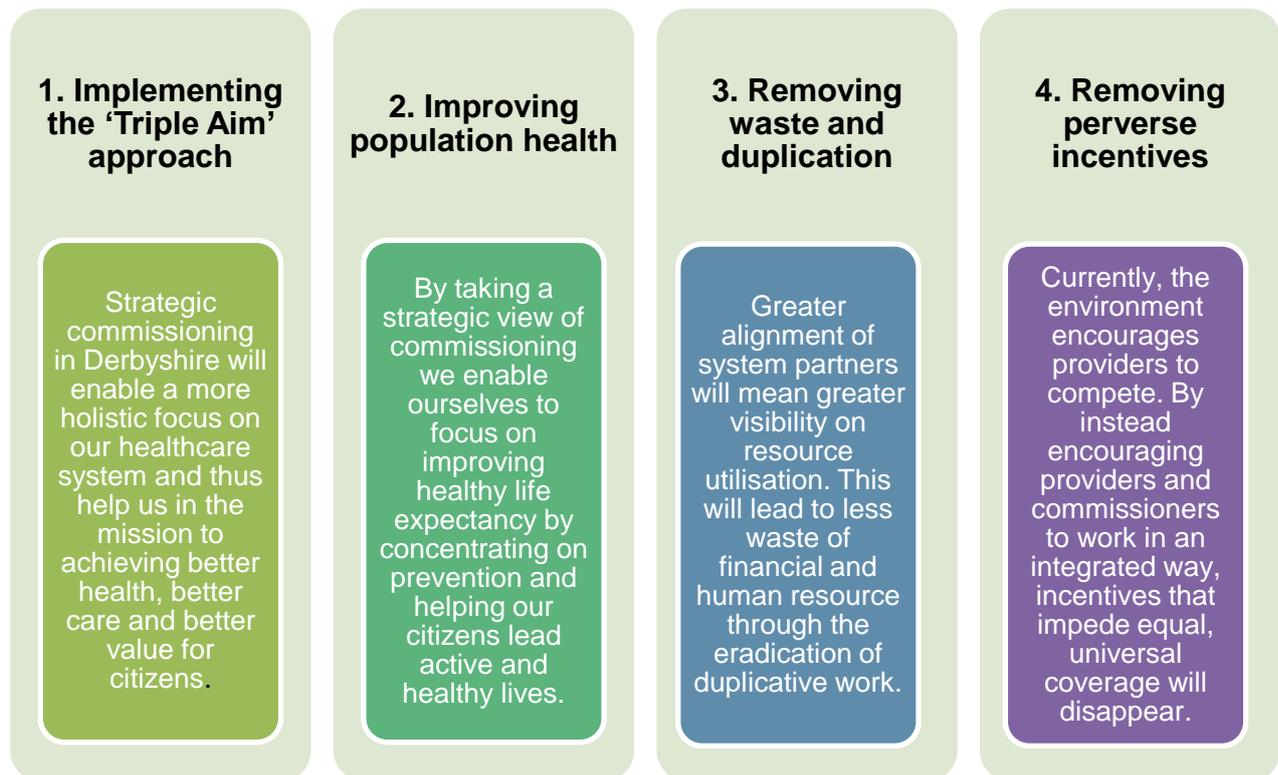
- Are kept as healthy as possible
- Get the best quality care
- Have well-run services which make the most of available resources

Our strategy aligns to these goals and is further informed by key health improvement areas identified by our quality and performance data. The effectiveness and success is dependent on characteristics which are integral to ensuring our plans are both apt and sustainable.



## 4. Development of the Strategic Commissioner in Derbyshire

The organisation has identified **four key areas** that strategic commissioning will act as a catalyst for. These are all underpinned by our overarching ‘why’ statement – *‘Unleashing the potential of our people and communities’*.



## 5. How strategic commissioning will look for Derbyshire

Strategic commissioning will be a departure from the current state for both the NHS and Local Authorities. There will no longer be a focus on detailed contract specification, negotiation and monitoring or the routine use of tendering. Rather, the emphasis will shift to defining and measuring outcomes, putting in place capitated budgets, assigning appropriate incentives for providers and using longer term contracts extending over five to ten year timelines.

The Joined Up Care Derbyshire plan included a strategic outline case which sets out how partners within the Sustainability and Transformation Programme would achieve greater efficiencies within their organisational form. For the former Derbyshire CCGs, this was achieved by the implementation of a merger of Erewash CCG, Hardwick CCG, North Derbyshire CCG and Southern Derbyshire CCG to a single Derby and

Derbyshire CCG. This allows us to align and harness all of our work into a single set of priorities to benefit the whole of Derbyshire.

The future of both the commissioning and provision of healthcare is moving quickly. The development of integrated models of care through provider partnerships, supported by strategic commissioning (working at a larger scale) is being identified as a future model for the NHS.

Integrated care, bringing together the best of list-based general practice with community-based care, supported by specialist services in a way that is not impeded by organisational boundaries has long been an ambition for the health and care sector. The triple aim of developing health and care systems striving for better health, better care and better value for our patients and the services that are provided still holds true and remains a key focus.

One of the key aims for commissioning is to support the development of integrated care for our patients whilst also maintaining and checking the quality (better care) and value for money (better value) of those services with the combined aim of improving the overall health outcomes for our population (better health). The functions of the Derbyshire CCG strategic commissioner are described below:

### **Strategic commissioner**

- Sets long term health outcomes for the Derbyshire population
- Commissions acute care and specialist mental health care at scale
- Drives transformational change, delivered through 8 Place Alliances
- Sets standards and consistent approaches to guide the 8 Place Alliances
- Coordinates & agrees the local (PLACE) core offer
- Develops standardised end to end pathways
- Provides the enabling infrastructure that Place Alliances will draw upon (Estates, IT, Workforce, Finance and Contracting and Business Information)
- Setting resource allocation processes
- Provider development
- Outcome based contract management
- Intelligence & research (learn & improve)
- Innovation (Developing new ways of working and scaling up what's working)

## **6. Relationships with providers**

The CCG will seek to work collaboratively with all providers to maximise the delivery of agreed outcomes through joined up and aligned partnerships across the system. The effective implementation of strategic commissioning will mean a shift in the relationship between commissioners and providers. This will require a number of changes on both sides, with providers undergoing a shift away from competition to collaboration and commissioners assuming more strategic functions.

**There is a requirement for providers to adapt their behaviours to fit the new model of care; the organisation has identified the following principles;**

- Be responsive and flexible
- Deliver outcomes based on need
- Work across organisations to deliver a collegiate response
- Understand our purpose
- Respect the strengths of all providers in the system

**Providers will need to change the way they deliver care, focusing on greater integration and increasing value for citizens, including:**

- Ensuring people in Derbyshire have access to the same standards of care, delivered in the most efficient and effective way
- Delivering proactive care in the most appropriate environment
- Making every contact count
- Increasing the value of care and ensuring it is evidence based

**To support the changes in delivery, the provider method of delivery will need to adapt to fit the new architecture by:**

- Unleashing the potential of our people through contacts
- Contributing to the strategic Population Health Management ask
- Not losing focus on operational issues
- Collaborating on schemes across providers
- Implementing outcomes-based contracting.

# Service Planning and Performance Priorities in 2020/21

## 1. Planned Care & Cancer

### Performance improvement priorities

Whilst the NHS awaits the outcome of the Clinical Review of Performance Standards, the three key priorities for the CCG in 2020/21 will be to ensure that our Contracted Providers deliver the following aspects of planned care performance:

- To ensure in aggregated terms across the Derby and Derbyshire CCG footprint, the number of incomplete pathways at March 2021 is no greater than the number recorded at the end of March 2020;
- To ensure that in aggregate terms across the Derby and Derbyshire CCG footprint, no patient will have to wait more than 52-weeks from referral to treatment (RTT); and
- To ensure that at least 85% of service users wait no more than 62 days from urgent GP referral to first definitive treatment for cancer.

In the light of this, a key focus of the 2020/21 Contract Negotiation Process will be on forming a credible set of improvement plans with Providers, where demand, capacity and financial planning assumptions are aligned and suitably tested from the following perspectives:

- Ensuring that planned care performance improvement for the admitted care pathway does not jeopardise the need for creating the bed capacity necessary to service urgent and emergency care needs;
- Ensuring that all service users waiting for elective care treatment have been listed in full accordance with relevant CCG commissioning policies;
- Ensuring that 26 week choice processes are embedded into Provider Operational Delivery Plans; and
- Ensuring that the planned level of elective care work is affordable to the system.

### Service Planning Priorities

The recently refreshed STP plan sets out ambitions for service transformation over the next 5 years and the CCG has been a key stakeholder as part of the refresh process. Given this, the CCG's primary objective for 2020/21 will be to focus on working with partners to translate the high level ambitions described in this work, into a practical set of delivery plans to facilitate successful implementation.

In this context, the CCG will seek to achieve the following in 2020/21:

1. We will improve the access to MSK services through the development and commissioning of a **single model of care across elective MSK pathways** to include primary care triage, Orthotics, Physiotherapy, Podiatry, Orthopaedic, Rheumatology and MSK related Pain Management services. A core component of this model will be to ensure that the First Contact Practitioner (FCP) service is fully rolled out across Derby and Derbyshire CCG.
2. The CCG will work with its Acute Providers to **standardise MSK related treatment pathways** for those procedures that consume the most NHS resource. A key outcome of this process will be to ensure that variation in the volume of activity delivered is reduced to a level which does not jeopardise patient outcomes.
3. We will ensure that our commissioning arrangements for the 17 procedures covered by NHS England's **Evidence Based Interventions Programme** are fully incorporated into activity and capacity plans with all Providers.
4. We will build on the work delivered in 2019-20, to commission a model of **specialist advice and guidance** for General Practitioners to cover all major elective care presentations.
5. We will commission a model of **follow-up outpatient care**, where avoiding unnecessary follow-ups is a key priority. Where follow-up care is required it is expected that the default method of delivery will be via 'non-face-to-face-means'. The development of Digitally Enabled Care within outpatient services will be a key enabler for this, and we will expect at least half of all outpatient follow-up care to be delivered by the most appropriate non-face-to-face method in 2020/21.
6. A fundamental aspect of our commissioning work for planned care services will be to ensure that 'narrow' specialty level input is replaced, where appropriate, with a more holistic approach to **manage the multi-morbidity needs of patients**. We will look to develop plans with our Providers so that more multi-specialty and multi-professional clinic provision is delivered
7. We will continue to develop **the Ophthalmology offer** across the elective pathway and seek to balance demand and capacity across the system. Where appropriate, progress will be made towards delivery of some services in community settings in line with the development and improvement of Derbyshire wide Glaucoma, Cataracts and Acute Age Related Macular Degeneration pathways. We will also complete the implementation of a system-wide agreed approach to hydroxychloroquine screening.

8. Working with the Cancer Alliance and all Providers, we will ensure that **referral pathways for all cancer types** are as effective as they can be and access to diagnostics is streamlined to prevent unnecessary delays. In addition, we will ensure that the Faecal Immunochemical Test (FIT) for symptomatic and non-symptomatic populations is delivered in line with national policy, and that Human papillomavirus (HPV) as a primary screen in the cervical screening programme is fully rolled out.
9. Following a review of evidence on the effectiveness of **shared care decision making and social prescribing** in managing elective care need, the CCG will bring forward proposals to integrate these strategies as part of the treatment protocol for a range of conditions.
10. We will look to Implement Derbyshire's **Midwifery Continuity of Carer (CoC)** Pilot Plan, with a focus on the most deprived areas across the System.
11. We will launch **Personalised Care Plans (PCP)** with CoC pilots, the Choice Offer website (Mother Hub) and establish task and finish work for hubs and a Single Point of Access (SPOA).
12. We will seek to **improve postnatal care** by supporting the establishment of Maternal Medicine Networks and launching the Social marketing campaign 'For you and Baby'. We will also work with Providers to progress delivery of the ATAIN action plan and the Saving Babies Lives Care Bundle.
13. We will support the establishment of NHS **maternal smoking cessation services**.

## 2. Urgent and Emergency Care

### Performance improvement priorities

The key priorities for the CCG in 2020/21 will be to ensure that our Contracted Providers deliver the following aspects of urgent and emergency care performance:

- To ensure 95% of service users are admitted, transferred or discharged within 4 hours of their arrival at an A&E department;
- To ensure delivery of all national ambulance performance standards on a quarterly basis across all counties, including Lincolnshire;
- To ensure that all national quality targets relating to ambulance handover are consistently delivered;
- To ensure there is a reduction in the number of people conveyed to an Emergency Department which were avoidable; and
- To ensure that a minimum GP streaming rate of 20% is delivered at Chesterfield Royal Hospitals NHS Foundation Trust and both major ED sites at University Hospitals of Derby and Burton NHS Foundation Trust with a specific objective of reducing A&E attendances.

In the light of this, a key focus of the 2020/21 Contract Negotiation Process will be on forming a single set of credible improvement plans with Providers, where demand, capacity and financial planning assumptions are aligned and suitably tested from the following perspectives:

- Ensuring that the bed capacity required to facilitate 95% 4 hr performance is reconciled with the needs to improve admitted RTT pathway performance;
- Ensuring that the resource requirements in the ambulance service are aligned to the agreed Indicative Activity Plan;
- Ensuring that the plan's focus is balanced so the interdependencies between different parts of the UEC system can be explained and quantified accordingly; and
- Ensuring that the delivery plan is set within an affordable financial envelope for urgent and emergency care.

## Service Planning Priorities

In the context of the recently formed Urgent and Emergency Care Strategy, the focus of the CCG's work in 2020/21 will be on delivering the following programmes of work:

- 1. Development of the Urgent Treatment Centres (UTCs).** The CCG will build on its decision to designate the current suite of Minor Injury Units at Buxton, Ilkeston, Ripley and Whitworth and the Derby Urgent Care Centre in Derby, as Urgent Treatment Centres in 2020/21, by working with the incumbent providers to ensure that the 'mandatory' service elements of a UTC are delivered.

At the same time, the CCG will continue to develop the longer term UTC solution, working with all system partners, so that from April 2021 we have a substantive offering of UTC provision that is integrated with the developing Primary Care Networks (PCNs).

- 2. Same Day Emergency Care (SDEC).** The CCG will build on the work delivered in 2019/20, and will commission a 7/7 model of SDEC so that, as a minimum, 30% of urgent care demand (excluding A&E attendances), is managed in a non-admitted same day setting. The model will cover all types of presentations and service user 'types', and focus will be put on high volume short stay presentations as a priority, so that emergency admissions are managed in the most cost-effective way possible. This will therefore require a new local pricing arrangement.
- 3. NHS111 Direct Booking.** The facility for the NHS111 Provider to book directly into GP appointment slots will be available across all General Practices by March 2020. In this context, the CCG will build on this in 2020/21 and focus on ensuring that this facility is being used appropriately to achieve maximum value.
- 4. Care Clinical Assessment Service (CAS) and Emergency Department (ED) Clinical Validation.** We will conduct work over the next 3 months, with colleagues from across the system, to assess the cost-effectiveness of the CAS and ED Clinical Validation provision with a view to informing the commissioning approach for 2020/21.
- 5. Care Clinical Assessment Services.** The CCG will work with EMAS to ensure that where appropriate, work will be transferred into the Clinical Assessment Services to support the appropriate ongoing management of care. Commissioners expect that the clinical assessment service within EMAS will manage all suitable patients through the Hear & Treat route at all times and not just during times of excessive demand.

- 6. Mobile Directory of Services** – The CCG will commission and implement a mobile Directory of Services (DOS) with the Ambulance Service to support redirection of patients away from the acute hospital environment where safe to do so. We expect this to have a positive impact on performance for ambulance and hospital handovers by reducing conveyances.

### 3. Primary Care

Our Commissioning Intentions for General Practice in 2020/21 are threefold:

1. Deliver the national strategy– GP Forward View and GP 5 Year Contract;
2. Deliver the local Derby and Derbyshire GP Strategy; and
3. Deliver three local priorities:
  - a. Commissioning enhanced services fairly across Derby and Derbyshire;
  - b. Supporting the quality of referrals and reducing unwarranted clinical variation; and
  - c. Supporting care homes.

The GP strategy (July 2019), sets out the vision for General Practice in Derbyshire. It describes how NHS Derby and Derbyshire CCG sees primary care services being delivered over the next five years, with a particular focus on the five key elements as set out in Chapter 1 of the Long Term Plan (LTP). Most crucially, it has at its centre a vision created by Derbyshire GPs themselves, supporting and supported by the CCG.

#### Derbyshire's vision for Primary Care

Our vision has been developed by GPs to provide high quality, patient-centred, general practice-led care which has freedom to innovate, with organisations and professionals behaving in a mutually supportive manner. In 2020/21, we will continue work to meet the three key objectives:

1. All patients will have access to a general practice-led multidisciplinary team of community care professionals by 2024;
2. In Derbyshire, the share of NHS resources spent on primary care should almost double (from 9% to 15%) within 10 years; and
3. By 2024, no member of the general practice team will leave the profession as a consequence of unsustainable workload and unreasonable working demands.

## Delivering the National Strategy

Long Term Plan priority	Our plan	How it fits		
		GPs' vision	GPFV	GP Contract
<i>Boost out of hospital care and dissolve the historic divide between primary and community health services</i>	<ul style="list-style-type: none"> <li>Establish 15 Primary Care Networks within 8 places across Derbyshire</li> </ul>			X
	<ul style="list-style-type: none"> <li>Recruit a more diverse skill mix to PCNs</li> </ul>	X	X	X
	<ul style="list-style-type: none"> <li>Recruit and retaining existing GPs and practice staff</li> </ul>	X	X	X
	<ul style="list-style-type: none"> <li>Develop teams of community providers at PCN 'neighbourhood' level (Integrated Care Teams)</li> </ul>	X	X	X
	<ul style="list-style-type: none"> <li>Bring PCN and ICT teams together as an MDT of community care professionals</li> </ul>		X	X
	<ul style="list-style-type: none"> <li>Use an interoperable single IT record</li> </ul>	X	X	
	<ul style="list-style-type: none"> <li>Build / create 'hubs' from which PCN neighbourhood teams can operate</li> </ul>	X	X	
<i>Reduce pressure on emergency hospital services</i>	<ul style="list-style-type: none"> <li>Improve access to General Practice with more staff and more diverse skill mix</li> </ul>	X	X	X
	<ul style="list-style-type: none"> <li>Support General Practice to work effectively - high impact changes / 10 building blocks</li> </ul>	X		
	<ul style="list-style-type: none"> <li>Support patients to self-care</li> </ul>	X	X	
	<ul style="list-style-type: none"> <li>Develop at scale 'on the day' primary care services to stream demand</li> </ul>	X	X	
	<ul style="list-style-type: none"> <li>Establish urgent MDT response</li> </ul>	X	X	X

	<ul style="list-style-type: none"> <li>Proactively care for patients at risk of admission</li> <li>Support the system transformation of urgent care; moving to UTCs and a consistent community based urgent care offer</li> </ul>		X	X
			X	X
<i>Give people more control over their own health and more personalised care</i>	<ul style="list-style-type: none"> <li>Develop social prescribing model</li> <li>Stratify population data to identify those at most need and co-produce personalised health plans</li> <li>Support patients to self-care; giving patients the technology to do so</li> </ul>			X
		X	X	X
<i>Move to digitally enabled primary and outpatient care</i>	<ul style="list-style-type: none"> <li>Integrate clinical IT systems across all providers and within PCNs</li> <li>Deliver faster data communications networks (HSCN) to improve practice performance</li> <li>Deliver on-line consultation targets and full roll out of the NHS App</li> <li>Standardise and agree referral templates and support clinical decision making</li> <li>Roll out paperless GP environment including the use of voice recognition software</li> <li>Enable remote access to support mobile working in an integrated team</li> </ul>	X	X	X
		X	X	
			X	X
			X	X
<i>Move to integrated care systems</i>	<ul style="list-style-type: none"> <li>Refresh the existing STP strategy in line with the LTP incorporating the Primary Care Strategy refresh, by Autumn 2019</li> </ul>			

	<ul style="list-style-type: none"> <li>• Develop integrated governance and support for PLACES, and the PCNs and practices within them</li> <li>• Establish population health data sets for PLACES; PCNs; practices</li> <li>• Establish a single outcomes based commissioning approach for PLACES; PCNs; practices</li> <li>• Model / shadow the development of ICS in PLACE, learning from accelerator sites</li> </ul>		<p style="text-align: center;">X</p> <p style="text-align: center;">X</p> <p style="text-align: center;">X</p> <p style="text-align: center;">X</p>	
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## Delivering the key targets in 2020/21

In 2020/21 we intend to deliver the following key targets which go beyond those described in the GPFV targets:

### Primary Care Networks

Targets	Plans
<ul style="list-style-type: none"> <li>• All PCNs delivering nationally agreed contract arrangements e.g.               <ul style="list-style-type: none"> <li>○ Clinical Director in place</li> <li>○ Additional staffing recruited</li> <li>○ Delivering new DES 19/24</li> </ul> </li> <li>• Provide £1.50/head financial support for management and organisational development</li> <li>• Support PCNs in their development</li> <li>• Provide with primary care data analytics for population segmentation and risk stratification to support population health</li> <li>• Ensure that PCNs work together at place level to play a full role in improving services at that level</li> </ul>	<ul style="list-style-type: none"> <li>• Commission national DES and ensure all funding is allocated appropriately to PCNs</li> <li>• Continue to fund PCN for time and development and support and monitor development programme in line with national programme and local needs</li> <li>• Develop primary care data pack and build with system wide population health data</li> </ul>

### Derbyshire General Practice Workforce

Within the workforce there are four main staff groups. These are:

- General Practitioners (895 headcount, 672.95 FTE)
- General Practice Nursing (505 headcount, 356.60 FTE)
- Direct Patient Care (299 headcount, 196.18 FTE)
- Admin and Non-Clinical (1,874 headcount, 1303.68 FTE)

The age profile for Derbyshire General Practice staff shows that 45% of the total workforce is aged over 50 and could therefore retire in the next 10 years; 46% of Nurses are 50 or over with 20% under 39. The key challenges for Derbyshire are

similar to those in the rest of the Country - a shortage of clinical staff; difficulty recruiting and retaining GPs and nurses and concern about increasing workload.

Targets	Plan for 20/21
<ul style="list-style-type: none"> <li>• Support the development of practices in the context of PCN development, specifically delivering: online consultations; reception and clerical training; time for care, and identify and support practices who need to build their resilience and become sustainable</li> <li>• Work with HEE to ensure robust training programmes are in place to adequately support workforce plans and recruit the share of additional GPs and other staff in line with the GPFV</li> <li>• Maximise retention of experienced staff</li> <li>• Ensure all staff have access to the support of a training hub and capacity to participate in training programmes</li> </ul>	<ul style="list-style-type: none"> <li>• Identify and support practices who need to build their resilience and become sustainable</li> <li>• Continue to recruit more people to training schemes and retained trainees by implementing a co-ordinated, structured and targeted approach to GP Recruitment &amp; Retention. Develop further plans to encourage GP trainees to work in Derbyshire area, including the recruitment of migrant GPs through Tier 2 sponsorship fund.</li> <li>• Develop attractive packages for a portfolio career within at scale working; CPD; mentoring; safe and supportive places to work through our retention schemes</li> <li>• Our 2 training hubs have now merged, with a plan in place to develop the right infrastructure and widen their training offer. Build on our national leadership around ACPs. Further development a single training hub to increase training capacity and retain people within the STP</li> </ul>

## Information Technology

Targets	Plan for 20/21
<ul style="list-style-type: none"> <li>• NHS App:</li> <li>• On-line consultation: 20% of practice appointments available online by 31/03/20</li> <li>• Web triage: ensure 100% of practices are offering this by 31.3.20.</li> <li>• Access for 111 to directly book into GP appointments</li> <li>• Ensure planned investment through Estates and Technology Transformation (ETTF) schemes</li> <li>• Improving interoperability between practices and system wide</li> </ul>	<ul style="list-style-type: none"> <li>• Work with practices to publicise and promote NHS App and to be able to meet the subsequent demand</li> <li>• Deliver and promote on-line consultation within practice and the wider population</li> <li>• Deliver and promote web-triage to practices and the wider population</li> <li>• Technical solution is in place 'in hours'. Ongoing work to develop solutions to allow for extended access booking and to agree appropriate clinical protocols to allow direct booking</li> <li>• ETTF plan in place and being delivered. Projects include: <ul style="list-style-type: none"> <li>○ F12 decision support</li> <li>○ Practice migration programmes</li> <li>○ Remote working solutions</li> <li>○ Digital care homes project</li> </ul> </li> <li>• Actively supporting practices within the PCN to move to the same GP system</li> <li>• Deploying the GP connect system to allow easier communication between EMIS and TPP systems</li> <li>• Rolling out the Medical Interoperability Gateway (MIG) system wide</li> </ul>

## Delivery of estates

There are 179 GP premises in Derbyshire with several practices having branches and a wide mix of city, town and rural premises of varying type, age, size and quality.

Targets	Progress and plans
<ul style="list-style-type: none"> <li>• Improve our strategic planning and management of the primary care estate</li> <li>• Improve the capability and capacity for Primary Care provision, including to address population growth and demographic change</li> <li>• Support and enable the delivery of clinical strategies and new models of care. Deliver better service integration, improvements in service efficiency and better outcomes for our residents</li> <li>• Improve the effective utilisation of the estate</li> <li>• Improve the quality, flexibility and condition of the estate</li> <li>• Increase efficiencies and ensure value for money both from our existing estate and from any investments in estate development</li> <li>• Reduce risk &amp; improve service resilience at local and system levels</li> </ul>	<ul style="list-style-type: none"> <li>• Further develop our new primary care estates management model as part of the new CCG governance arrangements</li> <li>• Implement the PC estates strategy and action plans</li> <li>• Ensure development of an estate with the capacity and flexibility to support new clinical and workforce models of care</li> <li>• Continue to work with partners across the One Public Estate to improve utilisation, address void spaces and to develop joint solutions making maximum use of estate and financial resources</li> <li>• Underpin planning with comprehensive demand, condition, capacity and utilisation data</li> </ul>

The CCG is committed to investing to deliver its digital and estates plans. The funding for this will, in large part, come through the Estates and Technology Transformation Fund (ETTF). The CCG has an agreed ETTF plan with NHSE and NHSI to which we currently work. A new investment plan for 2019 and beyond is

now being developed with NHSE and NHSI and will be used to fund our digital and estates strategy going forward.

## Narrowing health inequalities

There are three elements to Primary Care's work in narrowing health inequalities.

- i. **Reduce unwarranted clinical variation:** working with General Practice, the CCG will develop a programme of work to support practices to ensure that services are provided and referrals made to a high standard, with minimal unwarranted variation
- ii. **Commission services equitably:** the CCG will commission primary care to ensure that patients receive the same service regardless of where they live in Derbyshire and practices are funded at the same level, using weighted capitation to take into account deprivation
- iii. **Provide population health data and commission on outcomes:** working as part of JUCD, primary care will be provided with data analytics for population segmentation and risk stratification to allow them to understand and act on their populations' health and care needs. JUCD is developing this information and approach through the national Population Health Management Leadership Programme sponsored by NHSE and NHSI.

## Ensuring investment

The CCG's allocated budget for 2019/20 is £1.651 billion, which includes a savings requirement of £69.5m. The planned spend in primary care for GP services is £160m or 9.7% of the total budget. The £160m comprises:

	£'m
Primary care co-commissioning	141
Local enhanced services	15
PCN development (£1.50 per head)	2
Other primary care	2
<b>Total GP Primary Care Services Budget</b>	<b>160</b>

The £160m includes Derbyshire's 2019/20 share of the national investment to implement the Long Term Plan. We are committed to fully using our share of the £4.5 billion national funding over the 5 years to 2023/24, as set out in the LTP which is estimated to be:

	2019-20	2020-21	2021-22	2022-23	2023-24	Total
Additional Roles Scheme	1.95	4.55	7.33	11.18	15.69	40.70
Network support:						
- £1.50 per head from core allocation	1.60	1.59	1.61	1.60	1.62	8.02
- GP PCN leadership	0.55	0.74	0.76	0.78	0.79	3.62
Sub-total	2.14	2.34	2.37	2.38	2.41	11.64
Access:						
- Extended hours access DES	1.17	1.54	1.54	1.53	1.53	7.31
- Improving access to general practice *	0.00	0.00	6.48	6.63	6.78	19.89
Sub-total	1.17	1.54	8.02	8.17	8.31	27.21
<b>TOTAL £'m</b>	<b>5.26</b>	<b>8.42</b>	<b>17.72</b>	<b>21.73</b>	<b>26.42</b>	<b>79.55</b>

\* Improving access to general practice is part of the GPFV funding until the end of 20/21. Practice contract funding will increase nationally by £978m between 2019/20 and 2023/24 with annual uplifts ranging from 1.4% to 2.8%. Derbyshire is estimated to receive an additional £17.2m for practice contracts over the 5 years.

### Monitoring progress in 2020/21

There are 6 national Key Performance Indicators which will monitor progress against in the following areas:

- GP Patient Survey – This will assess Patients’ experience of healthcare services provided by GP practices.
- Workforce - The National Workforce Reporting System (NWRS) is run by NHS Digital to collect and present workforce based data. This enables the General Practice workforce to be consistently monitored and reviewed against national and local trajectories.
- GPFV monitoring survey – This provides the system with regular opportunities to review progress on key priorities within General Practice.
- Annual assurance statements – This provides assurance to the Regulator that the CCG is meeting the target on a set of national key deliverables.
- Patient Participation Groups (PPGs) – PPGs are a contractual requirement of GP practices and can be either virtual or a formal group who meet on a regular basis.
- Patient Participation Group Networks – The PPG networks bring together local groups of PPGs and provide a forum to share good practice.

### Derby and Derbyshire CCG is also developing 4 local Key Performance Indicators which will focus on the following areas:

- All patients will have access to a general practice-led multidisciplinary team of community care professionals by 2024.
- In Derbyshire the share of NHS resources spent on primary care should almost double (from 9% to 15%) within 10 years.

- By 2024, no member of the general practice will leave the profession as a consequence of unsustainable workload and unreasonable working demands.
- The development of a Primary Care Dashboard to monitor the quality of General Practice.

## 4. Long Term Conditions

The specific conditions currently being focused on are Respiratory, Cardio-Vascular Disease (CVD), Cerebrovascular Disease (Stroke) and Diabetes. In all conditions we will review the following outcomes:

### Population Outcomes

- Addressing health inequalities through the commissioning and provision of services.

### Prevention

- Improving access to community based low level prevention support.
- Access to 'hot clinic' services to allow patients to be seen on a same day service to reduce bed stays.

### Place Based Care

- Promoting local access to mainstream service provision.
- Ensuring coverages of multidisciplinary teams and specialist nurses in community setting to ensure support to all.

### System Efficiency

- Improving quality of care provision, reducing admissions and length of stay.
- Reducing inequitable access to service provision.
- Targeting variation in the achievement of conditions management, treatment and care processes.

### System Management

- Supporting integrated approaches to service provision and commissioning.
- Expanded provision of access to digital and face-to-face structured education and self-management support tools.
- Demonstrate links with PCN's regarding population management approach.
- Deliver education programmes for diagnosis and stable management.

### Clinical Pathways

Pathways across all conditions will be reviewed, working with key stakeholders to identify how these can be improved to support better end to end patient care resulting in reduced Elective, Non-Elective and Outpatient activity.

**NHS Health Checks:** Working with local authorities and Public Health, we will improve the effectiveness of approaches such as the NHS Health Check, rapidly treating those identified with high-risk conditions.

**Respiratory:** We will work with providers to ensure that Respiratory priorities are focused on adopting a 'whole person' approach to respiratory care whereby those at risk of lung disease, or those with confirmed disease, are proactively supported earlier in their pathway to prevent health deterioration and unnecessary admissions.

The focused priorities will be:

- **Hospital Outpatient Treatment (HOT) Clinics**

Aim: to reduce the number of people admitted to hospital via provision of a Respiratory HOT Clinic. This will enable health professionals to refer people who they believe are threatening admission to a respiratory consultant who will see the patient on the same day with the aim of providing earlier access to specialist support, to enable people to be discharged into the community on the same day of referral.

- **Place Based Service include review of Pulmonary Rehabilitation**

Aim: to ensure a more cohesive patient pathway incorporating community based services along with specialist respiratory care. Review of the existing Impact+ service.

- **Smoking Cessation**

Aim: to increase the quit rates for smokers with lung conditions as part of a hospital admission via provision of an inpatient smoking cessation service.

- **Secondary Care case finding**

Aim: to increase early and accurate diagnosis of lung conditions via provision of spirometry and/or FeNO testing for people who are attending either, Accident and Emergency for suspected respiratory infections, or outpatient clinics for chronic cough.

- **Home Oxygen Services**

Aim: to reduce the numbers of patients who are inappropriately on home oxygen through provision of a clear patient referral pathway for Secondary Care. Most patients who are prescribed oxygen have respiratory disease, typically chronic obstructive pulmonary disease (COPD), cystic fibrosis or pulmonary fibrosis. People with chronic asthma or sleep disordered breathing may also benefit. Oxygen therapy is also an effective treatment for some people with cardiac or neurological disease (e.g. cluster headaches) and is an important element in palliative medicine.

## **Cardiovascular and Cerebrovascular Disease**

- **Early Diagnosis:** Early detection and treatment for CVD & Stroke will help patients live longer, healthier lives. Too many people are still living with undetected, high-risk conditions such as high blood pressure, raised cholesterol, and Atrial Fibrillation (AF). AF detection through the use of AliveCor devices within primary care will be extended across Derbyshire.
- **Clinical Pathways:** We will review Pathways across all areas of Respiratory; Diabetes CVD & Stroke, working with key stakeholders to identify how these

will be improved to support better end to end patient care, resulting in reduced Elective, Non-Elective and Outpatient activity.

- **Patient Case Finding:** A key part of the programme will involve case finding of those people at high risk who remain undiagnosed, at risk of exacerbation and continuing health care issues. Various initiatives, approaches and tools will aid in case finding including RAIDR and PRIMIS.
- **Prevention:** We will identify patients with these conditions, and commission appropriate preventative treatments that can be offered in a timely way.
- **Specialist Care in the Community:** We will review our community services in order to improve specialist care in the community allowing shorter bed stays in acute based services.
- **Consultant Connect:** Mapping and scoping of Consultant Connect service opportunities to support a reduction in GP referrals to acute services.
- **Secondary Care - Specialist MDT Team:** Ensure matrix working to achieve better outcome for people diagnosed with long term conditions and where possible prevent further or earlier admissions.
- **Telehealth Digital:** Telehealth to be explored for further development to support greater patient self-management and monitoring.
- **Cardiac Rehabilitation** across Derbyshire will be reviewed resulting in improved accessibility and choice.

### Diabetes Treatment and Care Programme

In 2017-20 the Derbyshire STP was awarded the NHSE Diabetes Transformation funding to deliver four projects. We will continue to work with providers in order to deliver these projects:

1. **Diabetes Structured Education:** Improve access to evidence based courses by developing Derbyshire wide delivery models for both Type 1 and Type 2 diabetes structured education with central coordination.
2. **Improve achievement of three treatment targets (3TTs)** to increase the proportion of people with diabetes whose three key treatment targets BP, Cholesterol and HbA1c are in range, to reduce incidence of diabetes complications and the subsequent outpatient and inpatient activity. Finally, to support primary care to achieve this aim through quality schemes and the upskilling of the workforce.
3. **Improve access to Multi-disciplinary Foot Care Teams** by improving the foot care pathway for people with diabetes aiming to reduce episodes of foot disease. To reduce foot complications particularly minor and major foot

amputations and associated outpatient and inpatient activity. To increase capacity in Community Foot Care Teams, enabling them to take on more follow-up care.

4. **Diabetes Inpatient Specialist Nurses (DISN)** to improve patient experience through greater empowerment to self-manage and improve clinical outcomes, reduce medication errors and hypoglycaemic episodes, upskill ward based staff via training, direct support and greater interaction with community diabetes provision.

DISN will assess people in A&E to support return home with Outpatient or telephone follow up over the next 48hrs from the DISN rapid access clinic. Our EMAS pathway is to be developed whereby ambulance teams can contact the DISN from the patient's house to avoid unnecessary conveyances to Hospital.

### **Specialist Community Diabetes**

There is variation across Derbyshire in access to a specialist community diabetes service. We will work with providers to address and ensure that all people with diabetes in Derbyshire can be escalated to a specialist community diabetes service, then de-escalated back to the management of primary care as required.

## 5. Integrated Community Care

### Service Transformation Priorities

The recently refreshed STP plan sets out the ambition for service transformation over the next 5 years and the CCG has been a key stakeholder as part of the refresh process. Given this, the CCG's primary objective for 2020/21 will be to focus on working with partners to translate the high level ambitions described in these plans into a set of practical action plans to facilitate successful delivery.

In this context, the CCG will seek to achieve the following in 2020/21:

- Identify the current position and deliver year one actions to progress towards the 2024 target of a 2 hour community rapid response service where clinically appropriate;
- Identify the current position and develop system wide delivery plans needed to progress towards the 2024 target of reablement within 24 hours of referral;
- Establish effective communications and working relationships between community teams and PCNs identifying opportunities to work together flexibly to meet local need;
- Partners will work together to agree and deliver priority actions to increase effective anticipatory care (using the principles of identify, stratify and intervene);
- Agree prioritised actions in line with the Enhanced Care in Care Homes Framework to reduce unwarranted variation in the flow of people into hospitals and include care homes in the local health and social care system; and
- Community capacity and utilisation will be better understood and recommendations from the JUCD Improving Flow workstream will be actioned.

## 6. End of Life

In July 2019 the JUCD Board agreed to the addition of an STP workstream for End of Life (EoL) Care. By creating a JUCD EoL workstream, the system has demonstrated its commitment to improve EoL services for patients. The workstream will be managed through a JUCD EoL Board, comprising senior decision makers from providers and commissioners committed to improving EoL care. The original

JUCD EoL group will become the JUCD EoL Operational Group, with task and finish groups established to deliver the commitments.

The EoL Board will ensure there is collaborative, co-ordinated care from all providers of EoL Care, standardised Countywide, whilst being personalised to the individual. The aim is to allow people to die in their preferred Place of Care with support and maximising symptom control.

The *Ambitions for Palliative and End of Life Care* document sets out 6 ambitions. The document can be found below via the link:

<http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf>

**Ambitions:**

1. Each person is seen as an individual.
2. Each person gets fair access to Care.
3. Maximising comfort and wellbeing.
4. Care is coordinated.
5. All staff are prepared to care.
6. Each community is prepared to help.

The group have set out the Commissioning Intention that all patients, regardless of their disease, who need care in the last year of life, can access this in a timeframe appropriate to the urgency of their current need and, where possible, in their preferred place of care.

## 7. Medicines, Prescribing and Pharmacy

### Performance standards

All Provider Trusts shall comply with the Derbyshire Joint Area Prescribing Committee Prescribing Specification:

[http://www.derbyshiremedicinesmanagement.nhs.uk/medicines-management/joint\\_area\\_prescribing\\_committee](http://www.derbyshiremedicinesmanagement.nhs.uk/medicines-management/joint_area_prescribing_committee) .

This document outlines the role and responsibilities of our provider trusts in ensuring a transparent and collaborative approach to the safe and effective management of medicines, seamless care of patients between NHS organisations and ensuring high quality prescribing.

In addition, it is the CCG's expectation that all Providers (including General Practice, where relevant) will:

- Adopt strategies to remain within agreed budgetary allocations and engage and escalate with the commissioner where unplanned circumstances may show spend deviation from budget.
- Ensure that maximum financial opportunity is realised from the optimal use of high cost drugs. This includes maximising biosimilar uptake, and biosimilar to biosimilar switching where appropriate.
- Report any medicines related incidents via the relevant national and local systems. All serious incidents should be reported to the CCG, this includes serious Controlled Drug incidents. Providers maybe periodically asked to provide medicines safety intelligence/reports to inform system wide learning and improvement.
- Engage and support system wide strategies and plans to tackle Antimicrobial Resistance (AMR) in line with the NHSE/I AMR 5 year strategy.
- Support the medicines elements of the NHSE Oversight Framework (Improvement and Assessment Framework) including achieving appropriate prescribing of antibiotics in primary care and reducing the rate of low priority medicines (low value medicines) to agreed targets.

## **Transformation**

- All providers working in PCNs, including GPs and community pharmacists shall work together as a system, to realise the ambition of the NHS Long Term Plan as relevant to medicines and pharmacy. This includes:
  - Transfer of care around medicines (TCAM);
  - New and integrated models of primary and community mental health care to optimise medicines use;
  - Developing the role of clinical pharmacists in general practice;
  - Adoption of digital technology and optimal prescribing systems and intelligence;
  - Provision of pharmacist-led medication review clinics in care homes;
  - Stopping over medication of people with a learning disability, autism or both; and
  - Supporting Treatment and Appropriate Medication in Paediatrics (STOMP-STAMP) programmes.
- All Providers will also be expected to engage and support System Pharmacy Clinical Leadership to develop and implement a Derbyshire Integrated Pharmacy and Medicines Optimisation Strategy. This will include improving clinical outcomes for patients through medicines use, safe use of medicines

and reducing avoidable medicines related harm. It will also include cost-effective use of medicines by optimising treatment, reducing medicines waste and developing a pharmacy workforce that is fit for purpose to respond to future needs including competencies, recruitment and retention.

## **8. Mental Health, Learning Disabilities and Autistic Spectrum Disorder**

### **Performance improvement priorities**

The NHS Long Term Plan contains many important priorities for mental health. We will focus on delivery and foster a culture of continual improvement. In this context, there are a number of constitutional standards that the CCG will focus on specifically and ensure our providers continue to deliver at a high performing level or increase their current level of performance.

For adults these include:

- Ensuring that the mental health system (all age), is highly focussed on reducing the incidence of Derbyshire patients receiving acute mental health treatment as an inpatient outside of the county (out of area).
- We will ensure that providers are highly focused on maximising flow from the community, supported through the wards if necessary and back into the community with the correct help and support.
- We will ensure that performance increases and focus is maintained on reducing the number of people with a learning disability and/ or autism who are treated within inpatient environments. This will require specifically adapted joined up work for those people who are entering into crisis to ensure that work is done early enough so that unnecessary admissions can be averted. By 2025, we aim to have no more than 24 adults with LD/ASD in Derbyshire in any kind of inpatient bed including secure settings.
- Life years lost for those people with severe mental illness and for those with learning disabilities continues to be a national concern. We will ensure we have increased access to suitable comprehensive health checks both in primary care and secondary care, both for people with severe mental illness and for those with a learning disability. We will maximise the performance of the Learning Disabilities Mortality Review (LeDeR) Programme in Derbyshire.

### **Service Transformation Priorities**

The CCG's primary objective for 2020/21 for mental health, LD and ASD will be to focus on working with partners to facilitate successful delivery of the recently refreshed Mental Health Transformation Plan. We will specifically focus on:

- Improving the capacity and capability of Crisis Services is a key way to help reduce the number of people who need to go into hospital. We will ensure that

current service provision meet all 39 standards and secure joint working with Adult Social Care, Public Health and services for Learning Disabilities.

- Working to ensure that there is a new approach to finding graduated help at point of crisis in mental health and jointly invest in alternatives to admission.
- Engaging in transformative discussions on getting faster diagnosis for adults suspected of having ASD.
- Encouraging the development of specialist advisors within key MH teams and ASD services.
- Ensuring that crisis services transformational investment is made fully available to reduce admissions for the cohort. They will be available 24/7 and be open to new referral pathways.
- Ensuring that mental health liaison at UHDB is brought fully up to Core 24 NHS standards and contribute to reducing 12 hour trolley breaches in A&E.
- Ensuring that we can meet the required access to community specialist perinatal MH services in secondary care for at least 4.5% of our population's birth rate and extending care from 12 to 24 months.
- Through focusing on a Whole School Approach to Children and Young People's (CYP's) mental and emotional wellbeing, we will increase the number of children and young people who benefit from early identification and intervention, to build resilience and reduce the likelihood of escalation. We will embed Mental Health Support into referral units and targeted schools.
- Introducing intermediate help for CYP needing Mental Health Support via Action for Children. Together these measures will reduce the chances of CYP needing specialist CAMHS and we will ensure that all providers develop working relationships to build new pathways.
- Concluding a review of CAMHS services across Derbyshire and maximise the delivery model to reduce the current waiting times for CAMHS services, which are unacceptably long. In line with national targets, at least 34% of those with a diagnosed MH condition will receive treatment from an NHS-funded community MH service.
- Continuing to have high performing IAPT services and ensure that mental health support for long term conditions is available. We will launch a new procurement for the service.
- Transforming our offer for Looked After Children to get better mental health support and reduce the amount of CYP going into increasingly complex placements either out of county or otherwise.
- Revising our funding arrangements for completing assessments for Looked After Children who are out of area.
- Ensuring that investment goes into developing a better service response for Trauma Informed Care and for Personality Disorder.
- Ensuring that flow is maintained and length of stay reduced, for people on acute inpatient wards who often stay for longer periods than is warranted, including out of area and Psychiatric Intensive Care Units (PICU).

- Supporting the further development of local Mental Health and Learning Disability forensic pathways.
- Maintaining and sustaining fidelity to the model and access targets of the Early Intervention Psychosis (EIP) service and Individual Placement and Support service (IPS).
- Developing the Suicide Reduction and bereavement support offer.
- Supporting the development of revised inpatient options for people requiring more flexible needs-led inpatient care such as those with learning disabilities, autism or where challenging behaviour as a form of communication is an issue.
- Ensuring that Wave 2 investment goes into helping people with mental illness into meaningful employment.
- Ensuring the delivery of the recent LD (& ASD) Quality Standards across organisations, ensuring that reasonable adaptations are made.
- We will continue to work with our system partners to confirm the future bed based and crisis support model for individuals who would normally be admitted into Assessment and Treatment units which will include a shift in financial payments to match demand and usage.

## 9. Children's Physical Health

The NHS LTP contains many important priorities for a strong start in life for children and young people. We will ensure that the constitutional standards within the LTP are met, localising the LTP national policy. Many statutory targets around cancer wait times and Referral to Treatment are captured under Planned Care & Cancer.

The CCG is an active member of JUCD's Children's workstream:

- We recognise nationally identified workforce issues, seeking local solutions to address these across our services;
- We are working towards consistent service offers, performance and where appropriate models of care across our footprint;
- We are developing age appropriate linking of adult and children's services;
- We are developing services that are flexible enough to meet the differing needs of individuals;
- We are working with local partners - Local authorities, schools and the voluntary and community sector.

### **Performance improvement priorities**

The CCG is particularly focussed on some key areas as follows:

- Working with providers and our commissioning colleagues with responsibility for the SEND agenda to improve the performance of our Community Paediatrics

service, with a focus on improving waiting times, in particular in relation to the Neuro Disability pathway;

- Working with Local Authority partners to ensure more Children in Care and those with the most complex needs, benefit from personalised services closer to home:
  - Too many children are not able to have their needs addressed within our footprint
  - In response to LTP requirement of more care closer to home
- Working with providers to improve performance in relation to our urgent care pathways for children and young people, sharing local best practice to reduce avoidable non-elective admissions;
- Working with partners and our commissioning colleagues with responsibility for the SEND agenda to jointly commission services so that CYP with SEND have their needs met locally wherever possible.

### **Service Transformation Priorities**

The developing JUCD plans for Children and Young People's physical healthcare are defining our ambitions and the service transformation areas in which we will be working; aligned with the LTP's key targets. Given this, the CCG's primary objective for 2020/21 in this area will be to focus on working with partners to improve key elements of our commissioned services. Key work-streams have been or are being established to take this work forward:

- Reviewing and seeking to transform and improve our Community Paediatrician and Community Children's nursing services, ensuring a consistent standard of offer across our footprint and better integrating provision across service and organisational boundaries.
- Improving provision of Neuro Disability services and pathways to tackle inconsistency and different models with provision which is too clinically focused; seeking to move beyond the focus on assessment and diagnosis to intervention and support.
- Working with provider and other partner organisations, and adult urgent care commissioning colleagues to transform urgent care systems for CYP through:
  - Improving parental knowledge & coping strategies; empowering families to help care for their children safely at home when appropriate
  - Defining, identifying, and reducing:
    - Unnecessary and/or avoidable urgent care attendances (both hospital and other locations)
    - Unnecessary and/or avoidable hospital admissions
    - Unnecessary emergency ambulance use and conveyance rates
  - Seeking to increase the proportion of care delivered on an ambulatory basis
  - Working with a particular focus on those conditions that have the most impact on this area of care:
    - Head injuries

- Other minor injuries
  - Gastroenterological conditions (particularly constipation and infant feeding issues)
- Working with partner organisations to improve Occupational Therapy services for children across our footprint:
  - Ensuring a consistent standard of offer.
  - Seeking to better integrate provision across service, organisational and sector boundaries.
- Contributing to those joint projects where partner organisations lead including:
  - Childhood Obesity (led by public health).
  - Regional initiatives around paediatric palliative and end of life care.

# Business Planning Priorities

## 1. Financial Context: System Savings

The System is currently facing a significant challenge in relation to the delivery of savings in 2019/20. The financial outlook for 2020/21 and beyond suggests that the level of financial challenge will continue and will require a robust and effective system efficiency programme to support the delivery of the system control total.

The Derbyshire Healthcare System, including the following statutory partners: Derby and Derbyshire CCG (DDCCG), University Hospital Derby and Burton NHS Foundation Trust (UHDBFT), Chesterfield Royal Hospital NHS Foundation Trust (CRHFT), Derbyshire Community Healthcare Services NHS Foundation Trust (DCHSFT), Derbyshire Health and Care Foundation Trust (DHcFT) and the East Midlands Ambulance Service (EMAS) have agreed a single system saving plan for 2019/20. The submitted plan at 27th September 2019 identifies a £101.3 million (net) saving plan programme across the system, to meet the system control total, assuming the full £151m target is met for the 2019/20 financial year. Failure to deliver the current year target as planned on a recurrent basis will, of course, increase future years' savings requirements.

The System Chief Finance Officers Group is currently developing the System Financial Strategy, building out from the CCG's Medium Term Financial Plan (MTFP). The CCG's MTFP was agreed with NHS England in February 2019, as part of the Merger and National Financial Recovery programme and is summarised in Table 1.

**Table 1** Strategic Commissioner Medium Term Financial Plan Summary

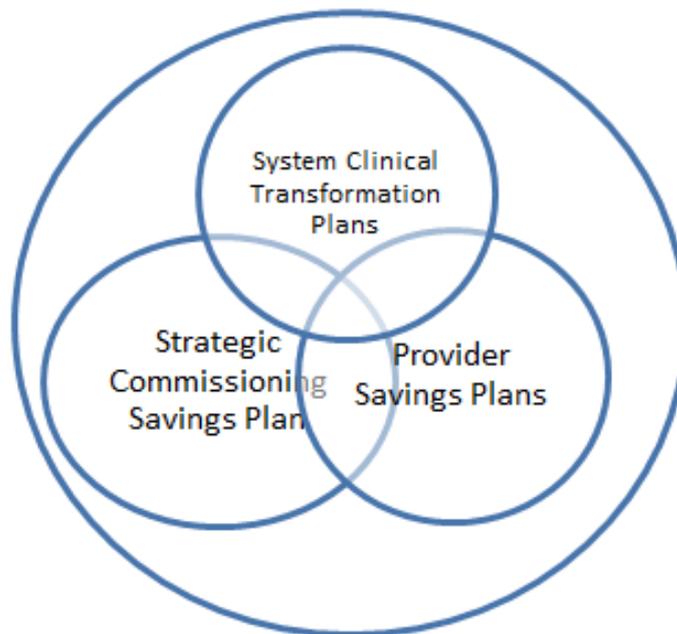
Key figures	17/18*	18/19*	19/20	20/21	21/22	22/23
In-year position before CSF & QIPP	(80.0)	(95.0)	(98.5)	(76.5)	(50.4)	(34.1)
CSF	0.0	39.0	29.0	-	-	-
Cumulative surplus drawn down	-	5.0	-	-	-	-
QIPP	38.0	51.0	69.5	76.5	66.4	56.1
In-year surplus / (deficit)	(42.0)	0.0	0.0	0.0	16.0	22.0
Underlying surplus / (deficit)	(45.0)	(61.0)	(41.3)	(15.3)	2.8	10.8
QIPP %	2.2%	3.3%	4.5%	5.0%	4.3%	3.6%
Cumulative surplus / (deficit)	(17)	(22)	(22)	(22)	(6)	16

The Derbyshire system must now work towards ensuring that the capability in the county is driving the best possible outcomes for the population, working within the financial resource available.

This provides us with a significant opportunity to focus on value based care and approaches to transforming the way our population and patients achieve best health outcomes and wellbeing, whilst implementing the components of the NHS LTP.

There are a number of factors that will support us in achieving this:

- A single system process to understand both the demand for health and care in Derbyshire and our current capacity. We must move beyond a consideration of capacity and demand planning in isolated parts of our system and look across the care pathways and settings of care accessed by our population.
- Clarity on the clinical and public/patient role in driving our clinical transformation programmes. We will ensure that our clinical leadership and public/patients define the outcomes that can be achieved through new approaches to care.
- We will maximise the support through our system governance framework to ensure accountability, ownership and capacity for implementing change.
- Agree our shared approach to incentivising change through new contract models that enable the delivery of best value outcomes and system efficiency.



Within this approach, we will continue to ensure that as health organisations we implement efficient and effective processes to release capacity, capability and resource into the whole system.

This is part of our wider programme to ensure we operate as an Integrated Care

System by 2021, coordinating care to achieve best value outcomes for the population and the Derbyshire pound.

## **2. Contracting Intentions**

### **1. Context**

We recognise that we cannot continue to do things in the same way as we've always done and we acknowledge that the next financial year represents transition to a new set of contracting arrangements. There will be a requirement for a combination of different approaches, transactional and transformational, to support the system's financial recovery.

On the basis of securing sufficient assurances on the quality of activity recording, billing practice and the reasonableness of "costed blocks", we will support the national direction of moving away from the transactional administration of the National Tariff Payment System, and other associated contracting mechanisms, which perpetuates the allocation of resource to maintain the interests of the organisational 'status-quo'.

Instead, we will move to a place where healthcare resource is framed and deployed to promote technical and allocative efficiency at an integrated clinical pathway level so that ineffective and inefficient process is removed and where the concept of separate provider care sectors, as the dominant organising principle, is replaced with a focus on professionals from across the NHS provider landscape working together.

In order to achieve this, the LTP is clear on the type of behaviours and working practices that are necessary to become a mature ICS. One of the core components that we need to focus on developing over the next 12 months is designing a set of incentives – financial or otherwise – to secure the improvements to health outcomes and quality of life for our population, whilst managing our finances at a system level, in a more proactive fashion and the CCG wish to accelerate this work.

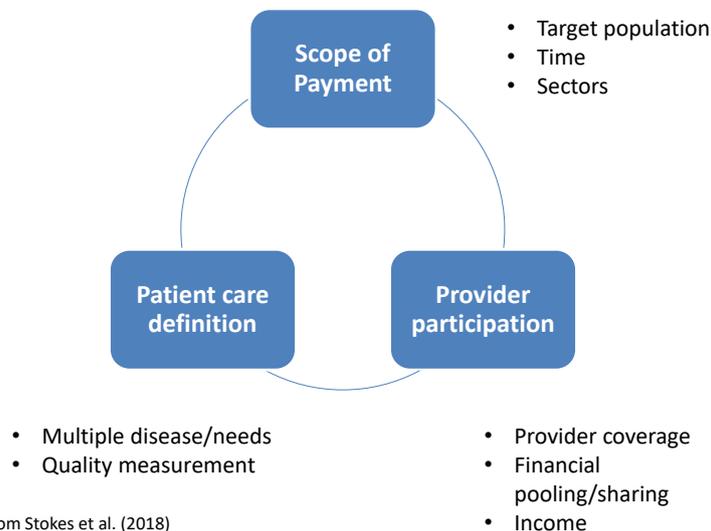
### **2. Testing a new way of contracting for integrated care**

The current suite of reimbursement mechanisms are not aligned to supporting the effective integration of healthcare provision. For this reason, the CCG wish to engage with all Providers over the next six months, to design a new framework for allocating resource with an aim to test some areas in shadow form during 2020/21, and we propose that the JUCD System Planning Group explore how this could be achieved.

One way of developing such a framework could be based on evidence drawn from areas within the UK and other countries across Europe, as described by Stokes et al. (2018), who describes payment in terms of eight dimensions cutting across the following three broad themes:

1. **The scope of payment:** Target population, the target population that the payment covers; Time, the period of time that the payment covers; Sectors, the number of health and care sectors (e.g. primary/secondary/social care) covered within the payment, i.e. whether it incentivises horizontal or vertical integration;
2. **The participation of providers:** Provider coverage, the extent of total providers within the sectors (and geography) covered by the payment; financial pooling/sharing, extent to which providers share risk and reward, incentivising interdependency issues to be addressed, e.g. through pooling funding/shared savings;
3. **The single provider/patient involvement:** Income; the proportion of the providers' total income that is attached to the payment,; Multiple disease/needs focus, the extent of an individuals' total potential health and care needs (i.e. services) covered by the payment; and Quality measurement, the holistic nature of the measurement that the payment/quality measures account for, e.g. measured on a single measure of the care process (which may or may not affect the patient outcome) or more holistically accounting for the final outcomes of the patient.

**Typology of payments for integrated care\***



\*Drawn from Stokes et al. (2018)

Furthermore, the framework proposed would guide our work to achieve a high level of integration in the following ways:

## Scope of payment

Level of integration Domain	Low integration	Medium integration	High integration
<b>Target population</b>	Payment covers one specific patient group e.g. 'high-risk'	Payment covers slightly wider defined group e.g. over 65s	Payment covers all patients in catchment area
<b>Time</b>	Payment covers one contact	Payment covers multiple contacts e.g. during an episode of care	Payment covers care over a longer period e.g. a year
<b>Sectors</b>	Payment covers care delivered by single sector e.g. primary care only	Payment covers care delivered by two sectors e.g. primary and social care/ primary and secondary care	Payment covers care delivered by three or more sectors e.g. primary, secondary and social care

## Provider participation

Level of integration Domain	Low integration	Medium integration	High integration
<b>Provider coverage</b>	Payment covers one provider only within the participating sectors e.g. a single GP practice within primary care	Payment covers care at multiple providers within the participating sectors e.g. all primary care providers and a proportion of secondary care providers	Payment covers care at all providers within the participating sectors e.g. all primary and secondary care services within the area
<b>Financial pooling/sharing</b>	No pooled funding/ shared savings for providers	Proportion of budget is pooled/ savings shared for the defined horizon for providers	Total health and care budget is pooled/savings shared for the defined horizon for providers
<b>Income</b>	Payment provides a small proportion of providers' total income	Payment provides a relatively large proportion of providers' total income	Payment provides the largest proportion of providers' total income

## Patient care definition

Level of integration Domain	Low integration	Medium integration	High integration
Multiple disease/needs focus	Payment covers care for one condition for a single patient e.g. diabetes care only	Payment covers care for multiple conditions for a single patient e.g. all chronic condition care	Payment covers all care for a single patient e.g. all health and social care needs
Quality measurement	Payment measures/rewards process measures e.g. number of health checks	Payment measures/rewards intermediate measures and lifestyle behaviour e.g. HbA1c, smoking	Payment measures/rewards health outcome measures e.g. Quality of life

### 3. Acute Care Contracting Intentions

#### 3.1. Contracting issues to resolve during the 2020/21 Planning Round

As set out above, we recognise that transition to a new way of working will occur in 2020/21, where transactional action and adoption of national changes to contractual/financial policy instruments will be used to support financial recovery, whilst at the same time developing a new contracting architecture, as one enabler for better integrated care.

In this context, there are a number of 'live' contract issues that need to be resolved during the next 6 months:

- Block funding.** For all services currently funded by a block payment, a clear and unambiguous description of the core components to the service supported by relevant activity and costing will be required by Commissioners. We would like to work with you over the next 6 months to ensure that this action is completed. In many cases, there will already be work underway on this as part of the Service Benefit Reviews agreed through the Systems Savings Group or other associated work.
- Non-elective unit cost increases.** This has been a feature across a number of contracts over the last 18 months, with evidence of a more targeted approach by Providers to improve their ICD-10 and OCDS coding practice. Whilst the Commissioner is supportive of generating more accurate data, not least to support key quality indicators e.g. HSMR, it is not acceptable for the change to be transacted without prior authorisation of the Commissioner, particularly if cost increases as a result. In the light of this, 2020/21 contracts

will not incorporate the financial effect of this work if prior authorisation has not been sought and granted.

- **Nurse-led clinic activity.** We will work with all Providers to review all non-PbR pricing arrangements for outpatient activity, with a particularly focus on nurse-led activity, to increase the volume of this work which is more cost-effective for the System. The aim of this work will be to ensure that all clinics are appropriately charged in accordance with guidance on consultant clinical responsibility and with the principles agreed between us.
- **Daycase and Outpatient Procedure classification.** The activity recording practice which underpins work charged as a daycase, where there is also an outpatient with procedure tariff, is currently under review in 2019-20. We will expect the outcome of this review to be reflected in 2020/21 Contracts.
- **Recording of short stay emergency admissions and medical assessment unit activities.** The activity recording practice for this type of work is currently under review in 2019-20. We will expect the outcome of this review to be reflected in 2020/21 Contracts.
- **Implementation of the Emergency Care Data Set (ECDS).** Whilst we expect all Providers to be submitting data in line with ECDS guidelines, the financial effect of capturing more granular diagnosis and/or procedural information does not create additional cost for providers and so should not alter the balance of financial burden on any system partner in 2020/21.
- **Same Day Emergency Care local pricing.** Given that other areas have moved to a new reimbursement model for this work, we will be seeking to agree a standard local price across the system for Same Day Emergency Care which we are all working to deliver in line with national targets and timescales. This local price should be based on the actual costs of delivery which we expect from national guidance to be lower than the cost of admitted non-elective activity.
- **Pre-Operative Assessment Charges.** In line with usual practice nationally, we intend to agree a local price for pre-operative assessments across all providers which reflects the actual costs of delivering this nurse-led activity. Similarly, in line with national targets to reduce outpatient activity, we would like to work with providers to reduce unnecessary pre-operative assessment attendances, perhaps by the introduction of online screening with selective invites to attend assessment.

### 3.2. National Tariff and Planning Changes

In agreeing 2020/21 contracts it is vital that all PbR-funded services are billed in line with the rules of the National Tariff Payment System, and all counting and coding changes should be appropriately notified to Commissioners before implementation according to NHS Standard Contract terms.

- **2020/21 Tariff development.** Early engagement sessions on the development to the 2020/21 National Tariff Payment System has shown that NHSI/E is considering the introduction of a blended tariff model for Outpatients, Maternity and Critical Care. The CCG welcomes the introduction of new pricing models which are outcome-focused and support the sharing of risk between system parties. If these models are introduced, we will be looking to agree outcomes-based elements to the payments which support the shared system transformation objectives and discussions will be held on these once the consultation tariff is published.
- **Operational Planning and Contracting Guidance.** Once national guidance is published later this year, we will review this and discuss with you the impact of any national requirements which may require reflection in our contracts or plans.

### 3.3. Other Contractual Matters

- **SUS/SLAM reconciliation.** A plan to improve the Trust's SUS/SLAM reconciliation is already in place for this year under the contractual DQIP. It is the CCG's expectation that SUS will become the repository for data that drives billing and service planning.
- **Contract Notice periods.** The CCG will be seeking to align its principal lead provider contracts in terms of notice periods and propose the following structure: a 6 month notice period for services provided under the contract and 12 months for the full contract.
- **Location of care.** In the interests of cost savings for both commissioner and provider, the CCG expects all care to be carried out in the lowest cost clinically appropriate setting and will not, for example, support funding at higher daycase prices for activity which could be safely carried out in an outpatient setting.
- **Best Practice Tariffs.** The CCG supports the use of Best Practice Tariffs (BPTs) to incentivise best practice in clinical care. However, the CCG will only fund these where, either data is submitted monthly, which evidences the

attainment of best practice standards, or, if appropriate, audits provide the supporting evidence required for the more complex standards e.g. Paediatric Diabetes.

- **Non-recurrent funding.** Any requests to transfer the award of non-recurrent monies, made either through national programmes or 'winter-funding' etc, into recurrent funds, will only be considered on receipt of a business case, which demonstrates cost neutrality to Commissioners and the system as a whole.
- **Block funding.** Where any specification for a block-funded service is not delivered in full as contracted, the CCG reserves the right to withhold an appropriate element of funding.
- **AIV Challenges.** The Contract Management Team at the CCG have worked closely with Providers throughout 2018-19 and 2019-20 to reduce the burden of the monthly challenge process and to ensure that challenges raised are accurate and appropriate. In this context, we will expect both parties to adhere to timescales that underpin the contract review and payment challenge process – payment will be held for those items where no response is received from Providers.
- **Transfers between providers.** The CCG will expect to reclaim any double counting or duplicate charging resulting from pathways that are split between providers. Where pathways are split between providers and the total cost to Commissioners is over and above the normal tariff price, the CCG will not fund the excess and it will be withheld; unless there is expressed agreement to the contrary in writing from commissioners.
- **IPG/MTG/DTG.** The Derbyshire Affiliated Clinical Commissioning Policy Advisory Group has considered these types of NICE guidance and have agreed that the use of any procedure or technology assessed by NICE under their IPG, MTG and DTG programmes are not normally funded, unless:
  - The NICE IPG states 'use with standard arrangements for clinical governance, consent and audit,' OR,
  - The NICE MTG states 'the case for adoption within the NHS as described is supported by the evidence,' OR,
  - The NICE DTG makes a recommendation as an option for use, OR,
  - The NICE MIB has evaluated the innovation;

**AND**

- The provider has submitted a robust, evidenced based business case to the commissioner and this has been subsequently approved.

## Summary

During 2020/21 it is important that we retain a firm grip and focus to improve our financial position as a system whilst accelerating the pace and breadth of our transformational change programme. This is vital to ensuring long lasting and sustainable delivery of improved outcomes for the local population we serve.

In this context, the 2020/21 Commissioning and Contracting Intentions detail:

- The need to see sustained improvement against constitutional targets and Long Term Plan outcome measures;
- The key service planning and transformation priorities which are fully aligned with the STP Refresh; and
- The intent to ensure an appropriate mix of transactional and transformational action to secure financial recovery whilst at the same time developing a range of new incentive structures to promote integrated care.