Darlington Shadow Clinical Commissioning Group

DARLINGTON
SHADOW CLINICAL COMMISSIONING GROUP

CLEAR AND CREDIBLE PLAN
2012/13 – 2017/18

Working together to improve the health and well-being of Darlington

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Contents

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Executive Summary

TO BE COMPLETED AT THE END- ONE PAGE

The summary to include

- CCG Vision/Purpose
- Summary of key health challenges/opportunities facing the CCG
- Overview of key priorities/initiatives that will be implemented during 2012/13 to address the key challenges/opportunities
- Performance management- how the CCG will performance manage delivery of the above initiatives

1. Introduction

As co-Chairs of the Darlington shadow clinical commissioning group (DSCCG), we are pleased to introduce our first Clear and Credible Plan to you. This plan outlines who we are, what our role is as a new commissioning organisation, what our priorities are and what we will be doing to deliver them over the next five years.

Who we are

DSCCG was established in October 2011 as part of the recent changes to the NHS outlined in the white paper 'Equity and Excellence: Liberating the NHS' (DH, July 2010) and the recent Health and Social Care Bill. This legislation has provided a unique opportunity for front line clinicians to lead the commissioning and design of local services to meet the needs of local people. Darlington SCCG is made up of twelve GP member practices and represents a population of just over 100,000 people. The area covered by DSCCG is predominately urban centred on the town of Darlington and is coterminous with Darlington Borough Council (DBC). Despite the compact nature of the area there are some marked differences in health between the various wards of the Borough.

Our new clinical commissioning organisation will build upon initial experience as a practice based commissioning (PBC) group and then a pathfinder consortium and GP lead commissioning group. We recognise we are at the very beginning of our journey towards being fully capable of delivering excellent commissioning of health and health care services, and as such, will continue draw on the skills and expertise currently within NHS County Durham and Darlington to assist our assimilation and development of commissioning skills, knowledge and experience. We do not underestimate the steep trajectory of development required to enable our organisation to become an intelligent commissioner with the capacity and capability to meet the health challenges of our population.

What we are trying to change and why

As clinicians working with patients and providers of health care services every day, we feel that we have a real insight to what changes could be made to improve the health and experiences of our patients. We have also accessed data from public health, service performance and financial experts to build up

a picture of the challenges and opportunities that face us as a commissioning organisation.

This plan captures what is different in the new healthcare system and puts forward a case for change based on sound clinical evidence, the thoughts of our patients and the public and our own experiences as clinicians delivering services. This plan clearly sets our priorities and why our chosen priorities will lead to greatest health gain taking into account future changes. Our plans now and in the future need to be built up from and reflect the contributions of all within the local health and social care system, stimulating clinical engagement and improving quality within the finance available.

How we are going to change services

To be an effective commissioning organisation, our CCG must develop and deliver ambitious, but practical plans to implement its strategies, developed with stakeholders and owned by its member practices and partner organisations.

We will work closely with our current hospital and community services whereby clinicians from a range of professions and a variety of settings are able to collectively shape services locally to best reflect our patients' needs. As part of our pathfinder programme we are taking forward clinical pathway work for Musculo Skeletal Services (MSK) and engaging a range of clinicians with a common purpose to improve services for the defined patient group. This work extends beyond the Darlington locality and through learning and evaluation of the programme of work we are informing a future model for pathway development which can be applied to a range of care pathways.

Equally importantly we will build a true partnership with Darlington Borough Council to support one another in tackling the common challenges that can only be solved, or outcomes optimised, by adopting a joined up approach across the health and social care pathway. This together with the coming together of organisations in the Darlington Partnership and its vision for Darlington expressed within "One Darlington Perfectly Placed" offers an early opportunity for our SCCG to sit alongside our partners to share a common vision and influence an approach that defines health and well-being in its wdest sense,taking into account the wider determinants of health

We will also work in partnership with the two neighbouring clinical commissioning groups in North Durham and Durham Dales, Easington and Sedgefield when whole health economy working will help deliver our aims and make best use of available resources and effectively manage levels of risk.

As a shadow CCG, and up until our full authorisation, we are supported by NHS County Durham and Darlington as the umbrella statutory NHS commissioning organisation. It is therefore essential that our commissioning plan acknowledges and remains consistent with the PCT Integrated Strategic and Operational Plan (ISOP) 2011/12 - 2014/15 whilst ensuring that our clear and credible plan captures the opportunities from this point onward for strengthening clinical leadership and engagement in the commissioning of health services.

The ISOP outlines how the PCT will ensure the delivery of national, regional and local priorities over the defined period, ensuring financial stability and improved levels of service performance whilst at the same time facilitating the transition towards clinical commissioning. We believe our clear and credible plan is consistent with the ISOP themes and will carry these forward and beyond the lifespan of the ISOP at which point we will be required to demonstrate alignment to the priorities of the new wider system including the Darlington Health and Wellbeing Board and refreshed Local Strategic Partnership at a local level and the overarching strategic aims of the NHS Commissioning Board.

Our governance arrangements will be reviewed and refreshed as we move along the trajectory from being a composite part of NHS County Durham and Darlington to a fully authorised governing body in our own right operating within the NHS.

Financial Overview

Our clear and credible plan is based on assumptions around National financial allocations and any required levels of efficiency we are required to achieve. These assumptions have allowed us to plan how we will deliver our key priorities whilst ensuring we meet our statutory financial requirements.

How we will measure that we are making a difference

Over the next five years we will track the progress of our efforts and measure the impact they have on the outcomes we are looking to improve. We will work closely with stakeholders such as Darlington Local Involvement Network (LiNK) and emerging HealthWatch and other patient groups as well as the new Health and Wellbeing Board for Darlington to keep you informed of our progress and celebrate with us where we demonstrate success.

Alongside this plan, we have developed a communication and engagement strategy for Darlington where there is potential for a joined up approach with

DBC that will enable our future work to reflect even more the needs and wants of our local population.

The next five years will be both challenging and exciting, but we are committed to making a difference to the people of Darlington and we look forward to updating you with our progress in the future.

Dr Andrea Jones

GP Commissioning Lead
Darlington Shadow CCG

Dr Harry Byrne

GP Commissioning Lead
Darlington Shadow CCG

Dr Richard Harker

GP Commissioning Lead
Darlington Shadow CCG

2. Vision, Purpose and Values

Darlington is a unique place in which to live and work, but not one without health challenges. Our role as a clinical commissioning group is to understand what our population both needs and wants, consider the evidence base and quality outcomes and then act to deliver these improvements within the defined financial framework. To give ourselves the best chance of success on behalf of our population, our vision alongside our partner organisations is:

> ***"working together to improve the health and well-being of Darlington"***

In order to achieve this vision, we have developed strategic objectives that cover and define the challenges facing us. These are:

- To improve the health status of the people of Darlington
- To address the needs of the changing age profile of the population of Darlington
- To take services closer to home for the people of Darlington

As a CCG we will be investing roughly £740m over the five year lifespan of this plan. At the same time our healthcare providers will have to become more efficient than ever to respond to the current economic climate. Because of this we recognise that as investors of public money, we have a fourth strategic objective to: Manage our resources effectively and responsibly.

Whilst delivering these aims given the current economic climate, we must ensure that we are making the best use of public money within Darlington.

Improving the health status of the people of Darlington

The Darlington Single Needs Assessment (SNA) indicates that nearly a quarter of the residents of Darlington live in the most deprived areas of England. Furthermore, just under a quarter or residents live in the least deprived areas which signifies a major disparity across the town of the varying levels of health and deprivation.

Men from the least deprived areas of Darlington live 13.4 years longer than those from the most deprived areas; with the difference in life expectancy for women between these two areas is 10.3 years.

By working with partners in social care and public health, we can jointly focus on the underlying risk factors and wider determinants of ill-health and health inequality so that the people of Darlington can expect to live longer, healthier lives in the future and the differences in life expectancy are narrowed. We will influence and shape this at a strategic level as core members of the

Darlington formative Health and Wellbeing Board as well as those areas of joint priority delivered through the established Joint Strategic Commissioning Group and including re-ablement and section 75/256 agreements.

Addressing the needs of the changing age profile of the population of Darlington

The percentage of the population over 50 years of age in Darlington is increasing and the majority of older people now live more independently within their own homes. A large rise is predicted in the number of people diagnosed with dementia and current statistics show that 19.3% of the Darlington population live with a long-term limiting condition, which is above the England average.

By working with partners and commissioning a range of new services, we will ensure that the people of Darlington with long term conditions will be able to live a healthier life that is less reliant on the NHS in the future.

Taking services closer to home for the people of Darlington

In recent years several significant changes have taken place in the way the configuration of healthcare services that the people of Darlington use. In the main these large scale changes have centred on more specialised services however with the strengthening of clinically-led commissioning comes the opportunity to re-shape the services to better reflect the needs of the people of Darlington. Over the next five years we aim to focus much more on what can be provided locally in Darlington, where it is safe and appropriate to do so. Our SCCG will develop a clinical strategy to inform this future direction and influence the shape of the provider landscape.

Making the best use of public money within Darlington

Given the financial challenge facing the NHS and the wider economy over the coming years, we are committed to making the best use of public money in Darlington and operating within our budget. Our CCG boundary is completely coterminous with Darlington Borough Council and as such is a recognised strength and opportunity. The consolidation of close working relationships with Darlington Borough Council alongside voluntary sector organisations can enable a clear advantage for those organisations to optimise the impact of joined up commissioning decisions on patient outcomes and the overall health and well-being of local people. Over the five years of this plan, local people will see that we will have considered the information we have on health and service needs, shared this with them and listened carefully to their views as we deliver planned changes in services over time services whilst living within our means and demonstrating real value for money. We will work closely with our local authority partners to ensure we are making the most of economies of scale and value for money.

Values

As a Darlington PBC group, local practices established a series of values that have been built into a ‘compact’ between the SCCG and its member practices and will inform our approach to clinical commissioning and responsibilities to the local community:

- Open, transparent and inclusive relationship between practices, practitioners and with patients the public and partners
- Commitment to improve the care and outcomes for people
- Fairness and equity in the use and deployment of resources
- Commitment to eliminate unwarranted variation
- Focused on transformation with a clear and credible clinical focus
- Foster strong clinical relationships as a driver for change

These values will be reviewed and refreshed as Darlington SCCG moves towards authorisation as a statutory body.

The tangible benefits of a compact can readily be demonstrated, for example all practices have contributed practice data to the SNA and all practices have agreed move to SystmOne as the preferred clinical system early in the next financial year. The practices have collectively taken forward a scheme to look at referral management through peer review at practice and SCCG level.

In developing our vision, purpose and values, we have worked closely with GPs and staff from our member practices through our management and decision making mechanisms. Over the course of 2011 we have held a number of engagement workshops with patients and stakeholders, including provider organisations, local authority and other statutory and non-statutory organisations to explore opportunities through the new and emerging clinical commissioning system.

To support on-going delivery of our Clear and Credible Plan, we have developed a Darlington Communications and Engagement Strategy (see appendix five) which is to be read alongside the Clear and Credible Plan, the Organisational Development Plan and Financial Plan as a formal strategic document. As the Clear and Credible Plan is an important vehicle for public accountability, we will develop a public facing version of the plan to provide a focus for discussions on local health needs and priorities.

The communications and engagement plan sets out how Darlington intends to engage with people at all stages of decision-making about health and healthcare through patient, carer and public involvement, in the context of existing NHS policy, best practice and legislation. It states a commitment to achieving effective engagement and communications and outlines how

Darlington will develop engagement and communications functions and implementation plans to support its vision and priorities. It also outlines how the Equality Delivery System will be implemented for Darlington.

This overarching strategy includes the following:

- Localised Operational Engagement Plan for Darlington;
- Engagement Plan for the Darlington Shadow Clinical Commissioning Group Clear and Credible Plan / Vision;
- Operational Communications Plan for Darlington;
- Stakeholder Map;
- Patient and Public Involvement Toolkit.

The delivery of the Engagement Plan is supported by a Patient and Public Involvement Toolkit which been developed to enable engagement throughout the commissioning cycle. This provides links to key channels and a range of techniques for informing, engaging and involving patients, carers and the public.

Involvement of stakeholders in the development of Darlington SCCG vision has included on-going communications via a series of regular briefings to NHS and local authority staff, GP practices, the Health and Partnerships Scrutiny Committee, Darlington Local Involvement Network (LINk), formative Health and Wellbeing Board, local Foundation Trusts, other providers and MPs.

We recognise the new NHS architecture will require a new approach to engaging with patients and public engagement, particularly given the emphasis on patient experience in the emerging quality and outcomes frameworks. While the Department of Health, the NHS and its constituent bodies have consulted and engaged with patients and the public in the past, the reforms imply a new set of players leading those discussions, with key roles for Clinical Commissioning Groups and HealthWatch.

Our shadow CCG, together with the Local Authority and Public Health colleagues have recently agreed to undertake a joint approach to patient and public involvement and engagement. A cross organisation task and finish group has developed a Joint Public Patient Involvement and Engagement Implementation Plan to be delivered by October 2012.

This joint working group recognises that we will need to develop innovative ways of engaging with patients and the public as Darlington's Single Needs Assessment and Darlington's Health and Wellbeing Strategy develop during 2012.

Working collaboratively with our Local Authority and public health partners, we intend to take a three tiered approach to Public Patient Involvement and Engagement in Darlington:

1. Strategic Commissioning level
2. Clinical Specific level
3. Practise Forum level

The SCCG clinical board assumes collective responsibility for driving forward its vision and aims in collaboration with member practices and other key stakeholders.

Our Darlington GP practices have a long established track record of good collaborative working across the practices as well as with other commissioners, particularly other localities. The three local shadow CCGs are developing how to work together, including specified areas for confederated working and risk sharing.

3. The Case for Change

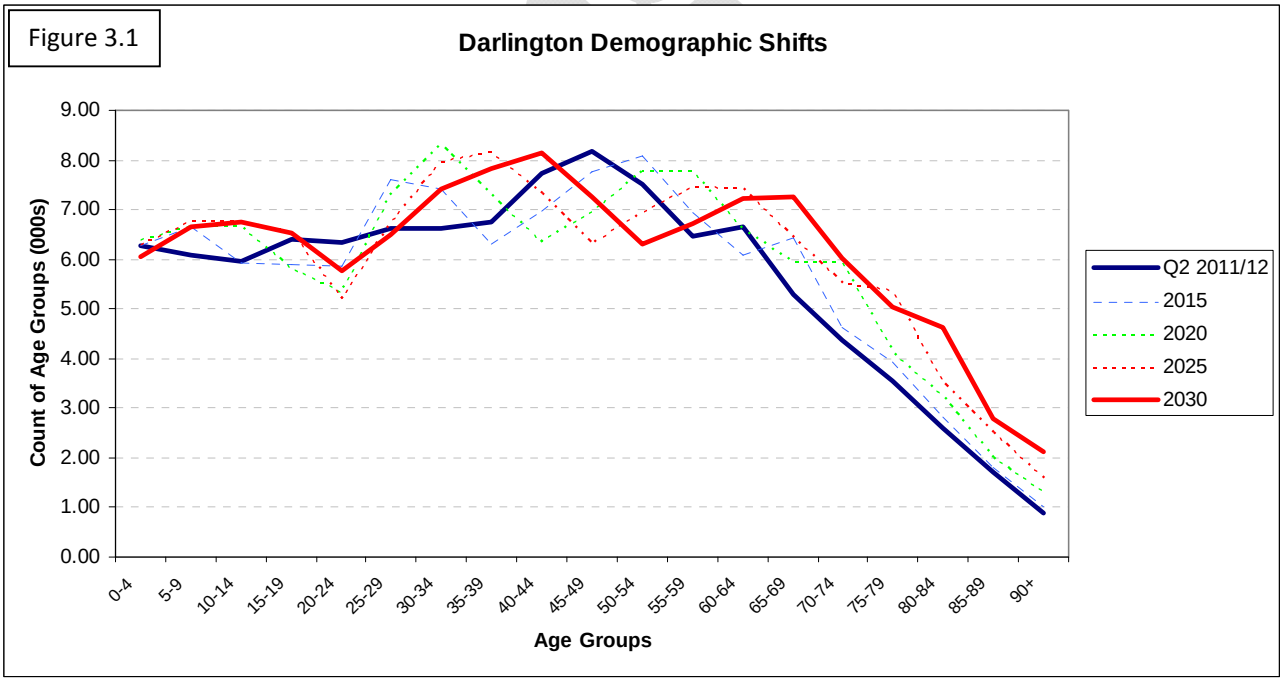
The starting point for the development of the vision for this plan was to fully understand the health needs of the local population, the patients' experience of the services they receive, insights from the GPs and their teams delivering care to their patients and the financial environment that we operate in. This was supplemented by the identification of opportunities to make improvements in service efficiency and performance. Our awareness of the public health challenges in Darlington through previous PBC arrangements and learning from our pathfinder projects further strengthens our case.

Health need and demographics

Using the Single Needs Assessment, Community Health Profile and other sources of epidemiological and demographic data, Darlington SCCG has developed a picture of the health challenges facing our local populations.

As shown in figure 3.1, the population of our CCG will age significantly over and beyond the life of the plan.

Figure 3.1



Whilst the population grows and ages, it also stands behind the national average in many of the key headline health measures:

- Men in Darlington are living 1.7 years less than the England average and women are living 1.5 years less than the England average
- Inequalities in life expectancy exist *within* Darlington with life expectancy for men living in the most deprived areas over 13.4 years lower than for men living in the least deprived areas. For women it is 10.3 years lower
- Between 2007 and 2009 1,129 people in Darlington died aged less than 75 years
- Cardiovascular disease (CVD) and cancer account for around 63% of early or premature deaths in Darlington.

The underlying risk factors that drive this level of ill health are also stark:

- Binge drinking prevalence is estimated to be 31% in Darlington, 18% higher than the National estimate
- Smoking remains the biggest single contributor to the shorter life expectancy experienced locally

Disease Prevalence (Quality Outcomes Framework)

QOF prevalence rates for Darlington can be used as proxy measures for disease prevalence for the Darlington locality. GP practice registered disease prevalence in Darlington is 20% higher than the England average for the following diseases:

- Chronic Obstructive Pulmonary Disease (COPD – also the second most common cause of emergency admissions to hospital)
- Coronary Heart Disease (CHD)

It is worth noting that QOF measures may reflect the proactive approach in Darlington to screening and disease detection by the member practices allowing for intervention and support at an earlier stage than would otherwise have happened (rather than a simple measure of high level of disease locally compared to the national picture). This is reflected in development of community CHD services by the Darlington practices including an integrated heart failure service comprising A GP with a special interest, specialist heart failure nurses and consultant cardiologist.

Finally, diseases associated with getting old are also significant locally:

- Dementia prevalence is predicted to rise in Darlington to 8.1% by 2030
- COPD prevalence is greater in Darlington (2.2%) than England (1.6%).

Darlington is significantly worse than the England average in the following areas:

- Lifestyle (smoking, healthy eating, binge drinking).
- Over 65's "not in good health"
- Incapacity benefit for mental illness
- Hospital stays for alcohol related harm
- Drug misuse

A full outline of the health need of our SCCG area and the gap analysis undertaken against our commissioning intentions can be found in Appendices One and Two.

Financial assessment

As a shadow CCG, we have made a series of planning assumptions regarding revenue and capital allocations to fund commissioned services, running costs and inflation and efficiency rates within tariffs/contracts.

These assumptions are based on the national funding allocations made in the 2010 Comprehensive Spending Review and detailed within the Operating Framework for the NHS in England 2012/13 and accompanying allocation schedules. The assumptions have been tested and calibrated across neighbouring CCGs, the PCT Cluster and NHS North Directors of Finance.

These assumptions have been used to create three funding scenarios:

- Base Case. This is the likely case on which the affordability of the Clear and Credible Plan is based.
- Downside Case. This case is used to determine a scenario where further prioritisation and targeting of initiatives would take place in order to create an affordable Clear and Credible Plan
- Upside Case. This case is used to determine a scenario where strategic initiatives can be extended in scope or introduced more quickly within an affordable financial model.

Allocation assumptions

The assumptions on allocation between 2012/13 and 2014/1 5 identified in figure X have been accepted across the CCG and agreed with the assumptions identified within the Cluster Integrated Strategic and Operating Plan.

Area	Scenario			3/14 mated)	14/15 (estimated)
Commissioning allocation	Downside scen			.0%	0.0%
	Base Case scer			.2%	2.2%
	Upside scenario	UPLIFT	3.0%	3.0%	3.0%

To be updated when DoFs confirm over 5 years

Figure X: CCG allocation assumptions

Taking the PCT allocations for 12/13 as a starting point, these assumptions form the basis of our financial plans that underpin the commissioning activities of the CCGs. The assumptions help determine what funding is available for investment and what we need to deliver in terms of efficiency, phased over the five years of the plan.

The CCG revenue position for the planning period (before efficiency gains are factored in) as follows:

		2012/13 (£000s)	2013/14 (£000s)	2014/15 (£000s)	2015/16 (£000s)	2016/17 (£000s)
Darlington CCG	Opening Recurring Baseline	135,812	139,615	142,407	145,255	148,160
	Recurring Growth	3,803	2,792	2,848	2,905	2,963
	Total Revenue	**142,331**	**145,199**	**148,103**	**151,065**	**154,087**
Darlington CCG	Subset of total revenue allocation (2%) to be held as non-recurring	2,716	2,792	2,848	2,905	2,963

These revenue assumptions also demonstrate the phased introduction of changes to budget setting (from those based on historic spend to budgets based on “fair-shares”) before to the CCG allocation and between the localities within it.

Running Cost assumptions

The 2012/13 NHS Annual Operating Framework indicates a CCG running cost allowance based on the size of the population for which we have commissioning responsibility.

This allowance of £25 per head of population from 2013/14 means that we have £2.686m to invest in the management structure that will oversee the statutory responsibilities and operational delivery of our CCG and also to purchase the technical commissioning support necessary to do this efficiently and effectively.

Running Costs based on £25 per head (£'000)	
CCG Total	2,686

We have confirmed our management and operational structure for our shadow CCG at the end of January 2012 (using a phased approach) and develop a specification and formal business agreement with the County Durham and Darlington/North East Commissioning Support Unit by 1 April 2012.

Programme Budget Data

Darlington CCG has access to the County Durham and Darlington Annual Value Population Review – a locally produced guide to the nationally collected programme budget data that compares spend with outcomes within disease areas. This guide identifies areas of potential opportunity to re-design services to improve efficiency and maximise effectiveness of spend. An overview of the Darlington spend profile can be found in Appendix Three.

Highlight from the AVPR

Expenditure across all but three programme areas for County Durham PCT is greater in secondary care than primary care. Darlington PCT during the 09/10 financial year allocated 63% of its programme expenditure into secondary care. This proportion has been decreasing over time (70% in 07/08), demonstrating a shift in the provider landscape.

In 2009/10 the level of expenditure on the Trauma and Injuries programme in Darlington was significantly greater relative to other PCTs, there were no programme areas where expenditure was significantly lower. With respect to outcome, there were no programme areas that had significantly worse or better outcomes than other PCTs during 2009/10. There are a number of areas in 2009/10 where there may be more moderate resource or outcome issues.

Programme areas with potential overuse of resources *(Higher Spend and Better Outcomes)*	**Programme areas with potential misuse of resources** *(Higher Spend and Worse Outcomes)*	**Programme areas with potential underuse of resources** *(Lower Spend and Worse Outcomes)*
Trauma and Injuries*	**Problems of the Respiratory system**	**Cancers and Tumours**
Endocrine, Nutritional and Metabolic (Inc. Diabetes)	**Neurological system**	**Conditions of Neonates**
Healthy Individuals	**Problems of circulation**	
	Dental Problems	

*significant

The majority of the budget supports the expenditure on the Healthy Individuals programme will move to the Local Authority as a part of the Public Health transition process. Investment in this area also fits in with the strategic direction of the CCG so in reality would not be considered at this stage an overuse of resources.

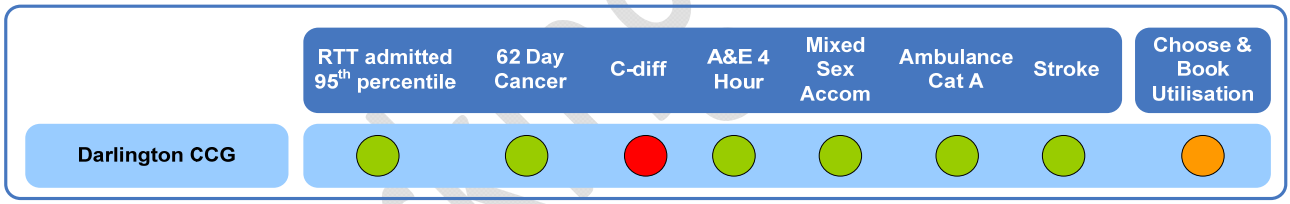
Service performance

As part of the transition from PCT- to clinical commissioning, the CCG has undertaken a review of the headline performance metrics that describe how the system is working for our patients.

This transition will be phased over the life of the clear and credible plan. In the early months of Year 1 of the plan, we will assume direct accountability for the performance across a range of key areas. These are measures are:

- 18 Week RTT 95th Percentile
- Cancer 62 Day Waits
- C. Difficile
- A&E 4 Hour Waits
- Ambulance Category A response rates
- Mixed Sex Accommodation
- Stroke patients spending 90% of time on a specialist ward
- Choose and Book

The current level of performance in these areas is RAG rated as follows:



What our patients tell us

We have well developed links with patients through our member practice forums and the face to face communication between clinicians and patients. We have developed a robust patient and engagement involvement strategy and operational plan for the whole of our community that will link these elements together into a comprehensive approach that puts patient needs at the centre of what we do.

In September 2011 and in collaboration with Darlington Borough Council we undertook a joint consultation exercise with attended by patients, carers, third sector organisations as well as local stakeholders. The event gave local people the opportunity to have their say about the health services that are important to them; how they can get involved in how local health services are commissioned (planned and purchased); and how they wish to be engaged and communicated with in the future.

The event had the following objectives:

- Commence sharing with the community of Darlington the national changes that are impacting on the clinical commissioning group and the local authority
- Highlight changes for Health and Social Care across Local Authority and Health
- Outline any key Public Health challenges
- Raise awareness of HealthWatch and consult on involvement of the community in future HealthWatch arrangements.
- Raise awareness that the NHS Clinical Commissioning group and the local authority are working together on this agenda
- Highlight local health priorities as identified in Single Need Assessment and engage the community in consultation around how we can address these priorities
- Commence discussions on how the community can influence the future and what we want public and patient involvement to look like in Darlington

Attendees identified the following health priorities in Darlington:

- Stopping smoking
- Reducing alcohol related deaths
- Improving dental health
- Tackling obesity
- Reducing teenage pregnancies
- Improving access and choice to services
- Prevention and education
- Concerns that there is insufficient funding to maintain existing health and social care services.
- Better promotion of health checks
- Lack of awareness around commissioning services, and the impact of future changes
- Improving communication with people using a range of methods
- The need to reduce health inequalities which affect the local population

Building on this successful event and as described earlier we are working jointly with DBC and Public Health to develop a Joint Public Patient Involvement and Engagement Implementation Plan. (To be completed by October 2012).

What we see as clinicians

As a part of the transition to the new system of clinical commissioning we are proactively informed by our clinicians about service changes that need to happen in order to improve service safety, quality, access, outcomes or efficiency. The opportunity of face to face contact with patients and their carers gives clinicians important insights into where we can direct our efforts to improve what health care services are provided and how they should be provided. This plan aims to triangulate the evidence of need and views of patients and the public with the experience and insights of clinicians delivering services so that any changes made bring about real improvements in the health outcomes and experiences of our local population

Public Health/ Prevention agenda

- We see a huge variation in terms of deprivation across Darlington, which is supported with the data presented within the Joint Strategic Needs assessment for the locality.
- The area that we feel would make the most impact would be the provision of more integrated obesity pathways if care and interventions to support our population to stay healthy and reduce the likelihood of developing other long term conditions in future years. There is a current gap in service provision for the Darlington population.
- As we know from our QOF prevalence rates we have a high percentage of our population diagnosed with coronary heart disease and diabetes which obesity levels can have a direct impact on these conditions.

Primary Care and Community Development

- Darlington primary care practices are working towards improving the services offered to the population of Darlington, by adopting a “one big practice” type approach. In essence this is to develop our approach to sharing best practice and developing more streamlined pathways.
- As part of our established way of working, Practices work collaboratively to improve pathways of care and reduce the unexplained variation that exists within primary care.
- We believe that we can do more locally by improving and enhancing the skill mix offered within a primary and community care setting to support our population’s needs and prevent unnecessary secondary care activity.
- We will work with all our partners including patients, community staff, social care staff, nursing and care homes, voluntary sector

organisations, to ensure the relevant people have input into the work we undertake to improve the health and well-being of our population and we work together in a much more co-ordinated approach to reduce the duplication of people's efforts.

Long Term Conditions

- We will be recognised for delivering proactive healthcare service rather than a reactive one where we can jointly care plan with our patients to help manage their long term conditions especially as Darlington will face an increasing elderly population in future years who are likely to be living longer with potentially more than one long term condition.

- We will lead the development of more streamlined and co-ordinated approach to long term condition care planning along with the pathways that support our patients throughout their condition.

- We are leading the development of more localised services for patients with long term conditions to address the current gap in local clinical knowledge and address the cost pressure associated with secondary care referrals.

Right Care, Right Place

- The North East in general has a high dependency on secondary care services. We want to ensure our patients are seen at the most appropriate care setting for their condition.
- We are initially focussing on eight musculoskeletal pathways for the population of Darlington and County Durham to improve not only the patient experience but also to drive efficiencies that exist within the healthcare system by reducing the "revolving door" experience that exists for many of our patients.
- We are capturing the learning from the pathfinder projects to strengthen our commissioning approach over time
- By streamlining the eight MSK pathways, we aim to achieve a more cost effective pathway that ensures patients receive the right care at the right time and to develop a framework for all future pathway developments.
- We also support the care closer to home agenda and we are currently reviewing the access to bed provision within the community so we are able to offer patients a facility when they require some specialist health support but do not require secondary care level input.

Mental Health

- An area of increasing prevalence for Darlington and we will ensure our patients have a sustained access to appropriate mental health services.
- We will focus on areas where current services do not fully support patients or areas we feel that an improvement in service can be made.
- For Darlington, we believe that further work around the pathway and access to care and support for patients with personality disorders needs to be undertaken.
- We aim to complement our local counselling service to offer more specialist support services particularly around psychosexual counselling.

Emergency Care

- We are investigating the reasons behind the high levels of A&E attendances and emergency admissions.
- We know that we have a high level of paediatric admissions within Darlington in particular related to respiratory conditions. This is another area of focus for us and one we are working on jointly with secondary care to improve the management of children with respiratory conditions.
- We aim to reduce the minor injuries that attend A&E within primary care working hours. We would like to be able to ensure that our population's health care needs can be met by improved access to primary care provision where it is feasible to reduce the reliance of A&E attendances for appointments that could be treated by a primary or community healthcare professional.

Provider Quality Issues

- Clinical letters from some of our providers are either late or inaccurate and often a clear care plan on discharge is not apparent. We are working with our providers to improve both the quality of the primary care referral letters that providers receive, but equally the quality of the information that is receive back to the referring clinician

Prescribing

- Our prescribing processes will be as effective as possible to maximise patient safety and best utilise our prescribing budget.

What our key partners are saying to us

The local authority perspective on key drivers and issues which need to be visible and addressed in our clear and credible plan

Key Drivers

- Delivery of joint strategies through joint commissioning between health and DBC need to be actively explored. There is a desire and an opportunity for collaborative working on pathways of care and programmes which prevent poor health and dependence on social care and those that enable people to better manage long term conditions. Some examples include
    1. Improve health status through early intervention and prevention programmes in adults and children
    2. Address the needs of the changing age profile- build capacity in the communities to self manage; joint commissioning of services to deliver Older Peoples Strategy; Intermediate Care Plus; Older Peoples Mental Health; Long Term care including support for people at home; Continuing Health Care
    3. Taking services closer to home- commissioning support for people in the community where appropriate.
    4. Effiecient deployment of public resources.- Making best use of public money -Align resources for best outcomes focusing on community premised on prevention, personalised and person centered but priortised care

- Opportunities for system wide working on community issues (anti-social behaviour, poverty, school attendances) that impact on well-being

- Financial position of “more for less”, reducing directly funded services for empowerment of individuals and communities, manage change in voluntary and community sectors- through “Darlington Together”.

- Quality of care and safeguarding for children and vulnerable people or for those in time of need- for example following planned admission.

Issues

- Consider opportunities for closer working with the DBC Strategic Commissioning Team- develop Commissioner led services rather than provider led.

- Transfer of shared line management responsibility for the Head of Strategic Commissioning & Partnerships from PCT to Darlington SCCG
- Balance need for Darlington SCCG to manage and monitor high proportion of budget for acute and secondary care with community prevention and provision.
- Smarter information sharing on which to base commissioning and monitoring.
- Governance of joint groups and reporting arrangemements;

Continued support from the SCCG for Darlington Joint Commissioning Strategies which have been developed with the PCT such as:

- Learning Disability Strategy
- Children and Young People Plan 2011-2014
- Autism Strategy- Draft
- Joint Early Intervention and Prevention Strategy
- Intermediate Care Plus Strategy
- Older People Mental Health Strategy

Continued support from the SCCG to champion areas of work such as:

- Champion for Children and Young People
- Champion for Learning Disability and Autism
- Champion for Mental Health
- Champion for Older People
- Champion for Carers
- Gap in physical disability and neurological conditions to be addressed.

What our main acute and community services provider is saying

CDDFT- Insert comments

TEWV- Insert comments

Strategic Analysis and Strategic Objectives

Based on the assessment of health need, demographics, finance, service performance and the insight of clinicians and patients we feel that the case for change is clear.

To determine our course of action, we have reviewed this evidence with the national policy direction laid out in the Operating Framework for the NHS in England 2012/13. This review was then supplemented by SWOT analysis of the external environment that our SCCG will be commissioning in and the internal capabilities of our SCCG itself.

Taking into account the case for change, the national policy direction and our own strategic analysis we have identified the following strategic objectives:

- To improve the health status of the people of Darlington
- To address the needs of the changing age profile of the population of Darlington
- To take services closer to home for the people of Darlington
- To manage our resources effectively and responsibly

The full detail of these drivers and analysis is as follows.

National policy direction

The NHS Operating Framework for 2012/13 outlines the key challenges facing the healthcare commissioners. Emphasis is given on the requirement nationally to deliver the QIPP agenda to make up to £20 billion of efficiency savings by 2014/15 in order to continue meet growing demand and continue improving quality.

Particular areas of national policy focus for 2012/13:

- Dementia and care for older people;
- Carers;
- Heath Visiting and Family Nurse Practitioners;
- Military and Veterans' Health

The Operating Framework also emphasises an outcomes based approach and lays out the high level domains that will form the NHS Outcomes Framework which include:

- Preventing people from dying prematurely;
- Enhancing quality of life for people with long term conditions;
- Helping people to recover from episodes of ill health or following injury;

- Ensuring that people have a positive experience of care;
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

In the forthcoming year these opportunities have already been identified and details of these can be identified in the strategic objectives section of this plan (page X), for example the Health Visitor and Family Nurse Practitioners expansion programme is being delivered across three SCCGs in one efficient work stream.

The outcome domains within the framework line up to a significant extent to our SCCGs overarching strategic objectives:

- Improving health of our population would prevent people dying prematurely;
- Tackling the challenges of the ageing population provides greater emphasis on those with long term conditions improving their quality of life;
- Making services more responsive and accessible to our communities needs will have the effect of increasing their experiences of the care that they receive.

As a SCCG, by delivering our strategic objectives we will ensure that our patients have access to the services that they require following episodes of ill health or injury and that the services are delivered in a safe environment, protecting them from avoidable harm.

External analysis

Strategic Objective	Strengths	Weaknesses	Opportunities	Likelihood and Impact L/M/H	Threats	Likelihood and Impact L/M/H
Improving Health	1. We understand the clinical needs of our population 2. We are able to influence the patient outcomes for those we see on a regular basis	1.There is limited information available at CCG level which enables the group to benchmark achievement 2.We have little direct influence on the lifestyles of those patients who we do not see regularly – possible time bomb 3.We need to better understand the wider determinants of health issues within our localities (e.g. Fuel Poverty)	1.Engage in partnership working with public health, local authority, 3rd Sector and private organisations adding value to a broader series of work packages 2.Use efficiencies to drive up investment in the prevention agenda 3.Develop strategies and increase support for those who are impacted by poor wider determinants of health	M likelihood H Impact M likelihood H Impact M likelihood H Impact	1.Required efficiencies in partner organisations reduce overall investment in the prevention agenda 2.The service changes will not deliver the necessary investment landscape shift and secondary care activity payments will prevent downstream investment	M likelihood H Impact M likelihood H Impact

Managing the Ageing Population (Inc. long term conditions)	1. We have the knowledge to more effectively manage our patients who have long term conditions 2. We can influence the lifestyles and treatments of our patients to keep them healthy into old age	1. There is limited capacity and resource in a local setting to manage the health care demands as the demographic pressure impact. 2.Our resources are currently invested in the wrong place (Over emphasis on secondary care)	1.Deploy models of care that maximise outcome for moderate investment (e.g. self-help) 2.Influence the work of other organisations to deliver against this agenda (commissioner and provider) 3.Shift investment into other models of care.(e.g.) outcomes based services; personal budgets; independent living 4. Promote Re-ablement	M likelihood H Impact M likelihood H Impact M likelihood H Impact H likelihood H Impact	1.Reduction in social care budgets placing greater pressure on the health economy 2. The demographic pressures expand quicker than our the ability make the necessary changes to the service models	H likelihood H Impact M likelihood H Impact

Improving Access	1. We have a good understanding of the access issues faced by our patients	1. People in rural areas do not have equal access to health services because of poor transport links, low incomes and low levels of car ownership 2.Lack awareness of the access issues of the hard to reach communities and those with learning disabilities and mental health issues	1.Shift services to a more community based provision 2.Improve transport links to healthcare 3.Collaborate and work in partnership with other organisations (including the voluntary sector)	H likelihood H Impact M likelihood H Impact M likelihood H Impact	1.The service changes will not deliver the necessary investment landscape shift and secondary care activity payments will prevent investment in more locally provided services. 2.Reduction in local authority budgets leading to further transport cuts 3.Reduction in social care budgets to vulnerable groups impacting on their access to services	M likelihood H Impact M likelihood H Impact M likelihood H Impact

Internal analysis

In order to assess our internal capabilities we have taken advantage of a range of organisational development events, diagnostic events and strategic planning events involving GPs from the Darlington locality as well as practice managers, other clinical staff and senior support staff from the PCT. These events over the period April 2011 to date together with the touch points for work up and prioritisation of the commissioning intentions is demonstrated in Figure XXX

The diagnostic events used a nationally recognised self-assessment tool to enable reflection on values, culture and wider organisational health. The tool describes six domains recognised as authorisation criteria. The self-assessed scores were to be expected of a newly formed organisation. (see table XX)

The Darlington SCCG Organisational Development Plan 2011/12 describes the full plans and timeframes for delivery. Full implementation of the OD plan will assist delivery of our clear and credible plan not only in terms of the capacity and capability to lead clinical commissioning but also to ensure delivery against priorities. Within our OD plan we have identified five key themes forming the building blocks for organisational development, namely:-

- **Leadership** [clinical and non-clinical]
- **Board development**
- **Team development**
- **Intelligent commissioner**
- **Partnerships and Engagement/relationship management**

Table XXX Average scores

	Domain	Average Score
1	Clinical Focus and Added Value	32%
2	Engagement with Patients / Communities	40%
3	Clear and Credible Plan	30%
4	Capacity and Capability	24%
5	Collaborative Arrangements	40%
6	Leadership Capacity and Capability	34%

To fully understand the stage of development that each score represents the table below links the five levels of organisational maturity to the numerical scores:

Level and %	Maturity level
1. (0 - 20%)	Not a CCG priority, as yet
2. (20 -40%)	Getting started

3. (40 -60%)	In development
4. (60 -80%)	Being rolled out
5. (80 -100%)	Fully in place

We assessed our strengths, weaknesses, threats and opportunities at a strategic planning event in early November 2011. Clinicians and other staff from the Darlington Practices attended this event alongside the SCCG support staff to have a collective view on the key areas for change that our SCCG will focus upon and where public health information and importantly the observations and experiences of clinicians of current providers was captured.

The strategic analysis is summarised in the form of a 'SWOT' analysis in figure xxxx and reflect the organisation at a point in time and within a rapidly changing and ambiguous transitional state.

The key areas from the internal analysis are outlined below and have helped to form the case for change and strategic objectives and initiatives set out in section five of the plan. The analysis takes account of our current and future organisational capabilities to lead commissioning of health care in the new system. Opportunities to commission services differently to what has happened previously requires developing capacity and capability aligned to the new CCG arrangements. We believe addressing the early priorities of our organisational development plan not only ensures successful set up of our new organisation but also underpins the successful delivery of this clear and credible plan.

The output of the internal SWOT analysis is set out below

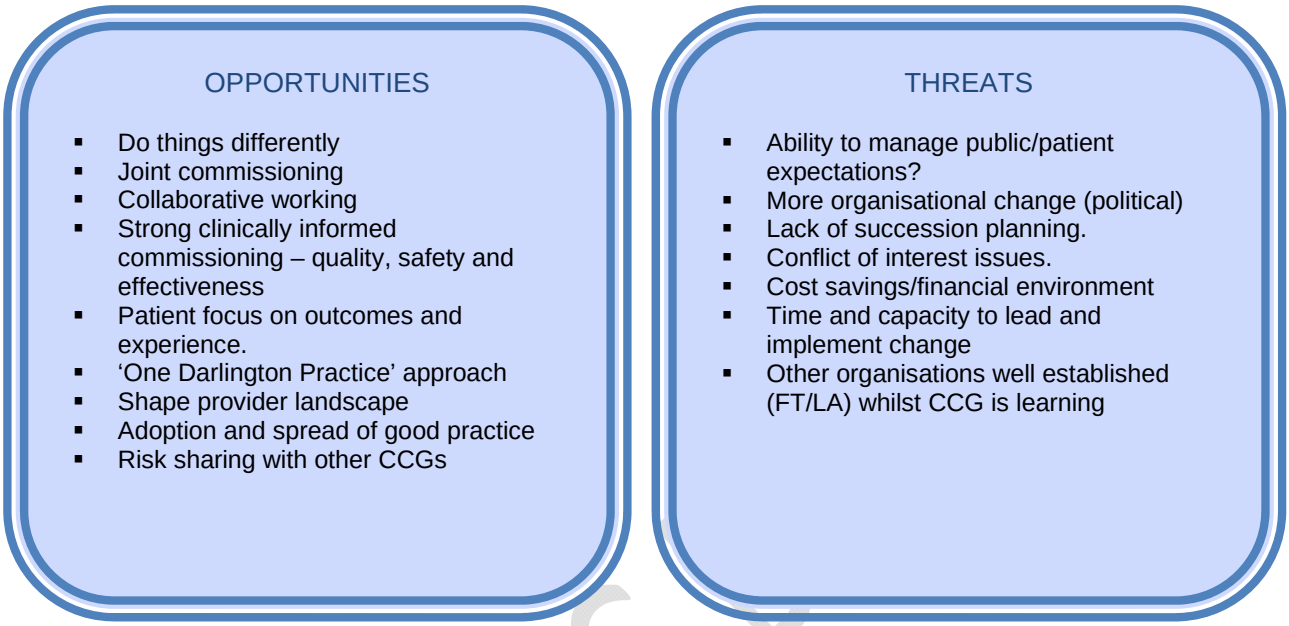
FIGURE XXXX_ TABLE NEEDS SORTING- CONTENT AND FORMATTING

STRENGTHS

- All GP practices engaged
- Commitment to a collective approach- one Darlington practice
- Size and Geographic coherance
- Single LA-co-terminous
- Strong sense of identity
- Commissioning experience through pathfinder projects
- Partnership working with LA and voluntary sector
- Clinical leadership (need more)
- Emerging understanding of needs of the population

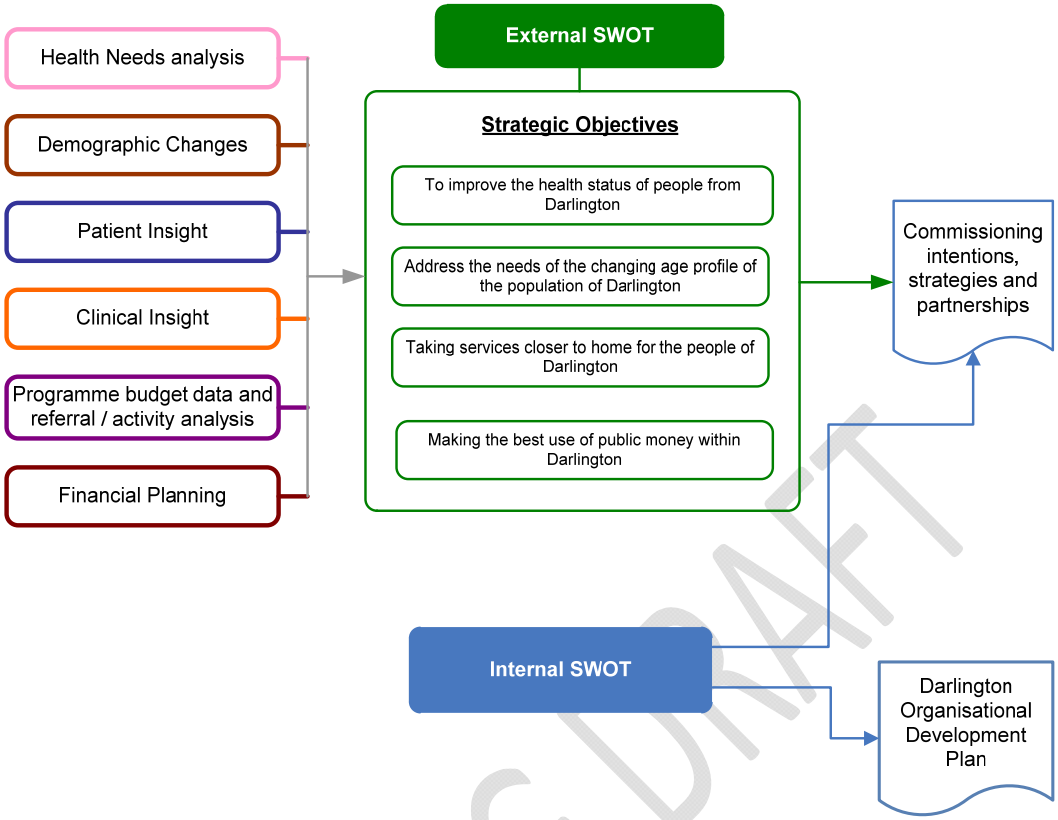
WEAKNESSES

- Size and lack of finances.
- Lack of succession planning
- Evolving organisation
- Large single provider FT
- Small pool of staff resource.
- Data analysis – obtaining relevant data to inform commissioning decisions
- Perceived changes to Dr/patient relationship
- Impact on practices to support active engagement
- Broader clinical engagement from nursing and other professions



Commissioning Intentions, Strategies and Partnerships

In order to deliver these objectives we have identified a range of commissioning intentions (need to describe the process by which we came to these priorities) which we have prioritised in a robust and transparent way with engagement and involvement from practices and clinicians to ensure maximum impact against priority areas. Many of these intentions built on the lessons learned and progress made in our pathfinder projects in 2011/12.



The detail of each of the schemes within these programmes of work will be found in detailed case for change documentation and supported by project plans for ensuring tracking and management of implementation. The schemes within these programmes will also benefit from analytical support that will help identify unmet need and the impact of the demographic changes so that the resulting service changes are reflective of future needs.

The following programmes outline the main commissioning initiatives to deliver each strategic objective. How these programmes fit into the wider strategic context can be found in the Strategy on a Page on page X.

Objective: To improve the health status of the people of Darlington

Link to case for change: *Premature Cancer, Stroke and CHD Mortality are greater than the England average. Prevalence of Heart Failure, CHD, Obesity, Hypertension, Diabetes and Cancer are greater than the England average.*

Population change	✓	*Premature mortality rates for the biggest killers (heart disease, cancer and stroke) in Darlington are higher than England. Cardiovascular disease (CVD) and cancer account for 63% of early or premature deaths in Darlington.* *Life expectancy for men living in the most deprived areas of Darlington is over 13 years lower than for men living in the least deprived areas.*
Health need	✓	
Patient insight	✓	
Clinical insight	✓	
Service issue/opportunity	✗	

What we'll be doing to address this in the next three years:

Year 1 (2012/13)

Reviews

- *Align mental health staff to GP practices- (to be led by mental health commissioning team)*
- *Urgent care provision within primary care and nursing/care homes*
- *Community bed provision including intermediate care beds.*

Pathway Re-design

- Primary/ *Community diabetes pathway*
- *Personality disorder pathway*
- *Asthma and wheezing pathway (under 16)*

Pilots

- *Psychosexual counselling provision*
- *Erectile dysfunction pilot (link to CVD and diabetic prevalence)*
- *Community COPD clinic*
- *Community diabetic clinic*
- *Extend sexual health clinics (Intrahealth proposal)*
- *On-line diabetes education tool.*

New Services

- *Podiatric surgery in a community setting (from Sedgefield pilot)*
- *Diabetic foot care*

(Grey text intentions dependant on outcomes of review/pilot)

CCG Initiatives

- *Agreeing primary care pre and post COPD exacerbation pathways*
- *Agreeing primary care pre and post asthma exacerbation pathways for under 16*
- *Continue with embedding best practice via POINTS tool for COPD management*

Contribution from Partners (2012/13)

***Public Health**: Expansion of Weight Management Services; Review and Expand Exercise on Referral Programme; Pilot a 12 smoking week quitter service; Re-Commission Healthchecks Programme; Full Cost Benefit Review of Public Health Services.*

***The PCT Cluster Children's Commission Team**: Expand the Health Visitor Programme; Commission Maternal Obesity Brief Intervention Training; Commission Physical Activity Interventions for Pregnant and Post Natal Women; Safe at Home Project; Review Maternity Services; Increase Access to Breastfeeding; Commission Childhood Obesity MEND Project.*

***PCT Cluster Mental Health Team:** Align Mental Health Staff to General Practice; Improve Access to IAPT; Improve Equity of Autism Assessment and Diagnosis.*

Darlington CCG will fully engage with partnership working to support the delivery of this strategic objective.

Year 2 (2013/14)			
Reviews	**Pathway Re-design**	**Pilots**	**New Services**
• *Weight management / Integrated obesity pathways*	• *Paediatric pathway for non-elective emergencies* • *Paediatric pathway to improve access to physiotherapy services and audiology services*	• *E-mail rapid advice service* • *Community ophthalmology service* • *Community cardiology clinic* • *Pilot for primary care urgent care provision including nursing and care homes.*	• *Community bed provision including intermediate care beds* • *Pulmonary rehabilitation (countywide provision)* • *Community COPD clinic* • *Community diabetic clinic* • *Erectile dysfunction clinic* • *On-line education tool for diabetes* *(Grey text intentions dependant on outcomes of review/pilot)*
Year 3 (2014/15)			
Reviews	**Pathway Re-design**	**Pilots**	**New Services**
To be determined	*To be determined*	*To be determined*	• *Community ophthalmology clinic* • *Community cardiology clinic* • *Primary care support for urgent care provision at nursing and care homes* • *E-mail rapid advice service.* *(Grey text intentions dependant on outcomes of review/pilot)*
What we'll measure to see if it's working:			
• Premature Mortality from Conditions (Cancer, CHD etc.) • Obesity Rates (Childhood and Adult) • Disease Management QOF Performance • QOF Disease Prevalence			

What targeted interventions are we doing to reduce the premature deaths with Cancer, CVD?- Are we reviewing the outcomes from our smoking cessation services as biggest contributory killer for Darlington population.
How are we targeting the wards where life expectancy is the poorest?

Objective: Address the needs of the changing age profile of the population of Darlington

Link to case for change: *The population of Darlington is ageing, and with the associated long term conditions of an a more elderly population places a significant growing pressure on the local health economy*

Population change	✓	*"Around 37% of the population is aged 50+. This is projected to rise around 41% by 2020".*
Health need	✓	
Patient insight	✗	
Clinical insight	✓	
Service issue/opportunity	✗	

What we'll be doing to address this in the next three years:

Year 1 (2012/13)

Reviews

- *Align mental health staff to GP practices- (to be led by cluster mental health commissioning team)*
- *Urgent care provision within primary care and nursing/care homes*
- *Community bed provision including intermediate care beds.*
- *Community nurses, Matrons and specialist nurses.*
- *Chiropody/podiatry provision*

Pathway Re-design

- Community diabetic clinic
- Personality disorder pathway
- Osteoporosis pathway- primary and secondary care prevention.

Pilots

- *On-line educational tool for newly diagnosed diabetics.*
- *Community COPD Clinic*
- *Community diabetes clinic*

New Services

- *Acute exacerbation pathway (COPD)*
- *Psychosexual counselling provision*
- *Urgent care co-location with A&E*

(Grey text intentions dependant on outcomes of review/pilot)

CCG Initiatives

- *Embed Gold Standards Framework (GSF) in nursing homes*
- *Establish education and training packages to be delivered within care and nursing homes.*

Contribution from Partners (2012/13)

***PCT Cluster Long Term Conditions Team** : Commission Home Oxygen Assessment Service; Review End of Life Services; Review Intermediate Care Services; Whole System Development of Services to Deliver LTC Support, Including a Review of Community Nursing; Establish a Gold Standard Framework for Locality Registers for Patients who are in their Last Year of Life due to their Illness and Diagnosis*

***PCT Cluster Mental Health Team:** Deliver the National Dementia Strategy*

Darlington CCG will fully engage with partnership working to support the delivery of this strategic objective.

Year 2 (2013/14)			
Reviews	**Pathway Re-design**	**Pilots**	**New Services**
• *Weight management / Integrated obesity pathways*	*Not defined*	• *E-mail rapid advice service* • *Community ophthalmology clinic* • *Community cardiology clinic* • *Pilot urgent care primary provision/ pro-active primary care management in nursing and care homes.*	• *Community bed provision including intermediate care beds* • *Pulmonary rehabilitation* • *Osteoporosis pathway for primary/ secondary care prevention.* • *Chiropody/podiatry provision* • *Community COPD clinic* • *Community diabetic clinic* • *Erectile dysfunction clinic* • *On-line education tool for newly diagnosed diabetics.* *(Grey text intentions dependant on outcomes of review/pilot)*
Year 3 (2014/15)			
Reviews	**Pathway Re-design**	**Pilots**	**New Services**
To be determined	*To be determined*	*To be determined*	• *Community ophthalmology clinic* • *Community cardiology clinic* • *Urgent care provision and primary care management for nursing and care homes* • *E-mail rapid advice service* *(Grey text intentions dependant on outcomes of review/pilot)*
What we'll measure to see if it's working:			
• Estimate of hospital admissions from care homes (aged 65+) • Average secondary care health cost for patients aged 65+			

Objective: To take services closer to home for the people of Darlington

Link to case for change: *The CCG has a varied demographic profile including small urban populations, small towns and large under populated rural areas. This variety presents significant challenges as regards access to health and other services.*

Population change	✓
Health need	✗
Patient insight	✓
Clinical insight	✓
Service issue/opportunity	✓

"We send too many of our patients to secondary care facilities when potentially they could be treated in a more cost effective local setting which is more convenient for the patient"

What we'll be doing to address this in the next three years:

Year 1 (2012/13)

Reviews

- *Community, district and specialist nursing review*
- *Align mental health staff to GP practices.*

Pathway Re-design

- *Anterior knee, pain, mechanical knee pain and OA Knee*
- *Shoulder pain*
- *Lower back pain*
- *Foot pain*
- *Osteoporosis pathway.*
- *Community diabetic clinic*
- *Personality disorder pathway*

Pilots

- *Community bed provision including intermediate care beds.*
- *Psychosexual counselling*
- *Erectile dysfunction pilot*
- *On-line education tool for diabetes*
- *Community COPD clinic*
- *Community Diabetic clinic.*

New Services

- *Carpal Tunnel pathway*
- *Co-location of Urgent care and A&E with Darlington CCG initiative of ensuring more low level urgent care needs are met by increased primary care provision.Urgent care co-location with A&E*

CCG Initiatives

- *Agreeing primary care pre and post COPD exacerbation pathways*
- *Agreeing primary care pre and post asthma exacerbation pathways for under 16*
- *Continue with embedding best practice via POINTS tool for COPD management.*

Contribution from Partners (2012/13)

PCT Cluster Long Term Conditions Team: *Whole System Development of Services to Deliver LTC Support, Including a Review of Community Nursing*

PCT Cluster Mental Health *: Align Mental Health Staff to General Practice; Improve Access to IAPT*

PCT Cluster Urgent Care: *Deliver Urgent Care Strategy Including and Satellite by Appointment Service in Rural Areas*

Darlington CCG will fully engage with partnership working to support the delivery of this strategic objective.

Year 2 (2013/14)			
Reviews	**Pathway Re-design**	**Pilots**	**New Services**
• *Weight management / Integrated obesity pathways*	• *Paediatric pathway (non-elective)* • *Paediatric pathway to improve access to physiotherapy and audiology services.*	• *E-mail rapid advice service* • *Community ophthalmology clinic* • *Community Cardiology Clinic* • *Urgent care provision and primary care management for nursing and care homes*	• *Community bed provision including intermediate care beds* • *Community Pulmonary rehabilitation* • *Community COPD clinic* • *Community diabetic clinic* • *Erectile dysfunction clinic* • *On-line educational tool for newly diagnosed diabetics.* *(Grey text intentions dependant on outcomes of review/pilot)*
Year 3 (2014/15)			
Reviews	**Pathway Re-design**	**Pilots**	**New Services**
To be determined	*To be determined*	*To be determined*	• *E-mail rapid advice service* • *Community ophthalmology clinic* • *Community Cardiology Clinic* • *Urgent care provision and primary care management for nursing and care homes* *(Grey text intentions dependant on outcomes of review/pilot)*
What we'll measure to see if it's working:			
• Patient Survey Results • Travel Times • Heath Care Equity			

Objective: To manage our resources effectively and responsibly

Link to case for change: *The CCG has a varied demographic profile with a large mainly urban population with a rural fringe. Darlington has some of the most deprived areas in England, therefore we need to ensure we drive efficiencies within the healthcare system to free up resources to ensure we can commission effectively for good outcomes.*

Population change	✓
Health need	✗
Patient insight	✓
Clinical insight	✓
Service issue/opportunity	✓

"We send too many of our patients to secondary care facilities when potentially they could be treated in a more cost effective local setting which is more convenient for the patient"

What we'll be doing to address this in the next three years:

Year 1 (2012/13)

Reviews	Pathway Re-design	Pilots	New Services
• *Darlington Health Centre (Darzi centre)* • *Community, district and specialist nursing review* • *Align mental health staff to GP practices.* • *Urgent care provision within primary care and nursing/care homes* • *Community bed provision including intermediate care beds.*	• *Anterior knee, pain, mechanical knee pain and OA Knee* • *Shoulder pain* • *Lower back pain* • *Foot pain* • *Osteoporosis pathway.* • *Community diabetic clinic* • *Personality disorder pathway* • *Community diabetic clinic* • *Personality disorder pathway*	• *On-line educational tool for newly diagnosed diabetics.* • *Community COPD Clinic* • *Community diabetes clinic*	• *Carpal Tunnel pathway* • *Co-location of Urgent care and A&E with Darlington CCG initiative of ensuring more low level urgent care needs are met by increased primary care provision.Urgent care co-location with A&E*

Contribution from Partners (2012/13)

PCT Cluster Long Term Conditions Team: *Whole System Development of Services to Deliver LTC Support, Including a Review of Community Nursing*

PCT Cluster Mental Health *: Align Mental Health Staff to General Practice; Improve Access to IAPT*

PCT Cluster Urgent Care: *Deliver Urgent Care Strategy Including and Satellite by Appointment Service in Rural Areas*

Darlington CCG will fully engage with partnership working to support the delivery of this strategic objective.

Year 2 /3 (2013/14 – 2014/15)

Reviews	Pathway Re-design	Pilots	New Services
To be determined	*To be determined*	*To be determined*	*To be determined*

What we'll measure to see if it's working:

- Financial position

Cross-CCG commissioning

Where appropriate we will co-ordinate commissioning activities with neighbouring SCCGs to ensure economies of scale, spread cost and maximise impact for specific programme areas. This may be done at service level (as in the review of community nursing) or across disease areas e.g. for patients with mental health needs and for those with learning disabilities. These programmes of work will be co-ordinated through the appropriate contract support lead with identified clinical leads within each SCCG.

Mental Health and Learning Disabilities

Review	Re-design / pilot	Commission / Implement
- Re-commission out of area placements	- Improve equity of autism assessment and diagnosis	- Deliver the local dementia strategy - Expand improving access to psychological therapies

These initiatives will be supplemented locally with the following initiatives:

?INSERT DARLINGTON SPECIFIC INITIATIVES

Partnership working

As well as co-ordinating commissioning activities with other SCCGs, we recognise that we must work closely in partnership with our local authority for the following reasons:

- To support patients who need both health and social care
- To engage in the commissioning of services that will move to be the responsibility of local authorities in 2013/14 (in particular Public Health and Childrens' Services
- To make best use of public resource and avoid "cost-shifting" between the health and social care sectors
- To deliver our strategic objectives

Link to One Darlington Perfectly placed

Children's Services

The key initiatives delivered in this way for children's services are to:

Review	Re-design / pilot	Commission / Implement
- Children's nursing service - Services for children with disabilities - Children and young people's occupational therapy services - Children and young people's physiotherapy services - Children and young people's speech and language therapy services - Youth offending services - Maternity services	- Re-design the enuresis referral pathways - Re-design paediatric pathways	- Implement the 'a call for action' health visitor expansion programme and the expansion of the family nurse partnership - Implement the national autism plan for children - Implement best practice for paediatric diseases - Implement the safe at home project - Commission locality based emotional wellbeing workers - Commission to increase breast feeding rates - Commission childhood obesity pathway support including healthy eating and the Mind Exercise and Nutrition Do it (MEND) project.

These initiatives will be supplemented locally with the following initiatives:

INSERT DARLINGTON SPECIFI C INITIATIVES HERE

Ref Darlington CYP plan- to add info from Mel Brown

Public Health

Review	Re-design / pilot	Commission / Implement
- Review and expand exercise on referral programmes across County Durham	- Pilot an enhanced 12-week smoking quitters service	- Expand access to community weight management services across County Durham and Darlington - Commission maternal obesity brief intervention training for agencies to access across County Durham and Darlington - Commission physical activity interventions for pregnant and post natal women across County Durham and Darlington - Re-commission the Healthchecks programme

These initiatives will be supplemented locally with the following initiatives:

INSERT DARLINGTON SPECIFIC LINKED INITIATIVES HERE

Joint commissioning

There are many opportunities for health and social care improvements to be led by jointly involving health and local authority commissioning. We will look to work closely with our local authority partners to fully understand the services that are currently jointly commissioned between health and social care.

A key feature of this will be to understand the impact the schemes funded through the Fund for Joint Working on Health and Social that was given to

PCTs to passport to local authorities using a Section 256 agreement. This fund was made on a two-year non-recurring basis for 2011/12 and 2012/13.

Add in values

This funding was directed to be used to develop new services and ensure the maintenance of current services that make an impact on issues identified in the Joint Strategic Needs Assessment. The Operating Framework has given no indication that this funding shall be made available again in 2013/14 so an assessment needs to be made against the impact of the withdrawal of funding for each of the services funded by this allocation. Plans will then need to be made to mitigate the risk of withdrawal of the service or to jointly identify alternative sources of funding.

Another area of potential joint working is on the re-ablement agenda. National funding has been made available to support the better re-ablement of patients waiting for discharge for a hospital setting. We will build on the work already undertaken across Health and Social Care to make best use of this investment.

TO INSERT COMMENT ON SPECIFIC JOINT WORKING WITH DBC HERE-JSCG PRIORITIES ETC

Delivering our Strategy

Darlington shadow CCG has developed its strategic objectives from the practice level upwards with significant contribution and involvement from GPs and other staff from the member practices as well as stakeholders and the public.

Within the new NHS architecture, Darlington CCG will be unable to achieve its goals and responsibilities in isolation. It needs to ensure it has the knowledge and skills to understand the relationships they need as good commissioners and good corporate citizens, and how to get the most out of these relationships.

Our CCG understands the importance of and has a track record of good collaborative working with other commissioners, particularly local CCGs, Darlington Borough Council and the emerging NHS Commissioning Board. The three local CCGs in County Durham and Darlington are developing how to work together including areas for federated working and risk sharing.

Darlington CCG intends to deepen its already close working relationship with Darlington Borough Council, particularly in their commissioning functions for local people and work is already underway to develop the public sector partnership.

Work is underway with colleagues in the PCTs to determine how the CCG will access the commissioning support it needs. Whilst limited staff will sit within the CCG itself, most capability and expertise will be drawn from the developing Commissioning Support Unit at local and potentially north east-wide levels. The CCG will be involved in formulating the 'core offer' both for commissioning support and public health.

The Darlington Pathfinder projects are already providing evidence of local clinical leadership and engagement underpinned by a better understanding of local population needs and system wide opportunities to improve patient outcomes and quality of service provided. This learning must be built upon to ensure that the CCG develops the knowledge, skills and mindset to shape care and services that improve outcomes for Darlington.

Behavioural change - public

We will use what we know about our communities to engage with different people and groups in ways that best meet their needs, and to communicate messages which aim to improve health.

We will utilise the intelligence gained through our engagement activities to ensure patients', carers' and the public's experiences, views and opinions are integral to our planning and commissioning of services. We will also make us

of links with demographic data held locally to support targeted engagement activity.

We will also develop our relationships with partners and providers and our engagement with communities, and better record the information we receive, to ensure increased impact on shaping local health services and health outcomes.

We will develop working relationships between the SCCG and Commissioning Support functions to ensure that patient experience data requirements are clearly included in service specifications and provider contracts; and are linked to performance and quality improvement.

We will also work in partnership with public health and health prevention professionals to actively contribute to the health prevention agenda through collaborative social marketing approaches.

Mechanisms for engagement and Communications

Successful engagement will ensure that we make decisions about the commissioning, delivery and development of services which are in line with local needs and reflect the wishes of local people.

The following are the key levels at which we will deliver engagement. These have informed the development of the Localised Operational Engagement Plan.

- Reputation/credibility - shaping overall relationships with patients, the public and other key stakeholders;
- Strategic engagement - involvement with local engagement and scrutiny structures e.g. Health and Wellbeing Boards, Overview and Scrutiny functions, LINks and HealthWatch over vision and plans;
- Service user involvement and patient experience - delivering service / pathway developments and changes;
- Systems and processes - developing and maintaining key mechanisms and networks which support engagement activity.

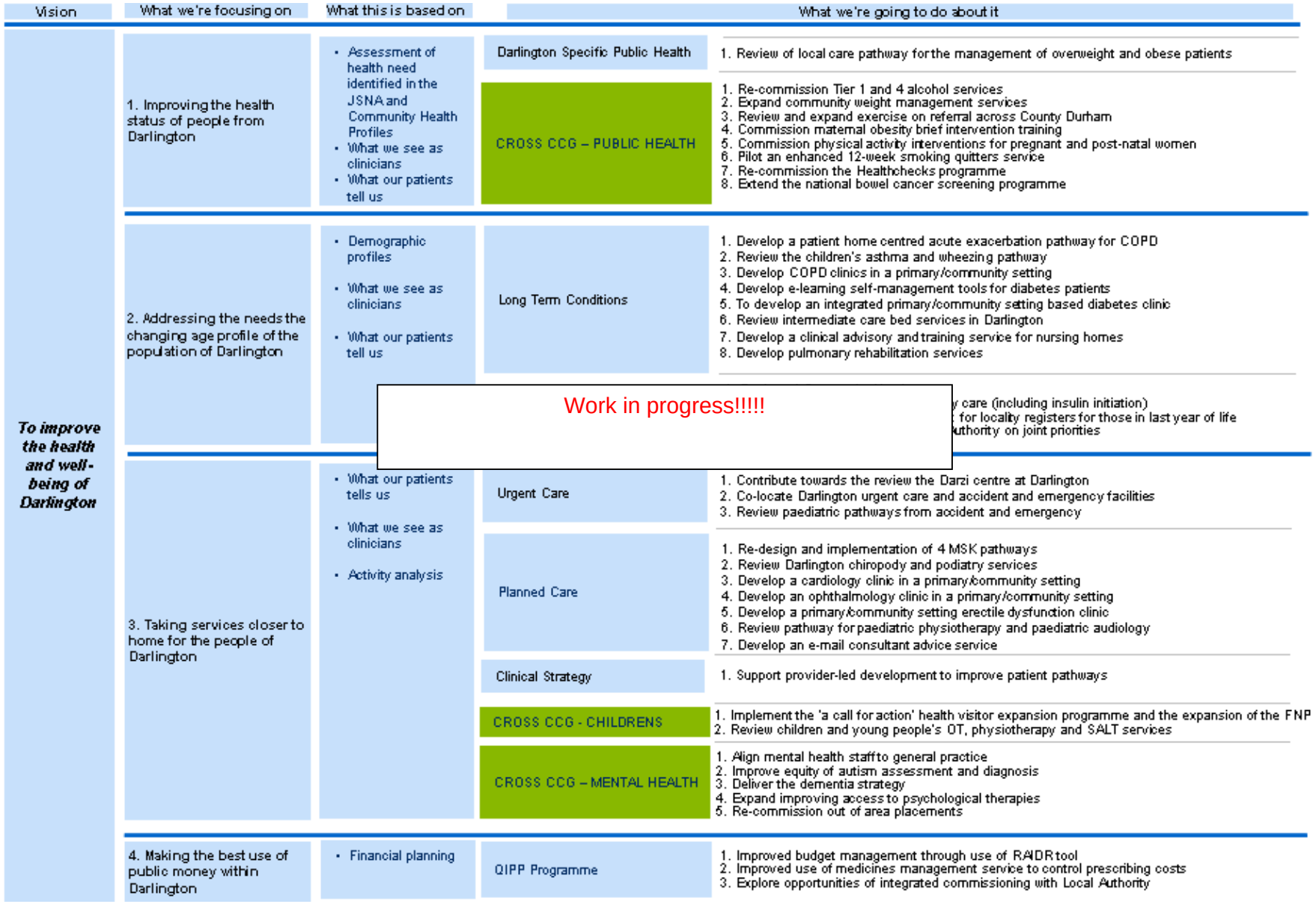
The delivery of the Localised Operational Engagement Plan is supported by a Patient and Public Involvement Toolkit, which has been developed to enable engagement throughout the commissioning cycle. This provides links to key channels and a range of techniques for informing, engaging and involving patients, carers and the public.

Equality and Diversity

In order to ensure that no groups or individuals are disadvantaged by our commissioning activities, we have carried out a full Equality and Diversity Screening assessment of our plan (see appendix X).

Further screening assessments will be carried out at service level when re-designing or commissioning pathways of care.

Strategy on a page



Governance

Governance arrangements for Darlington shadow CCG are still to be finalised. These arrangements are being developed in anticipation of the statutory body for health commissioning being clinically led as from April 2013. The governance arrangements are to recognise that the CCG comprises twelve constituent member GP practices each of which will be required to participate in commissioning activity.

During this transition period, prior to Darlington shadow CCG being fully authorised, the shadow CCG Board is established as a sub-committee of the PCT Cluster Board.

The CCG sub committee will have a membership comprising:

- three GP clinical lead representatives from Darlington practices,
- an interim chief operating officer (ICOO) who is an executive director of the PCT,
- a PCT non-executive director (NED),
- a lead nurse,
- a senior finance lead,
- the director of public health,
- lay representatives,
- local authority representative.

In the slightly longer term an accountable officer will need to be appointed when there is clearer understanding of the national requirements and person specification for this role. The terms of reference for the CCG sub-committee have been developed and agreed and articulate the responsibilities that have initially been delegated from the PCT to DSCCG.

The CCG subcommittee will have a membership comprising: three GP clinical lead representatives, an interim chief operating officer (ICOO), a PCT non-executive director (NED) as interim chair, a nurse lead, a finance lead, a public health representative and one or two lay representatives. The terms of reference for Darlington shadow CCG sub-committee have been developed and agreed and articulate the responsibilities that have been delegated from the PCT to the CCG.

An executive group is currently under development to support the work of the CCG subcommittee where the membership currently includes the three GP

Chairs, the ICOO, the deputy director, the commissioning project lead and the finance lead. The main purpose of the group is to oversee the operational management of the CCG in its commissioning role and ensure, in the short term, that the CCG successfully assumes commissioning responsibilities from the PCT and achieves full authorisation.

Beneath the subcommittee level there is a clinical board with representatives from every practice in Darlington.

As described earlier we are currently working on significantly strengthening the organisational configuration for public, patient and stakeholder involvement – this work is being taken forward by a joint communications and engagement group comprising local authority, PCT cluster and SCCG and Public Health.

The clinical board and other sub group arrangements are currently under review to ascertain whether they are fit for purpose to deliver the business of the organisation and support clinicians to lead the commissioning process.

The final governance arrangements will capture and reflect the benefits of economies of scale and sharing of financial and other risks, in particular the ability to achieve financial balance.

Finance

Using the planning assumptions outlined earlier, Darlington CCG has ensured that this plan can be implemented in a range of financial scenarios through robust prioritisation of investment, realistic contracting of variable activity (acute tariff, prescribing and continuing healthcare) and delivery of efficiency through QIPP schemes. The main features of the three scenarios can be described as follows:

Base Case (Likely) Scenario

In this scenario the CCG will contract for a realistic level of activity over the life of the plan based on past activity performance and forecast future demand. Unallocated resource would be invested in the series of prioritised initiatives that will improve health outcomes, reduce health inequalities identified and bring care closer to peoples' homes.

Upside Scenario

In this scenario the CCG will again contract for a realistic level of activity over the life of the plan. The additional unallocated funding will be used to go further, faster on the delivery of the strategic priorities and to incentivise providers to further improve quality and experience for our patients who use their services.

Downside Scenario

In this scenario the CCG would shift the focus of activities to the management of demand and mitigation of cost increases. The CCG would contract for lower than expected levels of activity and use all the available levers to manage demand. This would include more time spent on the reduction of variation in referral patterns, introducing elective pathway changes (funded from the 2% non-recurring element of the allocation) and helping patients, particularly the elderly and those with long term conditions avoid admission to secondary care.

The full details of these scenarios and the wider financial strategy of the CCG can be found in appendix 6.

Risk Assessment and Ongoing Monitoring

The CCG has carried out a full assessment of this plan using a standard scoring methodology to understand the key risks to the delivery of the plan, the state of the CCG to implement it and the financial resilience of the CCG and wider health economy.

The top three risks are:

1.

2.

3.

To be completed after full risk assessment

Full details of the methodology, risks and mitigations can be found in appendix 8.

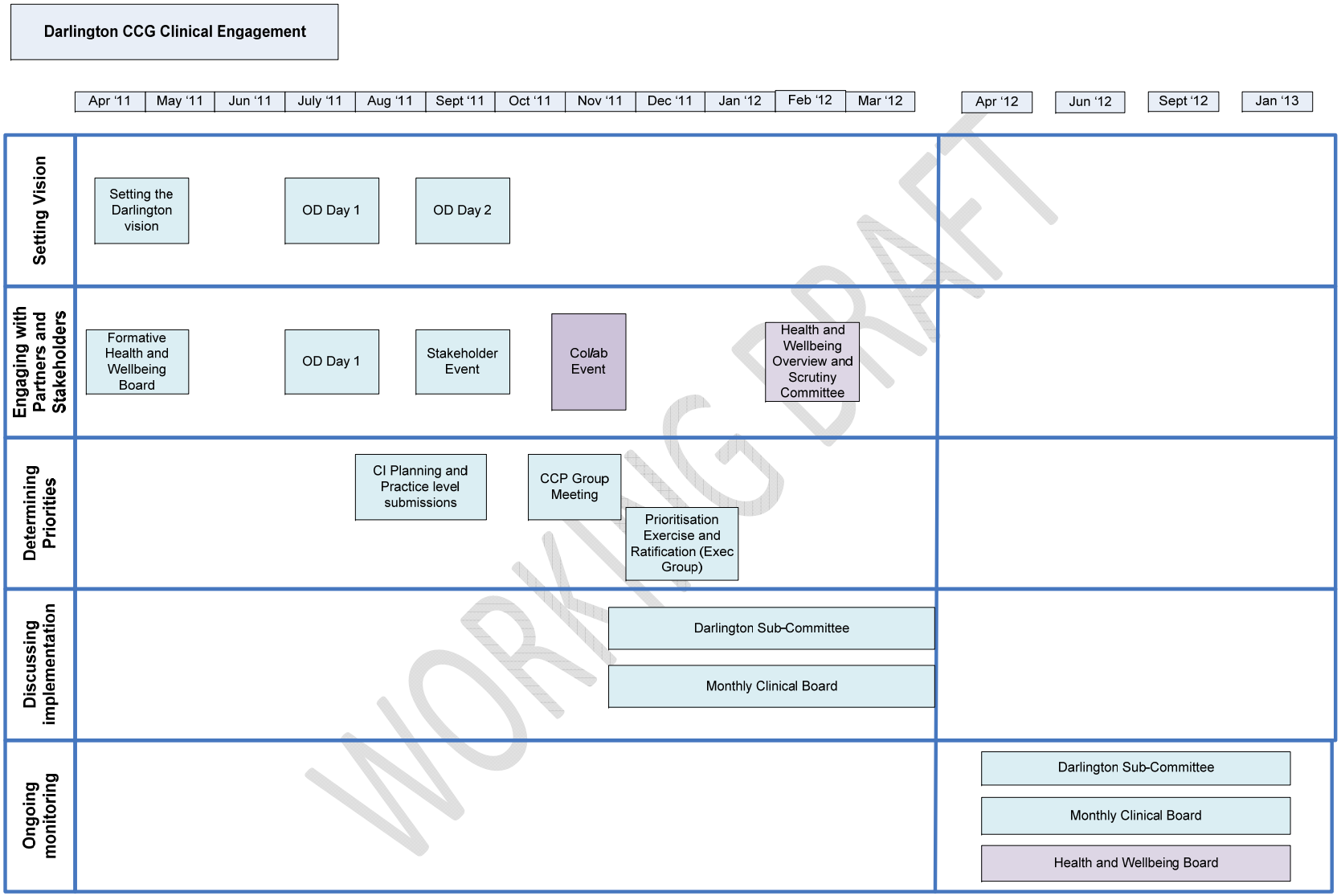
Ongoing monitoring

This Clear and Credible Plan was agreed through the formal CCG governance process at the following meetings:

XXXX

Performance monitoring of the implementation of the plan, impact of the strategic initiatives on their stated KPIs and associated health and quality outcomes will be monitored at both Locality and CCG Board level.

Developing and monitoring the plan –Touch points with clinicians and stakeholders



Appendices

Appendix 1: Overview of Health Needs

Appendix 2: Gap analysis

Appendix 3: Overview of Programme Budgeting

Appendix 4: Commissioning intentions

Appendix 5: Communication strategy and Engagement strategy

Appendix 6: Medium Term Financial Strategy

Appendix 7: Governance

Appendix 8: Full Risk Assessment

Appendix 1 – Overview of Health Needs

Key cross cutting health related messages from the Darlington Single Needs Assessment:-

Population Growth

- Darlington's population is ageing as a result of people living longer
- Darlington's aged 50+ population is projected to rise to 40.9% of the total population by 2020. The aged 75+ population is projected to increase to 10% of the total population
- Darlington has some of the most deprived areas in England, and is ranked 79th most deprived local authority out of 324 in England
- There are almost 4,200 older people are living in poverty in Darlington (ONS Mid 2008 LSOA population estimates).

Life expectancy

- People are living longer however inequalities in life expectancy exist *between* Darlington and England. For example, life expectancy for;
- Men living in Darlington are living 1.7 years less than the England average (Darlington Health Profile 2011).
- Women living in Darlington are living 1.5 years less than the England average (Darlington Health Profile 2011). Check wording
- Inequalities in life expectancy exist *within* Darlington. For example:
    - Life expectancy for men living in the most deprived areas is over 13.4 years lower than for men living in the least deprived areas. For women it is 10.3 years lower (Association of Public Health Observatories 2010,)

Disease and mortality

- Early death rates from cancer and cardio vascular disease have fallen however they are higher in Darlington than the England average.

Cancer incidence in Darlington*:*

- Is higher for women than men
- Is closely correlated with deprivation. The distribution of cancer incidence rates (2004-2008) in Darlington is not equal, it is higher in the more deprived MSOAs

Cancer mortality in Darlington is:

- Significantly higher for men than women
- Between 2007 and 2009 1,129 people in Darlington died aged less than 75 years
- Premature mortality rates (under 75years) for the 'biggest killers' (heart disease, cancer, stroke) in Darlington are higher than the England average.
    - Cardiovascular disease (CVD) and cancer account for around 63% of early or premature deaths in Darlington.
    - Smoking remains the biggest single contributor to the shorter life expectancy experienced locally

GP practice registered disease prevalence in Darlington is 20% higher than the England average for the following diseases

- Chronic Obstructive Pulmonary Disease (COPD – also the second most common cause of emergency admissions to hospital)
- Coronary Heart Disease (CHD)

Childhood Obesity

- Childhood obesity shows a significant variation in prevalence between reception and Year 6. Year 6 prevalence is almost double that of reception
- Childhood obesity prevalence in reception does not vary within Darlington; however there is variation in obesity prevalence in Year 6 children.

Poverty is key determinant of what families eat.

- Overweight young people have a 50% chance of being overweight adults
- Breast feeding is a major contributor to good health in both mother and child

Teenage Conceptions

- Teenage conception rates in Darlington are higher than the England average but have been falling over time
- there is a strong relationship between teenage conceptions and deprivation within Darlington
- Prevention of under 18 years conceptions is central to improved outcomes for young women and men

Alcohol

- Darlington has significantly higher rates of hospital admissions for alcohol related harm for both men and women compared to the England average
- Binge drinking prevalence is estimated to be 31% in Darlington, higher than 18% estimated adults who binge drink nationally
- The Social Norms Survey (a large scale drug and alcohol survey carried out in Darlington Schools) is the basis for development of positive messages to reinforce healthy choices with young people.

Substance Misuse

- Drug misuse is a complex public health issue which also has links with crime and disorder. The DAAT (Darlington Drug and Alcohol Action Team) commissions prevention activity and treatment services
- Most young people in Darlington do not misuse drugs or alcohol
- PDU (Problem Drug User) data suggests the majority of opiates users in Darlington are known to treatment
- Service data indicate people under 25 years are more likely to report cannabis, alcohol or cocaine use, while over 25 years were more likely to report opiates or amphetamine use
- Men are more likely to use drugs and access treatment than women.

Adult Obesity

- The Darlington Health Profile (201) reported that there is higher prevalence of obese adults in Darlington (26%) than England average (24%)
- NHS Health Checks programme has to date screened 5,561 patients between the age of 40 and 74, this population had an obesity rate of 30%
- The Darlington Sport and Physical Activity strategy is broadly based in approach and engages private and public sector partners.

Dementia

- The effect of an ageing population will include an increase in the numbers of people living with dementia, their health and social care needs and the needs of their carers
- Dementia prevalence is predicted to rise in Darlington to 8.1% by 2030 i.e., the proportion of people aged 65 years and over
- Dementia is the main cause of mental health admissions among older people.

Learning Disabilities

- The number of people with severe and profound learning disabilities is predicted to increase by 1% each year due to increasing life expectancy and the growing number of children with such disabilities
- In 2011 370 children attending school in Darlington had Special Educational Needs statement (2010 figure was 390). There were also 1,526 children receiving School Action support and 1,125 receiving School Action Plus support
- In 2009/10 there were 180 (71.9%) adults with learning disabilities known to Social Services who were in settled accommodation at the time of their last assessment there were also 15 (5.9%) adults with learning disabilities known to Social Services who were in employment

Inequalities exist both between Darlington, the NE region and England but also within Darlington with Darlington having some of the most deprived areas in England, and is ranked 79th most deprived local authority out of 324 in England.. Around 39% of Darlington's lower super output areas (LSOAs) are in the most deprived 30% nationally with almost 16% of Darlington's LSOAs are in the most deprived 10% in England

% of LSOAs by national deprivation deciles, Darlington. Source: ID2010, DCLG

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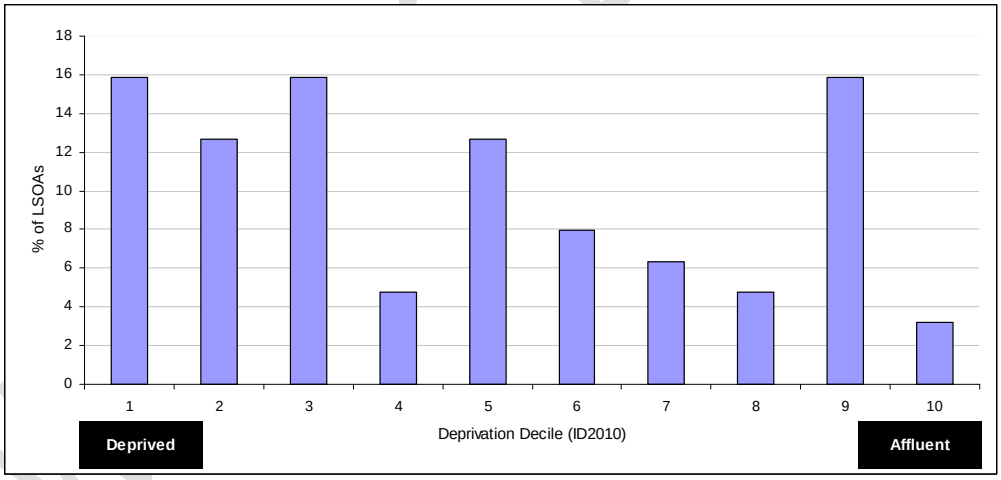

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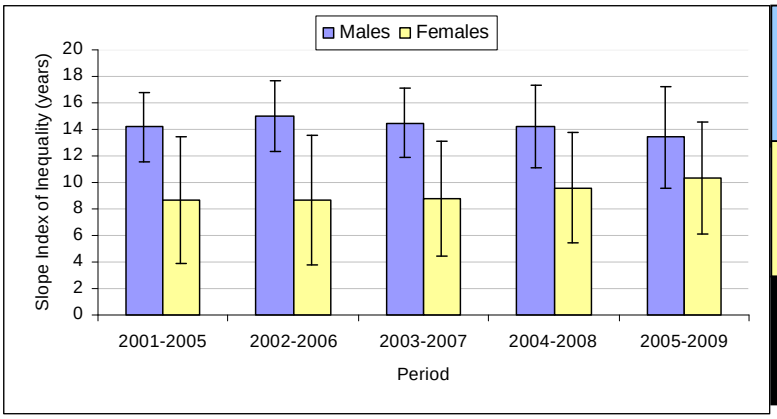
Inequalities in life expectancy exist *within* Darlington. For example life expectancy for men living in the most deprived areas is over 13.4 years lower than for men living in the least deprived areas. For women it is 10.3 years lower (Association of Public Health Observatories 2010).

Slope Index of Inequality for Life Expectancy by Deprivation Deciles – 2001-05 to 2005-09. Darlington.



The size of the gap in LE between rich and poor has fallen for males, but the difference is not statistically significant

The size of the gap in LE between rich and poor has increased for females, but the difference is not statistically significant

The size of the gap in LE between rich and poor is greater for males than females, but the difference is not statistically significant.

What does the Data tell us?

Darlington experiences significantly greater levels of premature deaths than England for many causes (SMRs figure). Between 2007 and 2009 1,129 people in Darlington died aged less than 75 years

SMRs which are statistically significantly higher in Darlington than England are:

1. Persons.

- COPD
- Acute myocardial infarction (AMI)
- Lung cancer
- All circulatory diseases
- All causes

2. Males.

- COPD
- AMI
- All circulatory dieases
- All causes

3. Females.

- COPD
- All causes

COPD

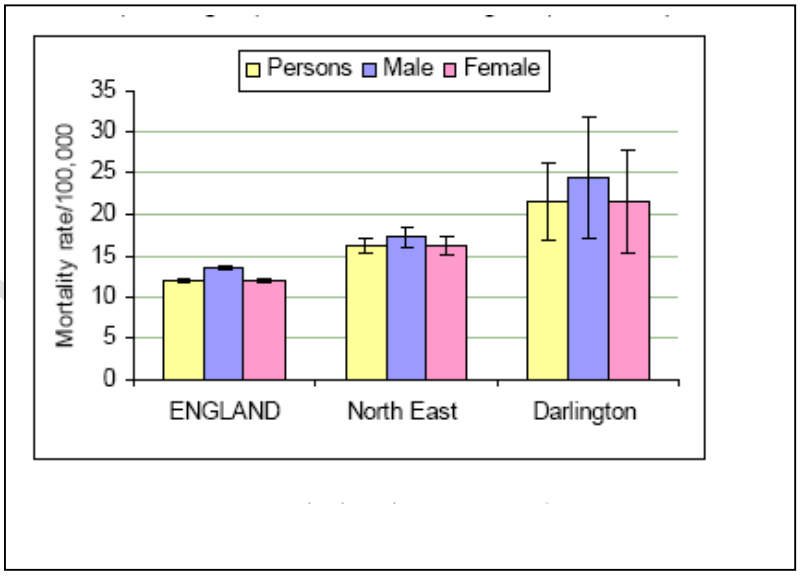
COPD prevalence is greater in Darlington (2.2%) than England average (1.6%). There are over 2,200 people registered with COPD in Darlington (QOF, 2009/10). This prevalence varies by practice by between 1% and 3%. It is estimated there are over 600 people in Darlington with undiagnosed COPD.

'*Invisible Lives – Chronic Obstructive Pulmonary Disease (COPD) – finding the missing millions*' (British Lung Foundation, 2007) estimated there are 2.8 million people in the UK with undiagnosed COPD, which if left untreated could severely restrict their lives and eventually kill them.

The COPD Prevalence Modeller (based on the Health Survey for England 2001 and a representative sample of the population of England who had lung function tests and data collected on relevant risk factors) estimates 600 patients with COPD in Darlington that have not been recognised by their GP ('missing').

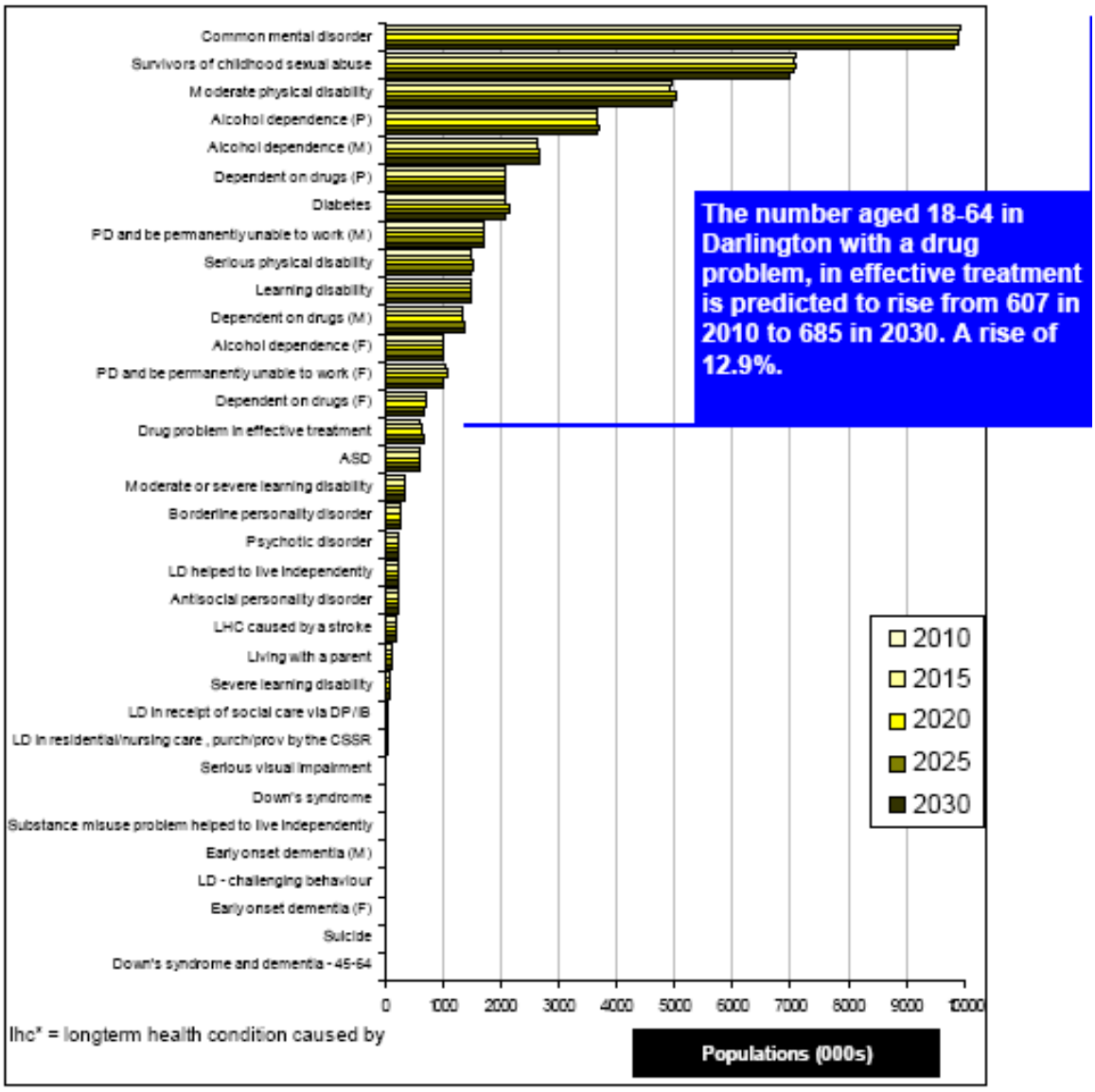
The model gives an estimate of the number of patients a practice could expect to have based on the population characteristics.
Premature COPD mortality rates for the period 2007-09 were significantly higher in Darlington than England for both males and females There was no significant difference between Darlington and the North East. During this period 78 people aged less than 75 died from COPD.

Directly age standardised premature mortality rates per 100,000 for COPD, Darlington, North East and England, 2007-09 pooled. Source: NCHOD.

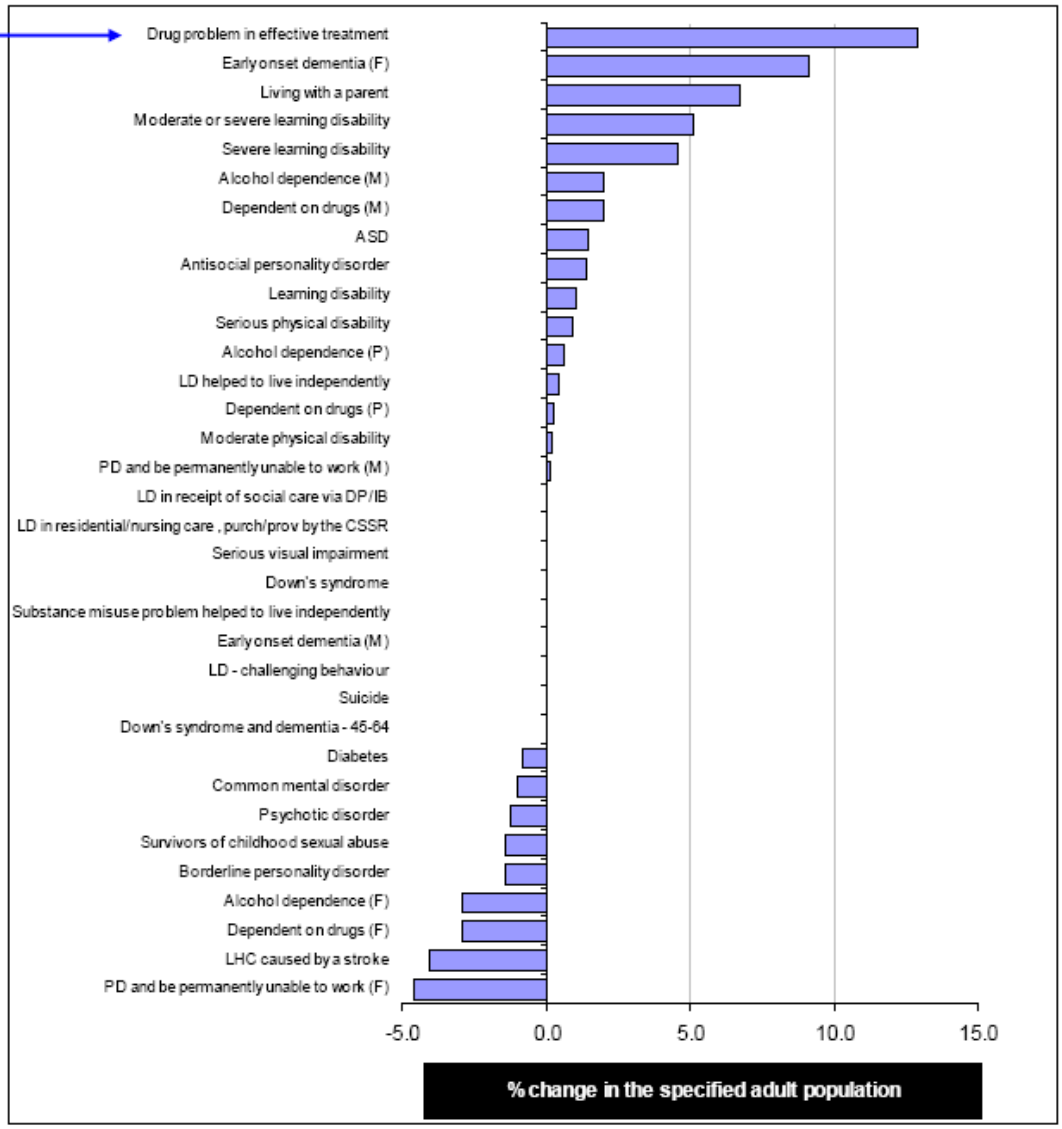


Mental Health

Prevalence modelling in health conditions likely to affect the care needs of those aged 18-64(2010-2030), Darlington. Source: PANSI, 2010.

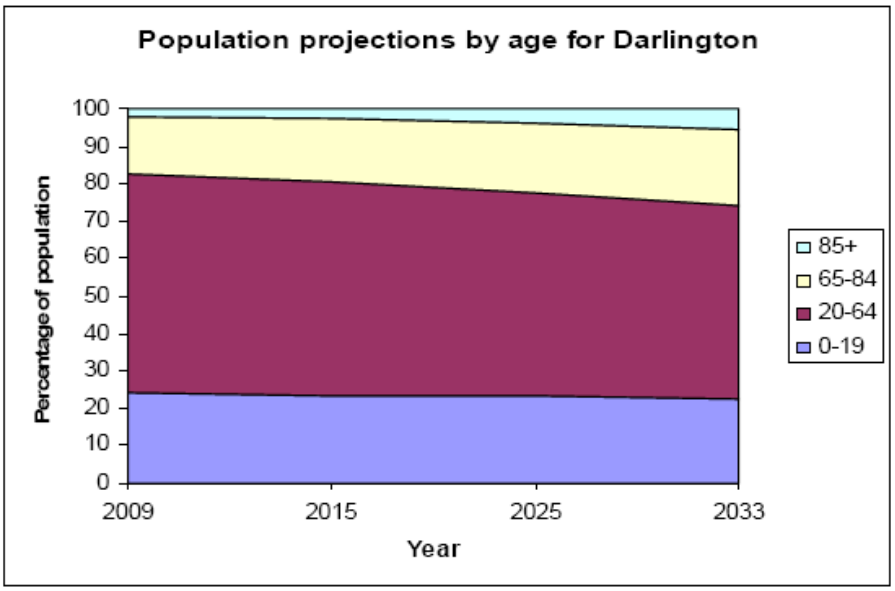


Projecting Adult Needs & Service Information System (PANSI)
% change over time (2010-2030)



The population projections show an increasing number of elderly people as illustrated in the graph below. The number of people aged 65 and over in Darlington is projected to increase from 17,400 in 2008 to 23,800 in 2023 and 29,100 in 2033. The number of people aged 85 and over is projected to increase from 2,400 in 2008 to 3,800 in 2023 and 6,000 in 2033.

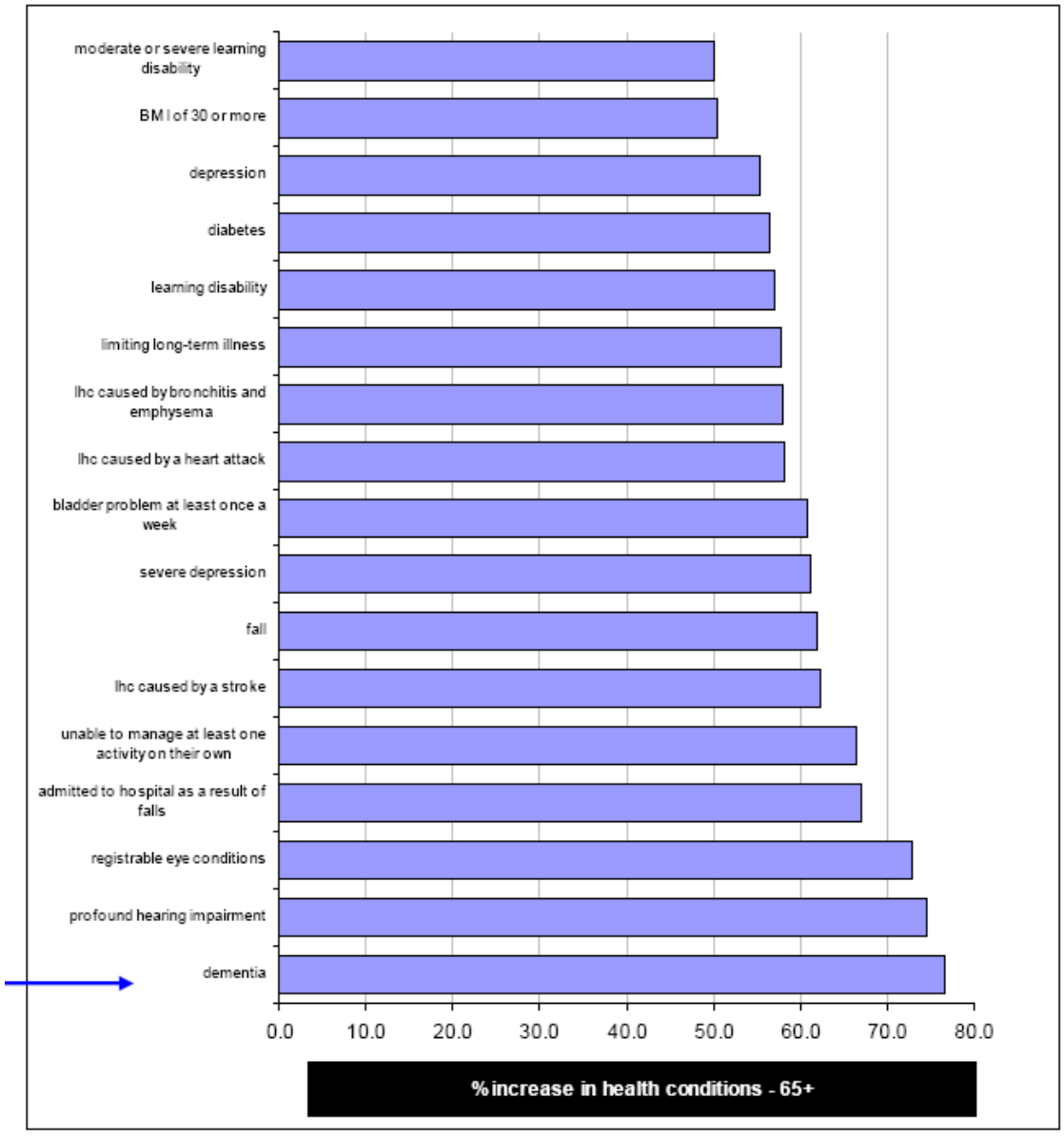
Population projections by age for Darlington (Source: ONS population projections)



This will have an impact on the prevalence of long term conditions overtime as well as the levels of dependency found in Darlington. The graph below shows the projected percentage change over time for significant health conditions for those over 65 years. Local QOF data (2009/10) indicates a prevalence of 0.6% for dementia for Darlington against a regional and national average of 0.5%. Dementia prevalence is predicted to increase in Darlington between 2010 and 2030. The proportion of people aged 65 and over with dementia in Darlington is predicted to increase from 7.1% in 2010 to 8.1% by 2030, a rise of nearly 1,000 cases.

Nationally, dementia is the main cause of mental health admissions among older people, accounting for 41% of all mental health admissions (21% unspecified dementia, 14% vascular dementia and 5% Alzheimer's Disease) (APHO, 2008).

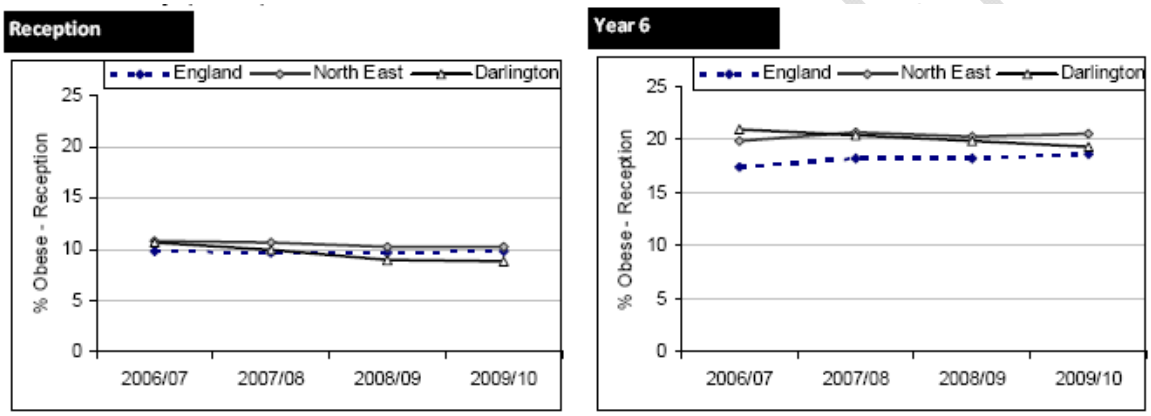
The national hospital admissions rate for dementia amongst 75- 79 year olds is approximately 200 per 100,000 rising to around 600 per 100,000 at 85 and over. The overall admissions rate for over 65's for dementia nationally (ibid). It is estimated that after the age of 60 the prevalence of dementia doubles every five years so that about 22% at 85 and 30% of those aged over 95 are affected.


moderate or severe learning disability
BMI of 30 or more
depression
diabetes
learning disability
limiting long-term illness
Ihc caused by bronchitis and emphysema
Ihc caused by a heart attack
bladder problem at least once a week
severe depression
fall
Ihc caused by a stroke
unable to manage at least one activity on their own
admitted to hospital as a result of falls
registrable eye conditions
profound hearing impairment
dementia
0.0
10.0
20.0
30.0
40.0
50.0
60.0
70.0
80.0
% increase in health conditions - 65+

Childhood Obesity

Childhood obesity is a key public health issue, posing a major health challenge and risk to future health and wellbeing and life expectancy in Darlington. Obesity prevalence varies significantly between reception and year 6 in Darlington, the North East and England Obesity prevalence in Darlington is not significantly from England or the North East for reception or year 6. Rates in both reception and year 6 have seen little variation over time in Darlington, the North East and England

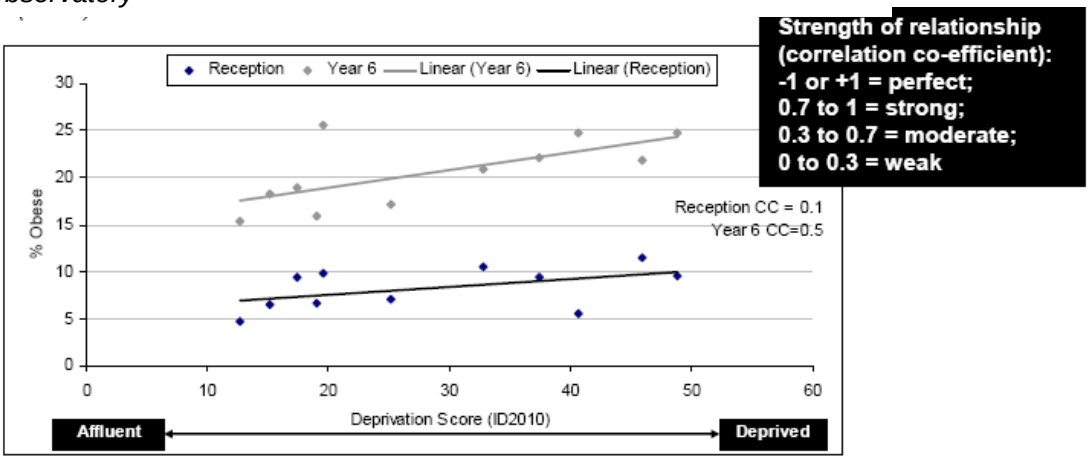
Obesity prevalence 2006/07-2009/10, Reception and Year 6, England, North East and Darlington. Source: NCMP 2009, National Obesity Observatory (NOO).



Overweight young people have a 50% chance of being overweight adults, and children of overweight parents have twice the risk of being overweight compared to those with healthy weight parents. Obese 10 to 14-year olds with at least one obese parent have a 79% chance of becoming obese adults (Whitaker et al (1997) cited in Kopelman *et al* (2004, p4).

Currently there is inequitable access to evidence based material, support to tackle obesity and specific targeted interventions for children and young people across Darlington.

Obesity prevalence and deprivation, Reception and Year 6, Darlington MSOAs. Source: NCMP 2007-09, National Obesity Observatory



Overweight young people have a 50% chance of being overweight adults, and

Poverty is the key determinant of what families eat. It is suggested that lower income families spend a much higher proportion of income on food than higher income families.

The link between sustained breast feeding and deferred weaning (to at least six months) and reduced risk of childhood obesity is increasingly well established. There is now good evidence of the link between breast feeding and improved emotional attachment between infant and mother.

Appendix 2 – Gap Analysis

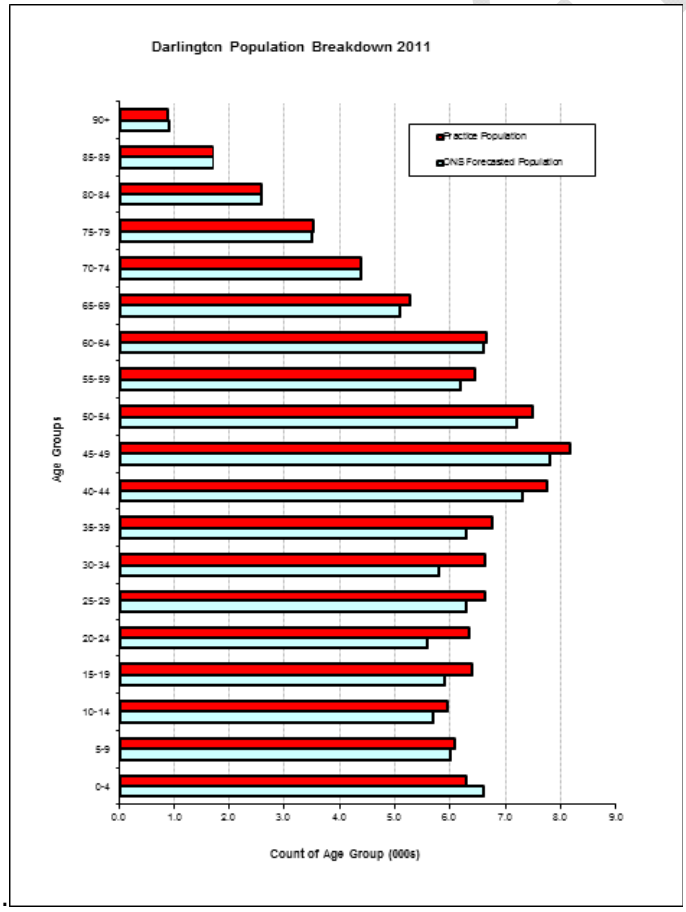
Through the health care planning process to meet the necessary timelines to both inform contract negotiations and inform healthcare providers of potential service changes Darlington CCG developed a set of commissioning intentions. Since this process a more locally focussed population profile has become available. This document is embedded below:

Population Health Profile - Darlington.pc

The purpose of the gap analysis is to ensure that the derived commissioning intentions delivers against any local issues identified in the health profile.

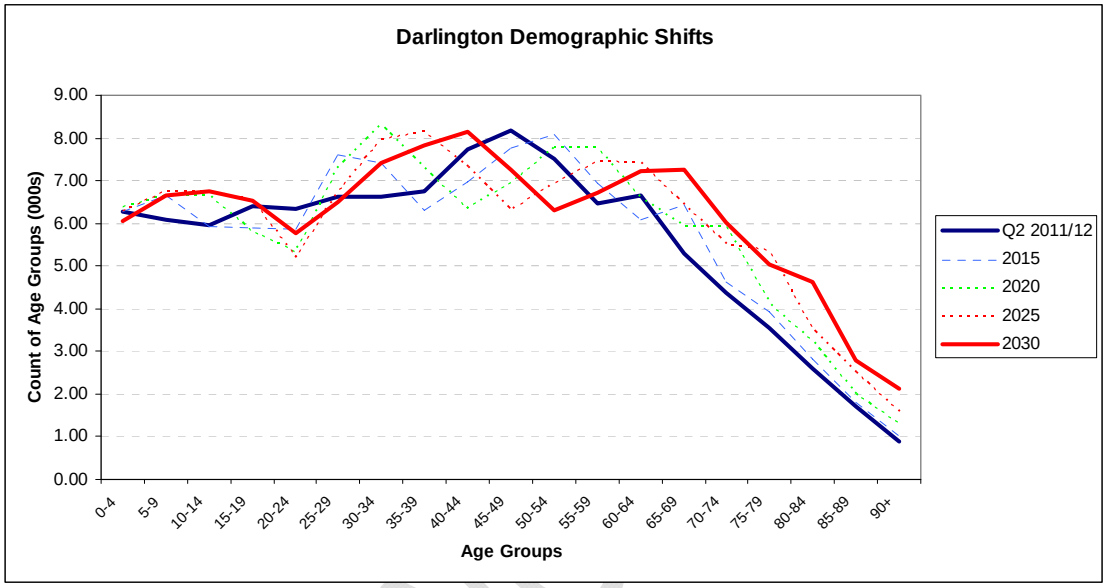
Demographic Changes

The ONS residential populations over the past 3 years have been significantly less than the population that is registered at general practices within Darlington CCG. The table below illustrated the extent of this difference



In order to plan for services, and address the need for the ageing population it is necessary to forecast the change in registered practice population. This was done by applying an error multiplier derived from average difference from previous 4 years applied to the ONS growth forecasts. Full methodology can be provided under request but due to the file size it has not been embedded.

Demographic Shifts in GP Registered Population



From the diagram above it can be clearly seen that over the next twenty years Darlington have registered practice population that are ageing. Ageing population make a higher demand on health services.

The table below indicates some key issues that the analysis has revealed:

	Age Group	2011/12 Q2	2015	2020	2025	2030
Darlington	0-19	24.71	24.72	25.44	26.3	26.01
	20-64	62.87	63.09	63.62	63.46	63.14
	65+	18.39	20.62	22.5	24.9	27.88
Total		105.96	108.44	111.55	114.66	117.03

By 2030 it is forecasted that there will by a 51% increase in the over 65 registered population in the Darlington CCG, with the other age groups remaining relatively stable (within -/+ 5%).

QOF Prevalence

The tables below provides Darlington CCG level QOF prevalence health data benchmarked against the North East (SHA) average and England average as included in the Darlington health profile. Red represents an indicator which is worse than the England average and the North East average; amber represents where the indicator is than the England average **or** the North East average; green represents where the indicator is better than the England average and the North East average.

		Defintions of RAG ratings		
Applies to County Durham and Darlington		If worse than England and Northeast = Red		
		If worse than England but not the NE = Amber		
Applies to DDES, North Durham, Easington, Sedgefield, Dales, Derwentside and DCLS		If worse than England, NE and CD = Red		
		If worse than England and NE but not CD = Amber		

Table 1.1 QOF Prevalence

Disease Area	England		North East		Darlington	
	2009/10	**2010/11**	*2009/10*	**2010/11**	*2009/10*	**2010/11**
Chronic Obstructive Pulmonary Disease Register		1.60%		2.50%		2.30%
Heart Failure Prevalence		0.70%		0.80%		0.80%
Coronary Heart Disease Prevalence		3.40%		4.60%		4.20%
Stroke / Transient Ischaemic Attacks (TIA) Prevalence		1.70%		2.20%		2.00%
Obesity Prevalence (16+)		10.50%		13.10%		13.70%
Hypertension Prevalence		13.50%		15.30%		14.20%
Diabetes Mellitus (Diabetes) Prevalence (ages 17+)		5.50%		5.90%		6.30%
Mental Health Prevalence		0.80%		0.80%		0.90%
Asthma Prevalence		5.90%		6.20%		5.80%
Smoking Prevalence		n/a		n/a		n/a
Cancer Prevalence		1.60%		1.70%		1.50%
Epilepsy (18+)		0.80%		0.90%		1.00%
Hypothyroidism		3.00%		3.70%		3.10%
Palliative Care		0.20%		0.20%		0.40%
Dementia		0.50%		0.60%		0.70%
Depression (18+)		11.20%		15.10%		13.20%
Chronic Kidney Disease		4.30%		5.00%		4.40%
Atrial Fibrillation		1.40%		1.60%		1.60%
Learning Disabilities (18+)		0.40%		0.60%		0.50%

APHO derived Locality health indicators

Figure 21 and 22 in the locality Health Profile's provide information at Middle Super Output Level on some key health indicators. Unfortunately, this information is not readily available at the locality level, and due to a complex methodology it is not easy to definitively derive. However, due to the similar (size and type) populations of a middle super output area (within the localities) it would be reasonable to estimate a proxy measure using an average of the locality MSOAs.

Table 1.2 APHO MSOA derived health indicators

Disease Area (09/10)	England Actual	North East Actual	Darlington Actual
Obese Children	18.7	20.6	19.4
Obese Adults	24.2	27.8	27.6
Adults who smoke	22.2	27.9	24.4
Binge Drinking	20.1	30.1	28.5
Healthy Eating (>Good)	28.7	21.5	23.5
All Cause Premature mortality	100.0	116.2	115.0
Premature cancer mortality	100.0	117.2	108.2
Premature CVD mortality	100.0	115.9	112.4
Premature CHD mortality	100.0	121.3	114.5
All age Stroke Mortality	100.0	108.7	113.3
All age Respiratory Mortality	100.0	116.2	101.1

		Defintions of RAG ratings		
		If worse than England and Northeast = Red		
Applies to Darlington		If worse than England but not the NE = Amber		

Summary of Health Needs

From the statistics presented, Darlington CCG has the following health outcome which are both worse than the England and Northeast average:

- Heart Failure Prevalence
- Obesity Prevalence
- Diabetes Mellitus Prevalence
- Mental Health Prevalence
- Palliative Care
- Epilepsy Prevalence
- Dementia Prevalence
- Atrial Fibrillation
- All Age Stroke Mortality
- Ageing Population

Gap Analysis – Is the need addressed by the interim Commissioning Intentions

Health Issue	Commissioning Intentions / Workstreams That will contribute towards: Prevention, managing demand (need), better treatment, managing any long term effects
CVD Issues: Heart Failure and Atrial Fibrillation	Darlington specific: - Community Cardiology Clinic - Intermediate Care Beds - Specialist Nursing Home Care Support Service Clusterwide: - Re-commission Health Checks Programme; - Review Intermediate Care services; - Whole Systems Development of services that deliver Long Term Conditions Support, including Community Nursing; - Gold Standard Framework for Locality end of life Registers.
Diabetes Mellitus Prevalence	Darlington specific: - Community Nursing - On-line training tool for diabetes - Diabetic Community Clinic - Intermediate Care Beds Clusterwide: - Review Intermediate Care services; - Whole Systems Development of services that deliver Long Term Conditions Support, including Community Nursing

All Age Stroke Mortality:	Darlington specific: None Clusterwide: - Re-commission Health Checks Programme; - Review Intermediate Care services; - Whole Systems Development of services that deliver Long Term Conditions Support, including Community Nursing; - Gold Standard Framework for Locality end of life Registers; - Develop a community stroke rehabilitation team across County Durham and Darlington The re-design of the Hyper Acute service will contribute. The anti-coagulation service currently in procurement will also contribute.
Obesity: Adult Obesity Prevalence	Darlington specific: - Integrated Obesity Pathways Cluster CIs: - Expand access to community weight management services - Maternal Obesity - Review of Exercise on Referral; Physical activity interventions for pregnant and post natal women.
Palliative Care: Percentage of registered patients on palliative care register	Darlington specific: - Community Nursing; - Intermediate Care Beds; - Specialist Nursing Home Care Support Service Clusterwide: - Review Intermediate Care services; - Whole Systems Development of services that deliver Long Term Conditions Support, including Community Nursing; - Establish a Gold Standard Framework for Locality Registers for Patients who are in their last year of life due to their illness and diagnosis

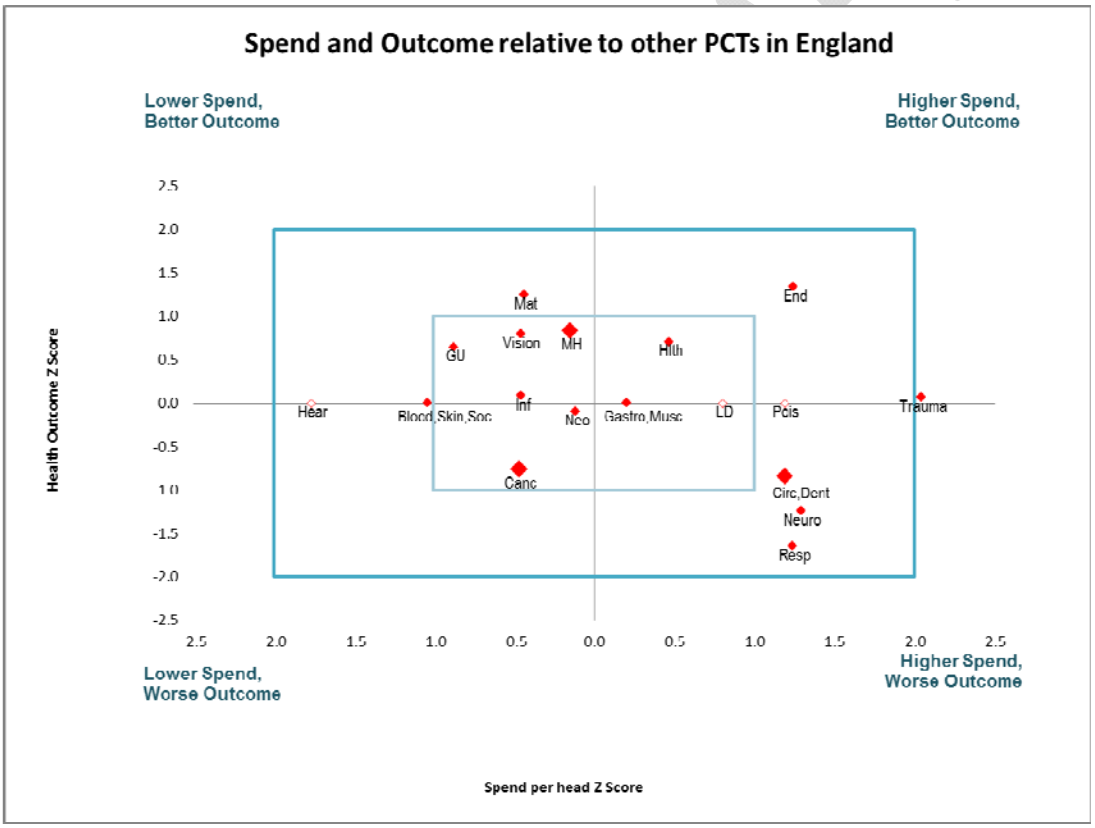
	The end of life rapid response pilot would contribute toward the end of life part of the palliative care pathway
Mental Health: Mental Health prevalence	Darlington specific: - Practice attached Community Psychiatric Nurse; Personality Disorder Pathway Clusterwide: - Align mental health staff to general practice; Expansion of Improving Access to Psychological Therapies; - Improve equity of autism assessment an diagnosis; - Deliver the dementia strategy; - Re-commission out of area placements.
Dementia: Dementia prevalence	Darlington specific: none Clusterwide: - Whole Systems Development of services that deliver Long Term Conditions Support, including Community Nursing
Epilepsy: Epilepsy prevalence	Darlington specific: None Clusterwide: - DDES CCG are developing an outreach Epilepsy service (which could cover the whole of the cluster)
Ageing Practice Population:	Darlington specific: - Community Nursing - Specialist Nursing Home Care Support Service Clusterwide: - Review Intermediate Care services; - Whole Systems Development of services that deliver Long Term Conditions Support, including Community Nursing

Appendix 3 – Overview of Programme Budgeting

Using the NHS County Durham and Darlington Annual Population Value Review (the local interpretation of programme budgeting data developed in-line with national best practice guidelines) the CCG has been able to understand (within the limitations of the data), the relationship between past investment and health outcomes.

As Darlington CCG shares a boundary with the predecessor commissioning PCT, a direct interpretation of the programme budget data is possible.

Figure X depicts the high level relationship between spend (low to high) and outcome (poor to good):

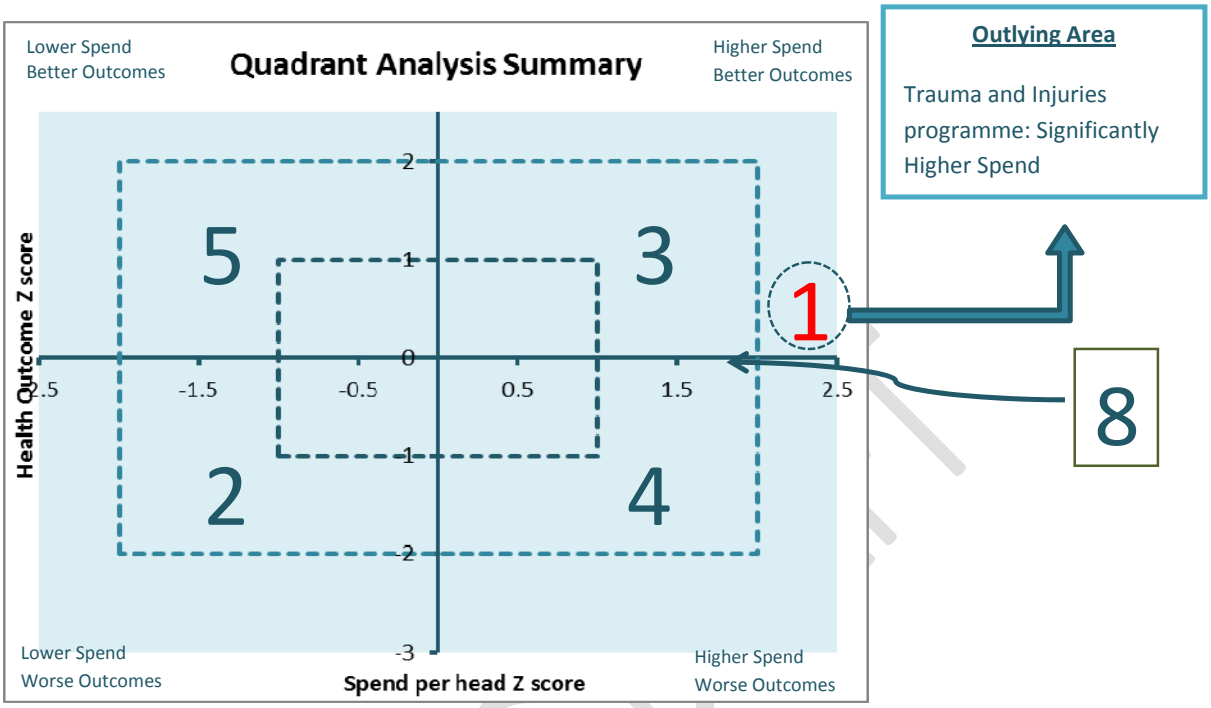


◇ No outcome indicators readily available
◆ Outcome indicators available

Programme Area Abbreviations

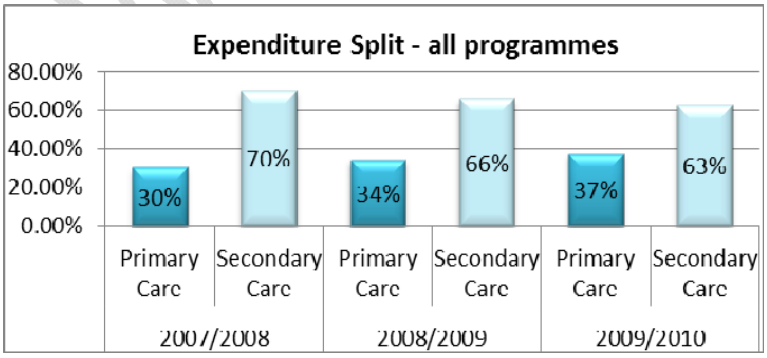
Infectious Diseases	Inf	Hearing	Hear	Disorders of Blood	Blood
Cancers & Tumours	Canc	Circulation	Circ	Maternity	Mat
Respiratory System	Resp	Mental Health	MH	Neonates	Neo
Endocrine, Nutritional & Metabolic	End	Dental	Dent	Neurological	Neuro
Genito Urinary System	GU	GI System	Gastro	Healthy Individuals	Hlth
Learning Disabilities	LD	Musculoskeletal	Musc	Social Care Needs	Soc
Adverse effects & poisoning	Pois	Trauma & Injuries	Trauma		

Figure X Darlington 2009/10 shows the programme budget spend and outcome summary.

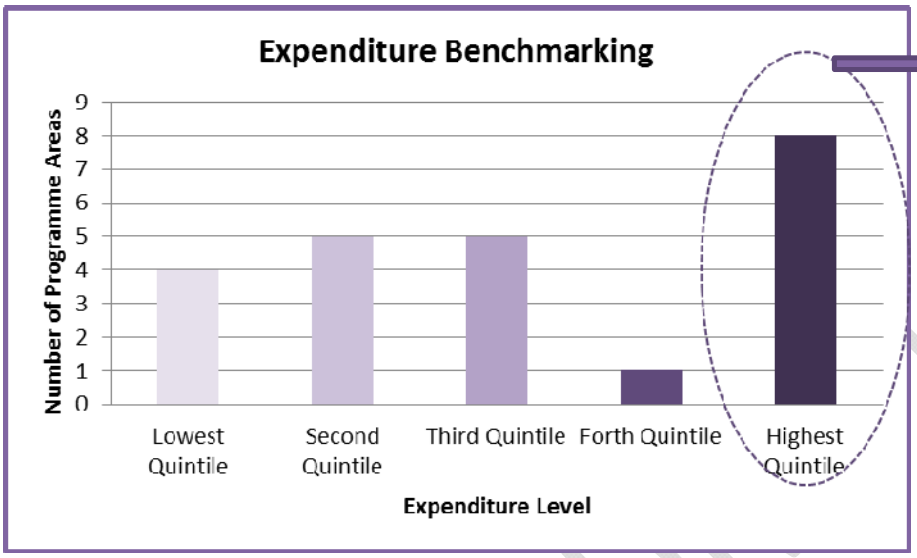


In 2009/10 Darlington PCT had:

- 3 programme areas within the high spend better outcome quadrant
- 5 programme areas within the lower spend better outcome quadrant
- 2 programme areas within the lower spend worse outcome quadrant
- 4 programme areas within the higher spend worse outcome quadrant
- 8 programme areas did not have a recommended outcome measure.
- Darlington PCT has 1 outlying programme area (greater the 2 standard deviations from the national average) within the quadrant analysis, which was the Trauma and Injuries programme area. The Trauma and Injuries programme area had a level of spend significantly greater than the national average.



In 2009/10 expenditure across all but 5 programme areas for Darlington PCT is greater in secondary care than primary care. Over the past three years the difference in proportion has decreased.



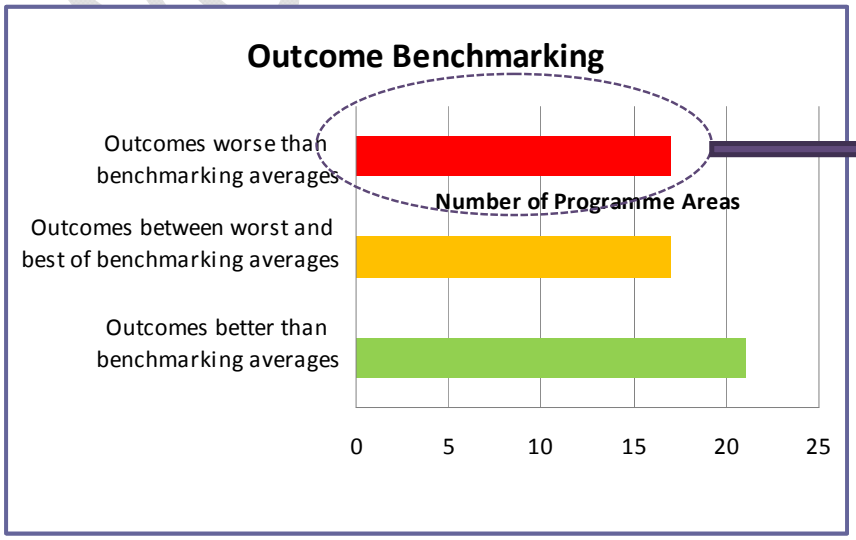
High Spend Areas

1. Endocrine, Nutritional and Metabolic Programme
2. Problems of Learning Disability
3. Neurological Disorders
4. Problems of Circulation
5. Problems of the Respiratory System
6. Dental Problems
7. **Problems due to Trauma and Injury**
8. Adverse Effects and Poisoning

Expenditure benchmarking analysis across the 23 programme areas informs that for Darlington PCT:

- 4 programme areas are within the lowest quintile;
- 5 programme areas are within the second quintile;
- 5 programme areas are within the third quintile;
- 1 programme areas are within the forth quintile;
- 8 programme areas and within the highest quintile, of which 6 were within the top 20 highest expenditure level and 1 in the top 10 highest expenditure across all 152 PCTs.

Darlington PCT spends the 9th highest amount per head of population on the Trauma and Injuries programme area out of 152 PCTs.



Outcome Hotspot

3 worse outcomes in:

- **Problems of the Respiratory System**

2 worse outcomes in:

- Cancers and Tumours
- Endocrine, Nutritional and Metabolic Problems
- Problems of Circulation
- Problems due to Trauma and Injuries
- Problems of the Genito Urinary System

Across 55 outcome areas during 2009/10 Darlington PCT has: 21 outcomes better than SHA, Industrial Hinterland and England Average; 17 outcomes between worst and best of benchmarking averages; 17 outcomes worse than SHA, Industrial Hinterland and England Average. Three of the worse outcome areas are within the Problems of the respiratory system programme area.

A more detailed programme level summary is given in table below:

Programme Area	Programme Expenditure Quintile / Outcome RAG Rating
1. Infectious Diseases	Expenditure
	Outcomes ↑ ↓ ↑ ↑ ↑
2. Cancers and Tumours	Expenditure
	Outcomes ↓ ↓ ↓ ↓ ↑ ↓ ↑ ↓
3. Disorders of Blood	Expenditure
	Outcomes N/A
4. Endocrine, Nutritional and Metabolic	Expenditure
	Outcomes ↑ ↓ ↓ ↓ ↑
5. Mental Health Disorders	Expenditure
	Outcomes ↓
6. Problems of Learning Disability	Expenditure
	Outcomes N/A
7. Neurological Disorders	Expenditure
	Outcomes ↓ ↑ ↑
8. Problems of Vision	Expenditure
	Outcomes ↑
9. Problems of Hearing	Expenditure
	Outcomes N/A
10. Problems of Circulation	Expenditure
	Outcomes ↑ → ↓ ↑ ↓ ↑
11. Problems of the Respiratory System	Expenditure
	Outcomes ↓ ↑ ↑
12. Dental Problems	Expenditure
	Outcomes ↓ ↓ ↑
13. Problems of the Gastro Intestinal System	Expenditure
	Outcomes N/A
14. Problems of the Skin	Expenditure
	Outcomes N/A
15. Problems of the Musculoskeletal System	Expenditure
	Outcomes N/A
16. Problems due to Trauma and Injuries	Expenditure
	Outcomes ↑ ↑ ↓ ↑ ↑
17. Problems of the Genito Urinary System	Expenditure
	Outcomes ↑ ↑ ↑ ↑
18. Maternity and Reproductive Health	Expenditure
	Outcomes → ↑
19. Conditions of Neonates	Expenditure
	Outcomes ↑
20. Adverse Effects and Poisoning	Expenditure
	Outcomes N/A
21. Healthy Individuals	Expenditure
	Outcomes ↑ ↓ ↑ ↑ ↑
22. Social Care Needs	Expenditure
	Outcomes N/A
23. Other	Expenditure
	Outcomes N/A

Outcome better than SHA, Industrial Hinterland and England Average

Outcome between worst and best of benchmarking averages

Outcome worse than SHA, Industrial Hinterland and England Average

↑↓→ Direction of travel between last 2 periods

Expenditure in lowest quintile

Expenditure in second quintile

Expenditure in third quintile

Expenditure in forth quintile

Expenditure in highest quintile

Appendix 4 – Commissioning Intentions

? insert overview document here

Appendix 5 – Communications Strategy

Appendix 6 – Medium Term Financial Strategy (MTFS) 2011/12 – 2016/17

Introduction

As commissioners of health and healthcare for [INSERT CCG AREA] we are working towards delivering excellence today for a healthier tomorrow.

2011/12 has marked the continued development and progression of a significant modernisation of the NHS in the shape of the Government's Health and Social Care Bill, which together with the current challenging economic environment and impact of the Government Spending Review, will ensure the coming years remain challenging.

We will continue to manage these challenges and invest our funding to ensure quality, promote innovation, maximise efficiency and maintain a focus on prevention, whilst also evolving and developing as a separate commissioning organisation.

Our Clear and Credible Plan (CCP) is under-pinned by a comprehensive medium term financial strategy (MTFS), which is a key element of the framework setting out our ambition for the future and enabling an effective transition to the new system of clinical led commissioning. The MTFS is a financial expression of the CCG's strategic plan and is fully integrated with the CCP.

The MTFS is supported by a comprehensive governance infrastructure including Standing Orders, Standing Financial Instructions and a Scheme of Delegation that clearly identifies budget responsibility. It has been developed from a shared understanding of staff from all disciplines and across all functional groups. It will be communicated to all staff and partner organisations.

Background

The MTFS is intended to describe the CCG's financial intentions and so support commissioner led provider development across the County Durham and Darlington health economy.

The MTFS will facilitate effective financial planning and help to provide a robust financial position to support the transition to clinical led commissioning. In addition the MTFS provides assurance to the CCG sub-committee and to the PCT Board that:

- commissioning intentions and service plans described in the CCP are both realistic and achievable.
- value for money will be delivered over the medium term timescale as well as the short term.

The MTFS has been updated to reflect the 2012/13 Operating Framework and revised resource and expenditure assumptions. The key changes relate to the impact of the new Spending Review period and the modernisation of the NHS detailed in the Government's Health and Social Care Bill. [TO UPDATE ONCE OPERATING FRAMEWORK PUBLISHED]

Strategic objective

The objective is to achieve recurring financial balance whilst delivering our CCP.

Key financial intentions

The key intentions underpinning our financial planning are as follows:

- Achievement of recurrent balance in each of the years covered by the CCP with all recurrent and non-recurrent resources and expenditure separately identified to minimise the danger of developing unaffordable strategies where non-recurrent resources mask recurrent deficits.

- Available financial resources will be allocated over the five year timeframe of the CCP to enable effective management of developments and resources.

- All services commissioned by Darlington will be undertaken within a clear financial framework. Service plans will link performance targets that include clearly defined outputs, outcomes and efficiencies to the required investment. They will identify associated risks and have exit plans prepared should performance deviate irreconcilably from target.

- Assets held by the CCG will be reviewed annually in order to ensure the best use of resources and achievement of clear, agreed service improvements.
- Recognising the service development pressures facing the NHS and finite funding available through the allocation process we will actively seek all appropriate external funding and explore all opportunities to make efficiency savings with local partners and national agencies to ensure value for money in the medium as well as the short term.

- Management of financial risk by maintaining a contingency amounting to 2% of recurrent revenue funding which will be deployed non-recurrently to support change and innovation.

- We will engage with local organisations across sectors to ensure that the healthcare market is well placed to deliver the best healthcare and to manage the financial risks to the health economy collaboratively.

Financial situation

Financial history

Although the CCG is a newly emerging organisation with little direct financial history, we are developing from a financially successful organisation in [COUNTY DURHAM OR DARLINGTON PCT], utilising the relevant experience and knowledge which has brought financial stability and a sound track record of delivery of statutory duties and financial targets.

County Durham PCT was created when five predecessor primary care trusts (PCTs) came together in October 2006. At that time 3 of the 5 organisations were in deficit and this was inherited by the PCT.

Darlington PCT's successful delivery of cost improvement schemes on a recurrent basis has seen the severe financial challenges of previous years overcome, allowing 2008/09 to begin on a sound financial footing.

The achievements of the PCT in respect of revenue resource can be seen below, with the PCT also meeting capital and cash limit targets. PCTs are assessed on these targets whilst still needing to achieve the operational targets set out elsewhere in this document.

Historical financial performance

Financial Year	NHS County Durham	NHS Darlington
2006/07	All limits met Revenue under-spend: £242k	All limits met Revenue under-spend: £56k
2007/08	All limits met Revenue under-spend: £981k	All limits met Revenue under-spend: £101k
2008/09	All limits met Revenue under-spend: £918k	All limits met Revenue under-spend: £301k
2009/10	All limits met Revenue under-spend: £1,020k	All limits met Revenue under-spend: £302k
2010/11	Forecast revenue under-spend of £1,000k	Forecast revenue under-spend of £300k

Delivery of revenue, capital and cash limits

The PCT has a history of good financial performance which has enabled them to continue to forecast delivery of financial balance and to remain within revenue, capital and cash limits. This knowledge and experience will be an essential component of the effective financial planning and management developed by the CCG.

Financial pressures have emerged in-year in acute healthcare in particular, continuing healthcare and prescribing, which are being directly managed by the CCG. Continued strong financial management and contract management will be required to ensure that these pressures are managed within revenue, capital and cash limits without adverse impact on operational performance targets.

Financial trends

NHSCD and NHSD have received confirmation of growth levels in their allocations for 2011/12. Modelling work has been undertaken to estimate the funding required for inflation, and identify the resources available for investment, both on a recurring and non-recurring basis.

Recurrent baseline and growth

The new funding available (growth) for NHS County Durham and NHS Darlington are shown in the table below:

	NHS County Durham	NHS Darlington
	2011/12	2011/12
Total growth	£29.1m (3.0%)	£5.3m (3.0%)
Social care funding to transfer to local authorities	£7.7m	£1.4m
Remaining PCT growth	£21.4m (2.2%)	£4.0m (2.2%)

As a result of this growth funding, total current revenue allocations for NHS County Durham and NHS Darlington are shown below. This includes recurring revenue allocations and non-recurring allocations confirmed to date.

	NHS County Durham	NHS Darlington
	2011/12	2011/12
Total recurring revenue allocation	£948.5m	£174.1m
Non-recurring revenue allocations confirmed to date	£42.3m	£10.1m
Total revenue allocations	£990.8m	£184.2m

Transition to fair shares budget and distance from target allocation

The Department of Health currently allocates funding directly to PCTs on the basis of the relative needs of their populations. A weighted capitation formula determines each PCT's target share of available resources, its target allocation, to enable them to commission similar levels of health services for populations in similar need, and to reduce avoidable health inequalities. Depending on how their current funding position then compares to their target allocation, PCTs receive growth in line with the pace of change policy.

Following the substantial investment shown above, both NHSCD and NHSD will still be under the allocation target by 3.5% and 0.9% respectively.

The position shown for NHSCD is an average for the PCT's entire population and as such it does not reflect the wide variation across the PCT, which will impact upon the financial resources available to the CCG.

The expected impact of the transition to a fair share budget allocation for the CCG is as follows:

[ADD CHART TO SHOW IMPACT OF MOVE TO FAIR SHARES]

Financial Strategy and Context

The scale of the financial challenge we face in the future is great. Every year we face additional pressure on the funding we receive due to inflation, demographic changes of an aging and growing population and the cost of innovative new technologies and drug advancements. In recent years we have received unprecedented levels of new money that have enabled us to fund growth in our health services to deal with these pressures. This level of new money into the system is not expected to continue into the future.

This means that we need to drive high levels of efficiency out of the current system in order to maintain a stable and high performing health service that can meet the growing needs of the population.

On top of this, if we are to continue to invest in additional new services, especially in our priority areas, we will need to fund them through disinvestment from services that are addressing a lower priority to us and by de-commissioning services that are performing poorly.

In addition, we are currently facing one of the most significant changes to the NHS in its history and trying to develop as a separate organisation in order to assume full responsibility for commissioning healthcare for our population.

Incorporated within the CCP is a comprehensive financial strategy underpinned by detailed financial models which allow dynamic scenario modeling and risk assessment, essential in this current transition period for healthcare commissioning.

The financial planning assumptions which support the CCP have been driven by a range of issues, the most important of which are set out below:

- **Government Spending Review**
  Despite the UK economic downturn, the outcome of the Spending Review represents a relatively favourable financial settlement for the NHS and we are now planning on a small element of real terms growth from 2012/13. This supports all the information available at the current time and is in line with the PCT allocations already confirmed for 2011/12. [TO UPDATE AS NECESSARY ONCE OPERATING FRAMEWORK PUBLISHED]

- **Move to Fair Share Financial Allocation**
  Financial allocations have previously been set at a County wide level. The financial plans incorporate the expected impact of a move to a fair share allocation for the CCG area.

- **Impact of tariff changes**
  The 2012/13 Operating Framework set out a number of changes to the tariff pricing framework including increased national efficiency requirements.

- **Implementation of Equity and excellence: Liberating the NHS**
  The impact of the modernisation of the NHS set out in Equity and excellence: Liberating the NHS has been recognised in our financial planning where possible, including the integration of social care with local authorities and support required to develop the CCG.

- **Implications of the QIPP initiative on the local health economy**
  The QIPP initiative has been developed to help with the management of the likely financial pressures to be experienced from 2011/12 and the need to generate significant efficiencies. QIPP is fully integrated into the CCP and the financial impact has been incorporated into our financial models.

- **Current year activity pressures**
  In year information on material activity pressures have been reflected in the revised plan, particularly in respect of the acute secondary care sector and continuing healthcare.

Taken together these changes will substantially reduce the scope for new investment during the current financial planning period.
It is expected that the QIPP initiatives will generate combined efficiencies of [xxxx] over the planning period, through innovation, tariff changes and service redesign, which can be used to fund additional strategic investments and cost pressures arising from demographic changes for example. Demand led cost pressures will need to be robustly managed for this methodology to be successful and to ensure that the increased activity levels experienced in the current year do not absorb a significant element of the expected efficiency savings.

The financial plan considers how the total resources of the CCG may be deployed. In addition it focuses in some detail on the impact of potential changes in activity, price/cost inflation as well as on priority areas for new investment.

The financial plan makes provision for investment in the initiatives set out in our CCP to support delivery of our strategic objectives. The current investments within the financial plan have been determined following a process of review and prioritisation based upon a combination of updated population needs assessments and national and local targets.

In support of the our strategic objectives over the course of the five years there is increased investment in care closer to home, improvements in health and addressing inequalities across the region. We do not expect to be able to deliver the investment required without achieving greater efficiencies. In particular we will be looking at the level of services provided through the acute secondary care setting and areas where the local health system compares unfavourably with the national position, such as the level of follow ups and length of stay in secondary care.

The combined impact of the performance savings and investment in our priorities is expected to result in a reduction in the relative level of expenditure on hospital based activity and an increase for community and primary care based services.

Regular review of investments against criteria used in the investment planning process will be undertaken and will help to inform the disinvestment process.

Financial Planning and Modelling

The financial models developed by the CCG ensure we can provide swift financial information on the impact of changing health needs, revised economic planning assumptions and evolving environmental and political factors.

In addition to the ongoing scenario modelling, which will be continually reviewed and refreshed throughout the planning period, the financial model will be formally reviewed and updated on at least an annual basis or more frequently when issues with a significant financial impact become apparent.

Our financial planning is also supplemented by a suite of financial management and governance policy documents including the cash management policy, standing financial instructions, standing orders and a comprehensive scheme of delegation.

The detailed financial model itself takes the form of a set of interdependent spreadsheets. Based on the input of basic funding and expenditure information, predicted activity and inflationary and growth assumptions, the spreadsheets produce operating cost statements and balance sheets covering a range of scenarios.

The financial model incorporates expected future developments and the related resource implications through the inflationary and growth assumptions applied, as well as additional investment included in respect of the initiatives highlighted in our strategy. The impact of any other potential developments and risks are assessed via scenario planning and sensitivity analysis.

Key assumptions

In preparing the financial models which support the CCP, we have utilised planning assumptions developed regionally.

For 2011/12 figures are based on the NHS Operating Frameworks published in December 2010. For 2012/13 to 2016/17, assumptions have been determined for three different scenarios which incorporate potential differences in the level of tariff uplift to be agreed nationally, together with the level of funding allocation received from the Department of Health. The key assumptions applied across three scenarios are as follows:

	DOWNSIDE SCENARIO %	BASE CASE %	UPSIDE SCENARIO %
PCT Growth Funding - 12/13 - 13/14 (estimated)	0.0%	2.0%	2.5%
PCT Growth Funding - 14/15 - 16/17 (estimated)	0.0%	0.0%	1.0%
Tariff Related Uplift / Efficiency Applied to Acute, Mental Health and Community Services			
12/13 (estimated)			
INFLATION	3.0%	2.5%	2.5%
EFFICIENCY	-4.0%	-4.0%	-4.0%
NET	-1.0%	-1.5%	-1.5%
13/14 (estimated)			
INFLATION	3.5%	3.0%	3.0%
EFFICIENCY	-3.5%	-3.5%	-4.0%
NET	0.0%	-0.5%	-1.0%
14/15 - 16/17 (estimated)			
INFLATION	3.0%	3.0%	3.5%
EFFICIENCY	-3.0%	-3.0%	-4.0%
NET	0.0%	0.0%	-0.5%
Uplift / Efficiency applied to Primary Care and Other costs			
12/13 - 16/17 (estimated)			
INFLATION	4.0%	4.0%	4.0%
EFFICIENCY	-3.0%	-3.5%	-4.0%
NET	1.0%	0.5%	0.0%
Uplift / Efficiency applied to Prescribing			
12/13 - 16/17 (estimated)			
INFLATION	6.0%	5.0%	5.0%
EFFICIENCY	-3.0%	-3.0%	-3.5%
NET	3.0%	2.0%	1.5%

The main non-financial demographic assumptions included within the plan are set out below. These demographic assumptions have been generated with reference to historical demographic increases observed in previous years, utilising the work on the refreshed JSNAs and reviewed for consistency regionally.

DEMOGRAPHIC ASSUMPTIONS 2012/13 - 2016/17	DOWNSIDE SCENARIO %	BASE CASE %	UPSIDE SCENARIO %
Acute	2.7%	2.0%	1.5%
Mental Health	4.0%	3.5%	3.0%
Prescribing	2.0%	2.0%	2.0%
Primary Care	1.5%	1.0%	0.5%
Community services	2.5%	2.0%	1.5%
CHC	4.0%	3.0%	2.0%
Specialised commissioning	2.5%	2.0%	1.5%

A key non-financial assumption is that there will be no increases in elective referrals and emergency admissions to secondary care other than those driven by the assumed demographic changes above. The model, however, does build in the recurrent impact of forecast out-turn activity for 2011/12. Where known we have included specific changes in demand, for example in respect of specialised services.

Income and expenditure

Revenue resources

An extract from the financial model showing income and expenditure forecasts for 2011/12 to 2016/17 under the most likely ‘base case’ scenario is included for the CCG below.

[INSERT TABLES ONCE FIGURES AVAILABLE]

The following table summarises the position in respect of the alternative scenarios and demonstrates a sustainable financial position for the CCG.

[INSERT TABLE OF SCENARIO POSITION FOR BOTH PCTS]

Scenario Planning

There are a significant number of up and downside risks to the assumptions included in the plan and, as a consequence, work has been performed to review the impact of different scenarios, a process which continues as new information comes to light.

As one of our key goals is sustainable financial health, the ability to flex the financial plan to take account of new and as yet unforeseen requirements and opportunities, whilst remaining in recurrent balance, is very important. Our in-year contingency reserve is just one element of our approach to risk management. Another is our approach to investment planning which has proven to be successful within the PCT in previous years in effectively managing the planning process without exposing the organisation to excess financial risk. A third is the flexing of the timing and scope of implementation of some of the initiatives identified in line with the QIPP agenda, and increasing the pace of service redesign/innovation to secure a more cost effective delivery of services to patients.

In terms of upside risks (or opportunities), we have been very prudent in our assumptions around securing new income from sources other than the general allocation from the Department of Health. It may also be possible to bring forward the profile for delivery of certain efficiency savings within the QIPP programme. Both could result in the ability to accelerate our healthcare investment programme.

On the downside, our assumptions around limiting the growth in hospital activity may prove too optimistic, and future national decisions on tariff uplifts and pay increases could add further cost pressures. Whilst this could be addressed using general contingency reserves, investment profiles will need to be kept under continuous review and the drive to secure best value for money in all areas of operations must be relentless.

As highlighted above, assumptions have been developed regionally for three different scenarios, each with different financial and non-financial assumptions around the level of the tariff uplift, allocation of funding and demographic growth.

Contracting assumptions

Figure X outlines the CCGs planning assumptions for contract and tariffs based on the Operating Framework for the NHS in England 2012/12.

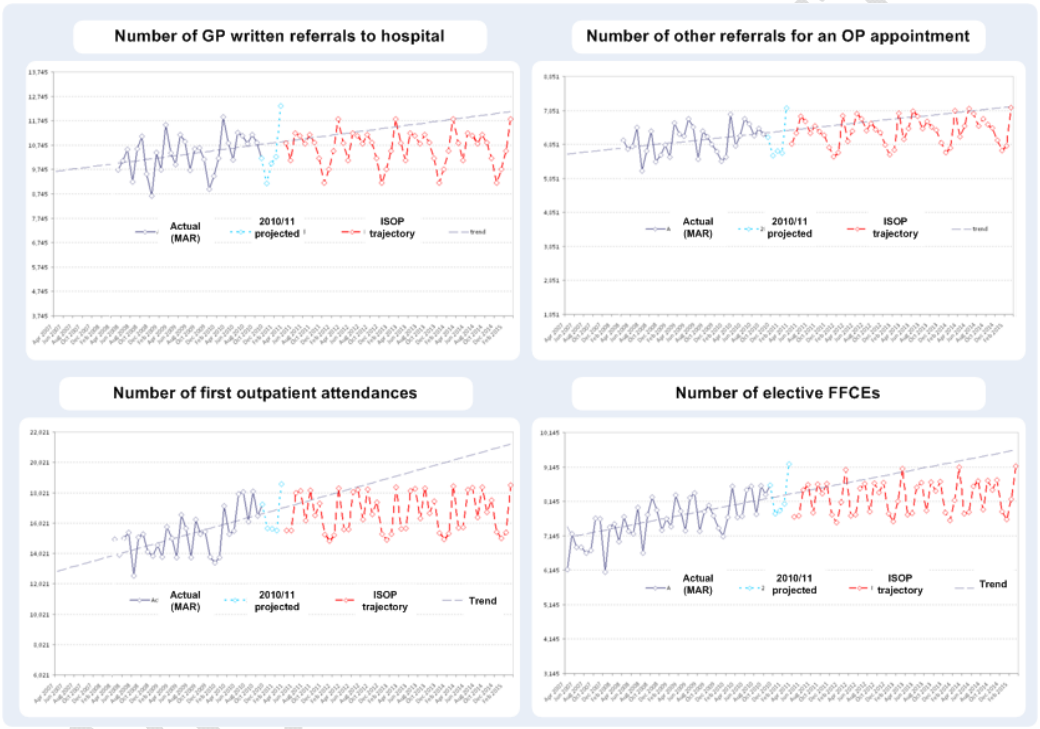
Area	Scenario	Assumption	2012/13	2013/14	2014/15
TARIFF (also applied to non-tariff, MH, comm services, spec. services etc)	Downside scenario	INFLATION	3.0%	4.00%	4.0%
		EFFICIENCY	-4.0%	-4.0%	-4.0%
		CQUIN	0.0%	0.0%	0.0%
		NET	**-1.0%**	**0.0%**	**0.0%**
	Base Case scenario	INFLATION	2.5%	3.50%	4.0%
		EFFICIENCY	-4.0%	-4.0%	-4.0%
		CQUIN	0.0%	0.0%	0.0%
		NET	**-1.5%**	**-0.50%**	**0.0%**
	Upside scenario	INFLATION	2.5%	3.0%	3.5%
		EFFICIENCY	-4.0%	-4.0%	-4.0%
		CQUIN	0.0%	0.0%	0.0%
		NET	**-1.5%**	**-1.0%**	**-0.5%**
PRIMARY CARE / OTHER / LA	Downside scenario	INFLATION	4.0%	4.0%	4.0%
		EFFICIENCY	-3.5%	-3.5%	-3.5%
		NET	**0.5%**	**0.5%**	**0.5%**
	Base Case scenario	INFLATION	4.0%	4.0%	4.0%
		EFFICIENCY	-4.0%	-4.0%	-4.0%
		NET	**0.0%**	**0.0%**	**0.0%**
	Upside Case scenario	INFLATION	4.0%	4.0%	4.0%
		EFFICIENCY	-4.0%	-4.0%	-4.0%
		NET	**0.0%**	**0.0%**	**0.0%**
PRESCRIBING	Downside scenario	INFLATION	6.0%	6.0%	6.0%
		EFFICIENCY	-3.0%	-3.0%	-3.0%
		NET	**3.0%**	**3.0%**	**3.0%**
	Base Case scenario	INFLATION	5.0%	5.0%	5.0%
		EFFICIENCY	-3.0%	-3.0%	-3.0%
		NET	**2.0%**	**2.0%**	**2.0%**
	Upside Case scenario	INFLATION	5.0%	5.0%	5.0%
		EFFICIENCY	-3.5%	-3.5%	-3.5%
		NET	**1.5%**	**1.5%**	**1.5%**

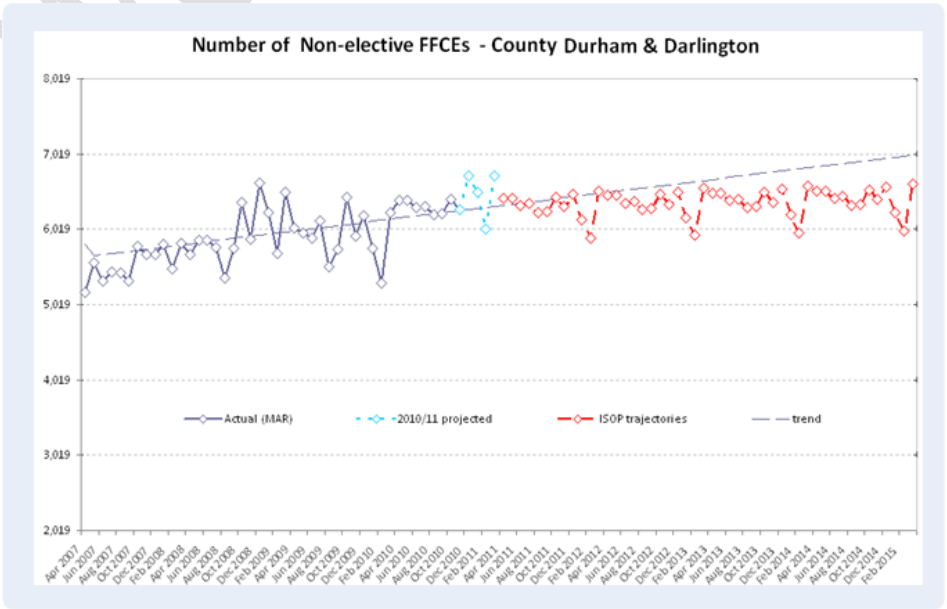
Figure X. contracting assumptions

Base Case Scenario

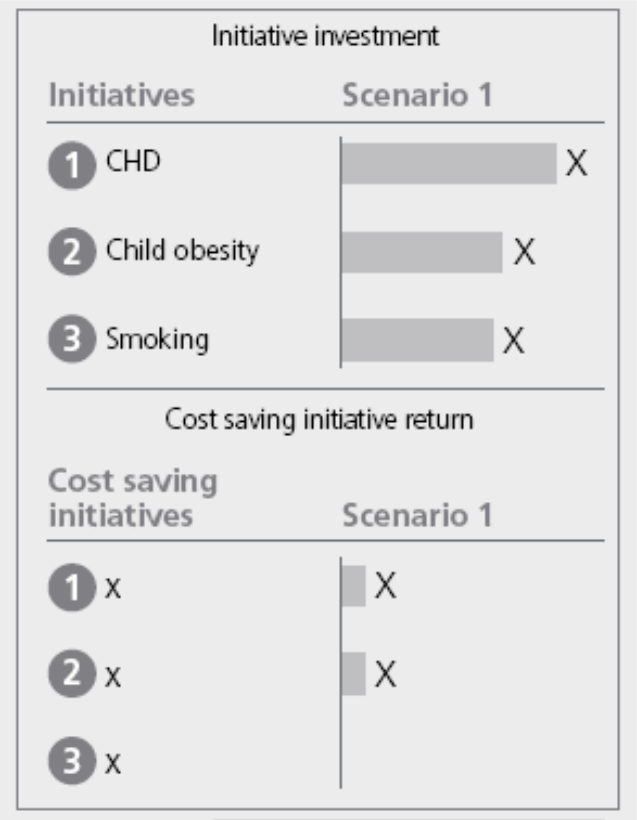
The Base Case Scenario describes the expected financial position in which the Clear and Credible Plan will be delivered based on analysis of past contracting, activity and budget performance and planning assumptions on expected levels of income.

In the Base Case Scenario, Darlington CCG will contract for a fair and realistic level of acute activity across the range of providers. This increased level of activity reflects changes in levels of service usage driven by referral patterns, changes in service models agreed between commissioner and provider and the impact of demography (i.e. an ageing, growing population).



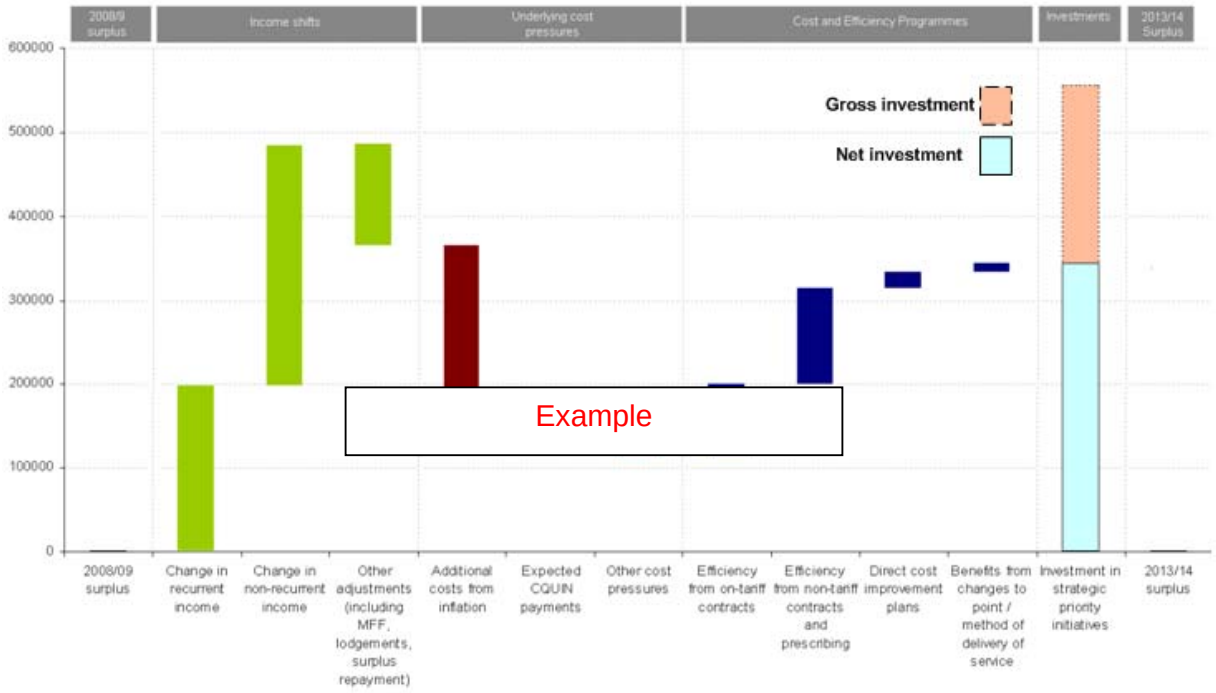


Once this level of activity has been assumed within the financial model, £XXX would remain available for investment in delivering the CCG strategic initiatives. Figure X provides an overview of how this funding will be applied:



SOME COMMENTARY ON INITIATIVES TO GO HERE (INCLUDE COMMENTS ON USE OF 2%NR TO PUMP PRIME TRANSFORMATION SCHEMES

Figure **X** provides an overview of how the investment in activity and initiatives is funded within the CCG financial planning,



ADD COMMENTARY IN HERE TO REFLECT ACTUAL FIGURES

Downside Case Scenario

The Downside Case Scenario describes a financial position in which the Clear and Credible Plan will be delivered where a lower level of income is assumed and/or contract/budget performance is higher than forecast then at the outset of the plan.

This Downside Scenario has meant that:

- commissioning initiatives have been further prioritised and targeted to remain affordable within the smaller funding envelope
- greater focus has been placed on managing demand and activity to minimise risk
- more management capacity directed to the release of efficiency over commissioning for longer term health gain

REPEAT LAYOUT OF BASE CASE SCENARIO BUT WITH TAILORED COMMENTARY

Upside Case Scenario

The Upside Case Scenario describes a financial position in which the Clear and Credible Plan will be delivered where either a higher level of income has been assumed and/or contract/budget performance has come in under-forecast than at the outset of the plan.

This Upside Case Scenario has meant that:

- commissioning initiatives have been widened or extended to deliver greater improvements
- greater focus has been placed on the re-investment of funding to deliver the CCG's strategic priorities or improved health outcomes and care closer to home

REPEAT LAYOUT OF BASE CASE SCENARIO BUT WITH TAILORED COMMENTARY

Risks & Opportunities

Significant activity pressures continue to be seen in certain key areas, including in particular the acute sector, prescribing and continuing health care which cause potential a financial risk and this pressure has been recognised in our financial planning. There are a number of other risks to the CCG's financial plans which are incrementally compounded through each additional year of the plans. These risks could either release or reduce resource availability and the potential impacts have been modelled through the MTFS as far as possible. These include, but are not limited to:

- Impact of transition to fair shares budgets for the CCG and constituent GP practices;
- Detailed PbR guidance develops each year and will undoubtedly change over the term of the plans;
- Contracts (along with relevant performance indicators) have yet to be agreed with provider organisations;
- Expectation driven demand which may increase as waiting times are driven lower along with costs and benefits associated with clinical and technological advances;
- Assumed receipt of allocations which have yet to be confirmed;
- Non-delivery of saving plans and QIPP initiatives;
- Increased exposure of the organisation, due to its reduced scale in comparison to the existing PCT, to fluctuations in demand particularly in respect of areas of relatively high cost per individual case.

These risks will continue to be actively monitored and managed to reduce the potential financial impact. The crystallisation of risks and opportunities would need to be viewed in light of the overall position of the CCG. In broad terms the CCG's financial strategy requires the maintenance of certain contingency reserves and allows for acceleration of future years investments. Ongoing in-year review of the financial strategy and financial performance will allow objectives to be achieved, including delivery of financial targets.

Whilst there are a number of generalised risks to the CCG's MTFS, some of which are highlighted above, the main risks revolve around the accuracy of the planning assumptions used throughout the plans. A prudent approach has been applied in developing those planning assumptions which should minimise any risks arising and in financial terms there are some other potential opportunities and ways to mitigate these risks which include:

- Potential ability to access 2% headroom on a non-recurrent basis;
- Unplanned gain from additional investment into social care for example;
- Financial gain from embedding more stringent business rules into contracts;
- Potential financial gain from performance penalties and underperformance against CQUIN;
- The negotiation of marginal rates and price discounts.

Cost Drivers

Our financial plan and the level of investment required is impacted by a range of cost drivers and the approach to the forecasting of costs is determined by our ability to influence and control those costs.

Factors influencing the future position can be categorised into those that are external (driven by factors external to the CCG) and internal (those within the CCG's decision making ability).

Applying the well recognised PESTEL (Political, Economic, Sociological, Technological, Legal/regulatory) methodology the following cost driver headings are identified:

- External cost drivers:
    - Economic, legal, regulatory and national policy
    - Demographic, technological and environmental

- Internal cost drivers:
    - Efficiency/savings programme
    - Investment programme

Economic, legal, regulatory and national policy drivers include:

- *Equity and excellence: Liberating the NHS* – the impact of transition to the new health and social care system with clinical led commissioning.

- Growth uplift - the annual growth increase in the CCG resource limit which is influenced by weighted capitation targets intended to ensure an equitable distribution of funding

- Tariff uplift/efficiency – the annual uplift/efficiency for healthcare providers operating under Payments by Results (PbR) which reflects the impact of inflation, service quality enhancements and efficiency improvements

- Legal changes – an example is the impact of legislation upon health and social care budgets of changing continuing healthcare eligibility criteria

- National policy changes – this area includes the annual operating framework which sets out policy initiatives and health targets which could impact upon CCG budgets.

Demographic, technological and environmental drivers include:

- Population growth – estimated changes in total population numbers
- Population mix – demographic changes in terms of age, gender, ethnicity within the overall population
- Deprivation – the impact of deprivation within communities compromising the total population
- New technologies and drugs – the effect of technological change within the NHS
- Impact of patient choice and expectations – the financial impact of increasing patient expectations in respect of access to and quality of healthcare

The key internal cost drivers include:

- Efficiency/savings programme – within the financial plan are both national and local expectations in respect of efficiency gains to be delivered over the period covered by the MTFS.
- Investment programme –we have a framework for developing investment proposals which, although demonstrating value for money, do impact upon our financial position.

Where we have a significant degree of control over costs, financial forecasting is largely based on activity forecasts and predictive planning of cost drivers.

Where we have limited indirect control or no control over costs, benchmarking such as programme budgeting and some trend analysis is performed, along with additional scenario planning and sensitivity analysis.

Investments and support for the Commissioning Intentions

As set out above, significant new recurring funding is available (growth) for NHS County Durham and NHS Darlington in 2011/12.

The table below sets out in broad terms the application of funds:

Summary showing deployment of additional revenue resources available in 2011/12		
	NHS County Durham	NHS Darlington
	£000	£000
Source of funds:		
Increase in revenue resource limit	29,088	5,335
Other non-recurrent allocation adjustments	(1,712)	(301)
Efficiency savings on tariff contracts, non-tariff contracts and prescribing	36,629	6,959
Other QIPP efficiency savings	15,840	3,168
	79,845	**15,161**
Application of funds:		
Tariff / inflationary uplifts	23,171	4,459
Prescribing uplifts	4,720	855
Social care funding to transfer to local authorities	7,698	1,362
2% contingency	18,970	3,480
AOP investments	25,286	5,005
	79,845	**15,161**

The allocation of revenue resources set out above delivers a balanced budget in 2011/12.

The financial plan makes provision over the course of the planning period for investment in the initiatives set out in our strategy and commissioning intentions to support delivery of our strategic objectives. It is, however, important to note that not all initiatives will require additional resources, as some are as much about changing the way services are delivered and the way we work with strategic partners and local communities.

Our aim is to have a transparent and accountable process for prioritisation of investment which will allow our partners, including provider organisations and local patients and the public, to have a clear understanding of our priorities and direction of travel.

The current investments within the financial plan have been determined following a process of review and prioritisation based upon a combination of updated population needs assessments and national and local targets. The risks related to the proposed investments are taken into account as well as the wider impact to the health system as a whole. The final decisions on investments over the next few years will be defined and agreed following our well-established business and investment planning processes, including the determination of exit strategies as required.

Internal processes that are now embedded produce and review business cases to ensure investment decisions are based upon achievement of required clinical outcomes, value for money and sustainability. The process allows for both clear financial information and robust challenge at different levels throughout the organisation. Regular review of investments against criteria used in the investment planning process will be undertaken and will help to inform the disinvestment process.

Further use of benchmarking and comparative performance information is fundamental to our approach. Programme budgeting information linked to public health outcome measures is being used to monitor progress and outcomes from investment as well as to inform financial investment and disinvestment strategies. While the absolute data is not robust at this stage, it is anticipated that this will improve over the financial planning cycle and will facilitate improved healthcare investment decision making.

Careful financial planning and strong financial management and forecasting over the planning period will allow us to remain on a sound financial footing and therefore to deliver our strategic objectives.

Investment priorities and commissioning intentions will continue to develop over the next 12-18 months as the transition to the new health and social care systems continues and the CCG begins to take increased responsibility for healthcare commissioning decisions.

In line with the requirements of the Operating Framework, the PCTs will continue to set aside 2% of recurring baselines to be invested on a non-recurring basis.

In 2010/11 this contingency has allowed us to manage in year pressures without compromising service delivery or financial balance. To ensure flexibility of the contingency reserve, commitments against it have been non-recurrent, thus ensuring the reserve remains uncommitted from 2011/12.

Cash management and other financial policies

The management of revenue and capital resources cannot be undertaken in isolation. There is a clear relationship between the cash limit, resource allocations and income and expenditure levels. All three elements must be planned and managed through both the short and the medium term. To facilitate this there is a separate cash management strategy that highlights the cash management arrangements within the financial services team to ensure robust and accurate cash management.

The cash management strategy focuses on minimising month end cash balances and ensuring that the PCT, and in due course the CCG, meet their year-end cash target. All actions to achieve this will be in accordance with the rules in cash management laid down by the Department of Health and will avoid any excess interest charges.

In addition the delivery of the MTFS will need to be underpinned by effective and robust financial management procedures. This will help ensure awareness of the financial position, both recurrent and non-recurrent, and facilitate improved financial planning by investment planning, commissioning and performance, public health and finance teams. The financial governance framework will be kept under review to ensure that it remains fit for purpose and well suited to the environment in which we operate.

Conclusion

Both NHSCD and NHSD have worked hard to establish a good track record in delivery of financial targets and health outcomes. The economic and financial environment remains uncertain and significant challenges are expected in the coming years, however the MTFS provides assurance that a balanced financial position will be maintained whilst delivering on our strategic objectives, enabling an effective transition to GPLC.

The uncertain economic environment means that there are many assumptions and potential risks attached to this strategy which will require continuing management and review looking a number of years ahead and refreshing of the strategy as necessary.

In the NHS there is an underlying duty of care to ensure that public funds are spent on the purposes for which they were intended and that good value for money is sought. This MTFS supports that duty of care by providing a robust financial planning framework to support the ISOP of NHSCD and NHSD.

Appendix 7 - Governance

CCP and ISOP

The Integrated Strategic and Operational Plan for NHS County Durham and Darlington 2011/12 - 2014/15 outlined the strategic direction for the cluster both in terms of operational activities and transition to the new commissioning landscape.

Our clear and credible plan is the next phase in the establishment of this new landscape whilst exploiting the opportunities of clinical leadership and improved clinical engagement in the commissioning of services reflecting the needs of Darlington population.

The main themes of the CDD Cluster ISOP are:

1) The delivery of improved services for patients across the full range of programme areas
2) Ensuring that gains made in previous years in terms of improvements in health outcomes are protected
3) Ensuring that the delivery or operations and management of the local system was carried out within a balanced commissioning budget
4) That commissioners would safeguard the stability of the provider landscape within the health economy for the lifetime of the plan
5) That transition to the new world would be carried out quickly, effectively and safely with no impact on services that patients use.

Our clear and credible plan is consistent with these ISOP themes and covers a three year period, 2012/13 – 2014/15 and therefore runs concurrently with the remaining lifespan of the cluster ISOP.

Appendix 8 – Full Risk Assessment

The CCG has used a standard risk scoring process that measures the likelihood and severity of each risk and combines them to create a compound risk score. The scoring system works as follows:

		Likelihood				
		1 = Rare	2 = Unlikely	3 = Possible	4 = Likely	5 = Almost certain
Severity	5 Catastrophic	5	10	15	20	25
	4 Major	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	2	4	6	8	10
	1 Negligible	1	2	3	4	5

Once these initial risks have been assessed, mitigating actions are identified and the risk is then re-assessed. This re-assessment measures the residual level of the risk in terms of both likelihood and severity.

The overview of the risk domain can be found in figure 1 (strategic delivery risk), figure 2 (financial resilience risk) and figure 3 (organisational readiness risk).

Domain	Risk	S	L	R	Mitigation	Res S	Res L	Res R
Strategic Delivery								

Figure 1 - Strategic delivery risk overview

Domain	Risk	S	L	R	Mitigation	Res S	Res L	Res R
Financial Resilience	Increases in elective activity above affordable level in-year.							
	Increases in non-elective activity above affordable level in-year.							
	Increases in prescribing costs above affordable level in-year.							
	Increases in Continuing Healthcare (CHC) costs above affordable level in-year.							
	Impact of ageing and growing population and technological/drug advances driving service and therefore cost pressures above affordable levels over the life of the plan.							
	CCG receives allocation below current base case during the life of the plan.				Clear investment and operations plan outlined within downside scenario.			
	CCG receives allocation below current levels in year immediately after plan following next CSR							
	CCG commissioning activities destabilise wider health economy / major providers increasing risk of reduced quality/patient safety levels							
	CCG to small to effectively manage risk							
	New tariffs for Mental Health and Ambulance Services introduces more financial risk to commissioners							

Figure 2 - Financial resilience risk overview

Domain	Risk	S	L	R	Mitigation	Res S	Res L	Res R
Organisational Readiness								

Figure 3 – Organisational Readiness risk overview