Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Bath and North East Somerset Health & Wellbeing Board (Shadow)

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	Date:	11 September 2012

To: All Members of the Health & Wellbeing Board (Shadow)

Members: Tony Barron (Chair of the PCT Board), Councillor Paul Crossley (Bath & North East Somerset Council), Patricia Webb (CCG B&NES), Councillor Simon Allen (Bath & North East Somerset Council), Ashley Ayre (Bath & North East Somerset Council), Diana Hall Hall, Ed Macalister-Smith (NHS B&NES), Dr. Ian Orpen (St James Surgery, Bath), David Smith (NHS), Simon Douglass (Member of the Clinical Commissioning Group), Paul Scott (Director of Public Health) and Jo Farrar (Bath & North East Somerset Council)

Observers: Councillor John Bull (Bath & North East Somerset Council) and Councillor Vic Pritchard (Bath & North East Somerset Council)

Other appropriate officers
Press and Public

Dear Member

Health & Wellbeing Board (Shadow)

You are invited to attend a meeting of the Board, to be held on **Wednesday, 19th September, 2012** at **2.00 pm** in the **'The Pultney Room', Manvers Street Baptist Church, Ground Floor, Manvers Street, Bath BA1 1JW.**

The agenda is set out overleaf.

Yours sincerely

Jack Latkovic
Committee Administrator

This Agenda and all accompanying reports are printed on recycled paper

NOTES:

1. **Inspection of Papers:**
   Any person wishing to inspect minutes, reports, or a list of the background papers relating to any item on this Agenda should contact Jack Latkovic who is available by telephoning Bath 01225 394452 or by calling at the Riverside Offices Keynsham (during normal office hours).

2. **Public Speaking at Meetings:**
   The Partnership Board encourages the public to make their views known at meetings. They may make a statement relevant to what the meeting has power to do. Advance notice is requested, if possible, not less than *two full working days* before the meeting (this means that for meetings held on Wednesdays notice is requested in Democratic Services by 4.30pm the previous Friday).

3. **Details of Decisions taken at this meeting** can be found in the draft minutes which will be published as soon as possible after the meeting, and also circulated with the agenda for the next meeting. In the meantime details can be obtained by contacting Jack Latkovic as above. Appendices to reports (if not included with these papers) are available for inspection at the Council's **Public Access Points:**

   - Guildhall, Bath;
   - Riverside, Keynsham;
   - The Hollies, Midsomer Norton;
   - Public Libraries at: Bath Central, Keynsham and Midsomer Norton.

4. **Substitutions**
   Members of the Board are reminded that any substitution should be notified to the Committee Administrator prior to the commencement of the meeting.

5. **Declarations of Interest**
   Board Members do not need to declare an interest in their ex-oficio status on the Board. If they have a closer involvement with any specific issue (via membership of a Sub-Committee for example), consideration would need to be given to whether a declaration was needed, and advice sought from the Monitoring Officer if necessary.

   The following member of the Board has roles in the Council and PCT:

   Ashley Ayre: *Strategic Director People and Communities, operating across the Partnership*

   The following member of the Partnership Board has role in BANES and Wiltshire PCT Cluster:
   Ed Macalister-Smith: NHS BANES and NHS Wiltshire Chief Executive

   However, when attending a meeting of the Board, each member is attending in the role shown on the invitation to attend the meeting, which is on the first page of the papers for the meeting.

6. **Attendance Register:**
   Members should sign the Register which will be circulated at the meeting.

7. **Emergency Evacuation Procedure**

   If the continuous alarm sounds, you must evacuate the building by one of the designated exits and proceed to the named assembly point. The designated exits are sign-posted.

   Arrangements are in place for the safe evacuation of disabled people.

Health & Wellbeing Board (Shadow)

Wednesday, 19th September, 2012
'The Pultney Room', Manvers Street Baptist Church, Ground Floor, Manvers Street, Bath BA1 1JW
2.00 pm

Agenda

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

3. APOLOGIES FOR ABSENCE

4. DECLARATIONS OF INTEREST

   Board Members do not need to declare an interest in their *ex officio* status on the Board. If they have a closer involvement with any specific issue (via membership of a Sub-Committee for example), consideration would need to be given to whether a declaration was needed, and advice sought from the Monitoring Officer if necessary.

   The following member of the Partnership Board has roles in the Council and PCT:

   Ashley Ayre: Strategic Director for People and Communities, operating across the Partnership

   The following member of the Partnership Board has role in BANES and Wiltshire PCT Cluster:

   Ed Macalister-Smith: NHS BANES and NHS Wiltshire Chief Executive

   However, when attending a meeting of the Partnership Board, each member is attending in the role shown on the invitation to attend the meeting, which is on the first page of the papers for the meeting

5. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

6. PUBLIC QUESTIONS/COMMENTS

7. MINUTES OF PREVIOUS MEETING — Jack Latkovic

   To confirm the minutes of the above meeting as a correct record.

8. ORGANISATIONAL UPDATES (35 MINUTES)

   The Board are asked to consider the following verbal updates:

   - Local Healthwatch (procurement) – David Trethewey

- Public Health – Paul Scott
    - Public Health Transition Plan
    - Memorandum Of Understanding
- PCT – Ed-Macalister Smith
- Clinical Commissioning Group (CCG) – Ian Orpen
- Council – Ashley Ayre

9. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) UPDATE (10 MINUTES) — Jon Poole

This report provides an update to the Joint Strategic Needs Assessment based and summarises findings of recent research conducted on the Bath and North East Somerset community.

The Board is asked to:

- Note the findings of the report and consider the impact of any new findings on local policy.
- Consider any other research or intelligence activity we should be including and who else should be informed.
- Promote the JSNA web-site www.bathnes.gov.uk/jsna .

10. STRATEGIC PRIORITIES (25 MINUTES) — Helen Edelstyn

The Health and Wellbeing Board is responsible for developing a set of strategic priorities that deliver the Boards aim to reduce health inequalities and improve health and wellbeing in Bath and North East Somerset

This report seeks agreement on 7 strategic priorities. These priorities have been developed by a task group of the Board and are based on the Joint Strategic Needs Assessment (JSNA) update 2012.

These priorities will form the foundations of the Joint Health and Wellbeing Strategy (JHWS), as well as inform the Boards work programme over the next 3 years.

The Board is asked to:

- To agree the 7 strategic priorities set out in this report (point 4.4). (in agreeing these priorities the board should consider the feasibility of aligning these 7 strategic priorities and commissioning/delivery plans)
- To agree to review the strategic priorities in 15-16 in line with the 3 year duration of the CCG Plan.

11. NHS BANES CLINICAL COMMISSIONING GROUP

STRATEGIC PLAN (20 MINUTES)

Each Clinical Commissioning Group is required as part of the CCG Authorisation process to develop an integrated plan. The integrated plan includes:

- A high level strategic plan for the 3 year period to 2014-15
- The CCG's Operational Plan for 2012/13
- Draft commissioning intentions for 2013/14

This paper sets out the CCG's draft high level strategic plan to the period 2014-15. At the June Health and Well-being Board meeting the CCG shared an overview of it's draft strategic service priorities. The CCG is sharing the fuller draft plan of its strategic plan with Health and Well-being members for their consideration.

12. COMMUNITY ENGAGEMENT (25 MINUTES) Helen Edelstyn

Health and wellbeing boards have a duty to engage the public in their work. This report seeks to discuss and agree a set of principles that will establish a consistent and rigorous approach to community engagement.

The Board is asked to agree a set of principles for community engagement included in the report.

13. FORWARD HEALTH AND WELLBEING BOARD (SHADOW) DATES

The Board are asked to note the schedule of future meetings:

- Wednesday 7th November 2012 at 2pm in Council Chamber, Guildhall.
- Wednesday 6th February 2013 at 2pm in Council Chamber, Guildhall.
- Wednesday 17th April 2013 at 2pm in Council Chamber, Guildhall.

The Committee Administrator for this meeting is Jack Latkovic who can be contacted by telephoning Bath 01225 394452

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HEALTH & WELLBEING BOARD (SHADOW)

Minutes of the Meeting held

Wednesday, 13th June, 2012, 2.00 pm

Councillor Paul Crossley	-	Bath & North East Somerset Council
Christine Reid	-	NHS B&NES and Wiltshire
David Smith	-	NHS B&NES and Wiltshire
Patricia Webb	-	NHS B&NES
Councillor Nathan Hartley	-	Bath & North East Somerset Council
Councillor Simon Allen	-	Bath & North East Somerset Council
John Everitt	-	Bath & North East Somerset Council
Paul Scott	-	Acting Joint Director of Public Health
Ashley Ayre	-	Bath & North East Somerset Council
Diana Hall Hall	-	Local Involvement Network
Ed Macalister-Smith	-	NHS B&NES and Wiltshire
Dr Ian Orpen	-	Member of the Clinical Commissioning Group
Dr Simon Douglass	-	Member of the Clinical Commissioning Group

1 WELCOME AND INTRODUCTIONS

The Chair was taken by Councillor Simon Allen.
The Chair welcomed everyone to the meeting.

2 EMERGENCY EVACUATION PROCEDURE

The Chair drew attention to the evacuation procedure as listed on the call to the meeting.

3 APOLOGIES FOR ABSENCE

Tony Barron sent his apology and Christine Reid was his substitute. Councillor John Bull (observer) sent his apology.

4 DECLARATIONS OF INTEREST

The following member of the Board has roles in the Council and NHS:
Ashley Ayre: Strategic Director for People and Communities, operating across the Partnership.

The following member of the Board has roles in BANES and Wiltshire PCT Cluster:
Ed Macalister-Smith: NHS BANES and NHS Wiltshire Chief Executive.

Dr. Simon Douglass declared non-prejudicial interest as he is running a GP practice in Radstock.

5 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

There was no urgent business.

6 PUBLIC QUESTIONS/COMMENTS

There were none.

7 MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting were approved as a correct record and signed by the Chair.

8 ORGANISATIONAL UPDATES (35 MINUTES)

Local Healthwatch (procurement) - David Trethewey (Divisional Director for Policy and Partnerships) informed the meeting about the on-going process of setting up the Healthwatch for the area. The procurement process has finished and it was publicly announced that the Wiltshire and Swindon Users' Network will be appointed. Everyone who has been involved has been notified about the appointment. The intention is that new organisation picks up the work as from the 1st of July this year. Also, the Cabinet agreed on funding for the Healthwatch. This is just a start to make the Healthwatch arrangements pretty effective.

David Trethewey informed the board that four organisations were involved in the procurement process.

Diana Hall Hall commented that LINk played its part in the process and that they would be looking forward on the future shape of the Healthwatch. One of the things that will need to be discussed is the role of the Healthwatch on the Health and Wellbeing Board. Diana Hall Hall asked to be recorded LINk's gratitude to Scout Enterprises who provided excellent service to B&NES LINk.

Public Health - Ed Macalister-Smith said that he was very pleased that Paul Scott had been appointed as Acting Joint Director of Public Health. Paul Scott was already involved in the transition and Public Health team have done a lot of work with Ashley Ayre and his team on the Transition Plan. In summary – Public Health is in good and solid position.

NHS - Ed Macalister-Smith informed the meeting that strategic objectives for this year, as NHS Cluster with Wiltshire, are to stay in control of day to day duties which is to commission excellent service to patients. Quite a lot of challenges around but overall the state of health services in the area is very good. The reform agenda is very substantial and it is speeding up. Nationally the changes in the NHS are affecting the whole NHS, not only the commissioning part. The key change for the commissioning part is the establishment of the Commissioning Board (which will drive many of the changes that are about to come around). Key decision of the NHS Commissioning Board was to make appointments to the four layer original tiers (London, South of England, Midlands and North). Chief Executive for South of England, that we are in, is Andrea Young. Andrea Young's will be thinking of setting up her own management team and also be responsible of setting up local offices for the Commissioning Board (27 in total across the country). Local office for this area will include Wiltshire, Bath, North-East Somerset, Gloucestershire and Swindon.

Each local area team will need around couple of months to make appointments. Each local area team will have common structure in the office (lead manager, lead doctor, lead nurse, etc.) and they will be expected to engage strongly with the local Health and Wellbeing Boards. Some of those 27 local offices will have additional functions on behalf of 2-4 of those local offices such as functions for special commissioning, managing the special services for military and ex-military personnel and similar. Transition Plan (handover from the PCT to the Council and Clinical Commissioning Group (CCG)) is in place. It is a difficult time for staff who has no clarity on what is going to happen to them although national promise is that people will be clear what will happen to them by December this year.

Ed Macalister-Smith explained that in future specialised commissioning will be responsibility of Commissioning Boards and not with the CCG as they have to cover quite wide area.

Clinical Commissioning Group (CCG) – Dr Ian Orpen said that the CCG are quite happy with the developments. The CCG have appointed the Project Manager to help them going through the re-organisation. The CCG also appointed Interim Strategic Finance Officer (Sarah James) and also Chief Operating Officer (Tracey Cox). The guidance for the CCG work has been rolled out. The key thing for the CCG is the development of its Constitution. Dr Ian Orpen also said that B&NES CCG had useful conversation with Wiltshire CCG on range of things including the arrangements on what information can be shared between different CCGs.

Council – Ashley Ayre said that People and Communities will start formal consultation with the staff, unions and associations and partners on 18th June. The re-design of the department is in two phases. The first phase is to sort out the divisional structure of the senior management and the second will provide the detailed structure of each of the Divisions. . The reason for the re-design links to the change strategy of the council and the range of external changes underway including NHS reform, reform of adult social care services and the changes to schools and the Munro review of child protection services.. Ashley Ayre said that he was also delighted that Paul Scott is appointed as the Acting Joint Director of Public Health. Ashley Ayre also said that White Paper on Adult Social Care will probably not be ready before Christmas 2012. There is also strong commitment to work very closely with the NHS and CCG on transition. Staff consultation is on-going and there were a number of briefings and meetings held with the staff and Trade Unions. The Council will start detailed consultation in mid-September on phase two of the re-structure.

The Chair thanked everyone who provided their verbal updates.

9 UPDATE REPORTS (20 MINUTES)

Children's Safeguarding – Liz Price (Acting Divisional Director for Children's Health, Commissioning & strategic Planning) gave apology for Maurice Lindsay (Divisional Director for safeguarding, Social care and Family Service) who is report author and took the Board through the report.

Patricia Webb commented that, looking at the reports, it seems like that the service lacks on resources to keep up with the increase in demand.

Ashley Ayre responded that the reasons are complex and include cyclical recruitment issues, increasing volumes, etc. However, it is not simply a case of needing extra resources.

John Everitt pointed out to the table in Appendix 1 of the report (page 18) and said that figures in '2011/12 Actual' row are identical with the figures in '2011/12 Quarterly/Q4' row and asked the officers to check that.

John Everitt also said that some of the indicators in the table should be challenged and that he doesn't think that there should be automatic presumption that we need more resources, especially in these times when everyone are struggling financially. The targets for 2012 looked pretty ambitious and John Everitt questioned if they are reasonable.

Councillor Simon Allen said that targets set are important but as Health and Wellbeing Board we need to investigate why the numbers of referrals increased drastically and collectively look how to make change in that area. Lots of red fields have to be challenged.

It was **RESOLVED** to note the update and for officers to take on board comments and suggestions from the Board.

Children's Health Services Commissioning Performance- Liz Price took the Board through the report.

It was **RESOLVED** to note the update.

Safeguarding Adults at Risk – Lesley Hutchinson (Assistant Director for Safeguarding and Personalisation) took the Board through the report.

Councillor Simon Allen said that the increase in referrals is a result of the increase of awareness. Councillor Allen asked about those referrals that were investigated, that are partly or fully substantiated, is there an increase in year by year on those cases.

Lesley Hutchinson responded that for this year there was a slight increase in the cases where there was no further action required and also slight increase on cases that partly or fully substantiated. The figures are broadly the same.

Paul Scott commented that it would be interesting and helpful to see some background data to these report in the annual report.

Lesley Hutchinson responded that the background data will be included.

It was **RESOLVED** to note the update

Adult Health and Wellbeing Commissioning- Dr Simon Douglass said that the results of the end of year are really good. Immunisation rates and screening programme really good, good engagement on child obesity measuring programme, NHS Healthchecks are also good. NHS Dentistry continues to improve. Better performance and results in un-planned care. No indicators yet for performance in Social Care due to delay of data. Planned care – met all of targets for this year. Increase in activity for referrals to RUH. Mental Health – we achieved agreement to

develop more robust understanding of performances affecting the AWP and we will look at those concerns to set commissioning intentions for future.

It was **RESOLVED** to note the update.

10 CLINICAL COMMISSIONING GROUP (CCG) PLAN (30 MINUTES)

Clinical Commissioning Group (CCG) Plan (30 minutes)

Dr Ian Orpen and Dr Simon Douglass gave a presentation called 'NHS B&NES CCG 3 Year Strategic Plan' where they highlighted the following points:

- Values and vision
- Why are we doing this?
- Outcome
- Our Mission
- Our Values
- Our overall vision
- National Priorities
- Key Local Priorities (CCG)
- Local Priorities (H&WB)
- CCG
- Public Health
- Social care
- Financial Planning
- CCG Commissioning Funds
- Key Planning Assumptions
- 2012/13 In Year Risks
- CCG priorities/action plans
- Priorities – Unplanned Care
- Priorities – Mental Health
- Priorities – Primary Care
- Priorities – End of Life Care
- Priorities – Long Term Condition & Frail Elderly
- Priorities- Learning Disabilities
- Priorities – Children
- Key Priorities – Planned Care
- Priorities – Public Engagement
- Next Steps

A full copy of the presentation named 'NHS B&NES CCG 3 Year Strategic Plan' is available on the minute book in Democratic Services.

Members of the Board welcomed the presentation and suggested that the CCG should have discussions with the public about the challenges ahead. It should also inform the public that the NHS is cash limited.

Dr Orpen and Dr Douglass said that one of the ways forward is to simplify services. The CCG want to be ambitious but not over-ambitious in their targets.

It was **RESOLVED** to note the presentation.

11 THE EMERGING PRIORITIES (25 MINUTES)

Councillor Allen said that this report is looking at the emerging priorities that will make up Health and Wellbeing Strategy as a requirement for this Board to produce. The aspiration is to link up with the CCG priorities.

Helen Edelstyn (Strategy and Plan Manager) took the Board through the report.

John Everitt commented that there are two principle funders, and those are Council and the NHS. When thinking about priorities for the partnership we need to know what national priorities are. The priorities of the Partnership need to be blend of the CCG priorities as well. Aspirational objectives are fantastic and challenging but we need to consider huge increase in demand in near future. Along with the increase in demand there will be requirement for improvement in services so the question is what is realistic. The next question is what will be reduced in order to improve in other areas. There is a need for balance and there is a need for a discussion with the public on those issues. The aspiration needs to be realistic. The key is that the next 5 years will be really tough and somehow that needs to be reflected to people.

Dr Simon Douglass said that out of all priorities urgent care is absolute must and that matter needs to be addressed when sending the message to the public.

Janet Rowse (Sirona Chief Executive) commented that priorities need to have political backup otherwise none of these things will be done.

Councillor Allen said that the strength of the Partnership is to do things together. It is not wrong to have aspirations but the question is if we have to have long term strategic objectives and have discussion on what to protect and what not to protect.

Members of the Board agreed with the points made by John Everitt and Janet Rowse and suggested that those issues should be considered when the priorities are set out.

Helen Edelstyn reminded the Board that the task group will meet again on 2nd July to review the emerging priorities.

Patricia Webb asked if the Board will receive performance reports in future.

Councillor Allen responded that as the Board moves away from its Shadow status it would be right to bring those reports before the Board.

It was **RESOLVED** to note the emerging priorities and ask the officers to take comments on board.

12 FORWARD HEALTH AND WELLBEING BOARD (SHADOW) DATES

It was **RESOLVED** to note the future dates

The meeting ended at 4.45 pm

Chair .....

Date Confirmed and Signed .....

Prepared by Democratic Services

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Bath & North East Somerset Council	
MEETING:	Health and Wellbeing Board (Shadow)
MEETING DATE:	19th September 2012
TITLE:	Memorandum of Understanding between B&NES Clinical Commissioning Group and Public Health in B&NES Council
AN OPEN PUBLIC ITEM	
List of attachments to this report: 1. Memorandum of Understanding between B&NES Clinical Commissioning Group (CCG) and Public Health in B&NES Council. 2. Equality Impact Assessment.	

1 THE ISSUE

1.1 The Health and Wellbeing Board is asked to approve the attached Memorandum of Understanding (MOU) between B&NES Clinical Commissioning Group (CCG) and Public Health. It is intended that the MOU will be in operation from October 2012, and sign-off is required to support the CCGs application for authorisation.

2 RECOMMENDATION

The Health and Wellbeing Board is asked to:

2.1 Approve the MOU so that it can be signed by the 4 key signatories (Jo Farrar, Ed MaCalister-Smith, Paul Scott, and Dr Ian Orpen).

3 FINANCIAL IMPLICATIONS

3.1 There are no new financial implications. All functions outlined within the MOU will be funded from the public health budget allocated to the Local Authority. (Any additional "enhanced" services provided by public health in the future would require funding by the CCG).

4 THE REPORT

Background:

4.1 Under the Health and Social Care Act, from April 2013 Clinical Commissioning Groups (CCGs) have a duty to access public health advice, information and expertise in relation to the healthcare services that they commission. At the same time, public health teams based in local authorities will have a responsibility to provide this specialist advice (often referred to as a "core offer") to clinical commissioning groups (CCGs).

5 The Department of Health published guidance in February 2012 (updated in June 2012), encouraging CCGs and public health teams to develop an MOU, which will support CCGs in making best use of public health expertise.

Purpose and scope of the MOU:

5.1 The purpose of the Memorandum of Understanding (MOU) is to establish a framework for working relationships between B&NES CCG and the public health team, and to set out the scope of the specialist service (i.e. functions) that public health will provide to the CCG. It also outlines the reciprocal responsibilities of the CCG in receiving these services.

5.2 The services that public health will provide to the CCG, includes the domain of *population healthcare*, which is informed by "core offer" guidance by the Department of Health. The MOU also outlines those services that will be provided under the other domains of public health: *health improvement* and *health protection*, so that all public health services provided to the CCG are captured in one MOU.

5.3 The MOU will be underpinned by an annual work-programme between the CCG and Public Health, which will define the particular priorities, deliverables and outcomes for a 12 month period.

Review:

5.4 The MOU will cover the period from October 2012 until March 2014, with the initial six month period being in Shadow form, allowing for review and revision, subject to local needs and national guidance for the period April 2013- March 2014.

5.5 Hence, an initial review will take place in February 2013, and annual reviews will take place thereafter.

Recommendation:

5.6 The Health and Wellbeing Board approve the MOU so that it can be signed by the 4 key signatories (Jo Farrar, Ed MaCalister-Smith, Paul Scott, and Dr Ian Orpen) prior to 1st October 2012.

6 RISK MANAGEMENT

6.1 The key risk is that public health overcommits resources to the CCG if the MOU is not considered alongside public health's "offer" to B&NES Council and other bodies such as Public Health England and the NHS Commissioning Board. To mitigate this risk, public health is taking the following actions:

- Developing an annual work programme with the CCG, which sets out the priority projects and outcomes to be delivered for the oncoming year, and attaches resource to this to ensure that public health does not over-commit. The work programme for the oncoming year is currently being developed.
- Scoping the likely public health "offer" to all other parties, including B&NES Council, NHS Commissioning Board, and Public Health England.
- Ensuring the above are considered within, and support, public health's Business Plan.

7 EQUALITIES

7.1 An Equality Impact Assessment has been completed and no adverse or other significant issues were found (see attached). On the contrary, the MOU provides an opportunity for public health to support the CCG in promoting equality and diversity through the provision of both public health intelligence and advice.

8 CONSULTATION

8.1 Prior to the MOU being submitted to the Health and Wellbeing Board for approval, it has been tabled, and subject to discussion and comment, at the following meetings:

- PCT Board (July 2012)
- Clinical Commissioning Committee (July 2012)
- People and Communities Department Leadership Team (August 2012)

8.2 The following stakeholders have also been consulted: Simon Allen (Ward Councillor and Cabinet Member); Monitoring Officer (Amanda Brookes on behalf of Vernon Hitchman), Section 151 Finance Officer (Tim Richens), B&NES Council Chief Executive (was John Everitt), CCG representatives (as they have developed the MOU with the public health team).

9 ISSUES TO CONSIDER IN REACHING THE DECISION

9.1 There are no significant issues that require consideration. In terms of the legal status of the MOU, whilst it is not legally binding, it does reflect national guidance under which the Local Authority is mandated to provide public health advice and support to the CCG. The CCG as a statutory partner of the Health & Wellbeing Board also requires sound public health advice on which to base its recommendations.

10 ADVICE SOUGHT

10.1 The Council's Monitoring Officer (Divisional Director, Legal and Democratic Services) and Section 151 Officer (Divisional Director, Finance) have had the opportunity to input to this report and have cleared it for publication.

Contact person	*Amy McCullough, Public Health Specialty Registrar.* *Paul Scott, Director of Public Health.*
Background papers	Information used to inform the content of the MOU: • Department of Health. June 2012. *Healthcare Public Health Advice to Clinical Commissioning Groups.* http://www.dh.gov.uk/health/2012/06/public-health-advice-to-ccgs/ • Department of Health. September 2012. *Health protection and local government.* http://www.dh.gov.uk/health/2012/08/health-protection-guidance/ • Core offer work programme being undertaken by Bristol, North Somerset, South Gloucestershire and B&NES. • Example MOUs from various PCTs/CCGs. The development of an MOU is recommended by the Department of Health; *Healthcare Public Health Advice to Clinical Commissioning Groups (June 2012).* http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_132760
Please contact the report author if you need to access this report in an alternative format	

Memorandum of Understanding

B&NES Clinical Commissioning Group and Public Health in B&NES Council

1.0 Purpose and scope

1.1 The purpose of this Memorandum of Understanding (MOU) is to establish a framework for working relationships between Bath and North East Somerset (B&NES) Clinical Commissioning Group and Public Health in B&NES Council.

1.2 The framework will set out the scope of the service (i.e. functions) that public health will provide to the CCG, and the reciprocal responsibilities of the CCG in receiving these services. The MOU will be underpinned by an annual work-programme agreed between the CCG and B&NES Council, which will define the particular deliverables and priorities for a 12 month period (see section 4).

1.3 This Memorandum, covers the 3 domains of Public Health and the strategic planning functions that underpin these domains:

- **Population healthcare** -. input to the commissioning of health services, evidence of effectiveness, care pathways.
- **Health improvement** - lifestyle factors and the wider determinants of health.
- **Health protection** - preventing the spread of communicable diseases, the response to major incidents, and screening.

1.4 The functions that public health should provide to the CCG within the domain “population healthcare” are outlined in guidance by the Department of Health; *Healthcare Public Health Advice to Clinical Commissioning Groups (June 2012).* This guidance has been used to inform the core functions that B&NES public health will provide to the CCG.

1.5 This Memorandum will cover the period from October 2012 until March 2014, with the initial six month period being in Shadow form, allowing for review and revision, subject to local needs and national guidance for the period April 2013- March 2014. The Public Health Directorate will transfer from NHS B&NES to B&NES Council on 1st April 2013.

2.0 Context

2.1 Under the Health and Social Care Act, from April 2013 clinical commissioning groups have a duty to access public health advice, information and expertise in relation to the healthcare services that they commission. At the same time, public health teams based in local authorities have a responsibility for providing this advice to clinical commissioning groups (CCGs).

2.2 The (healthcare) public health advice provided by the local authority will be funded from the public health budget allocated to Local Authorities at no cost to the CCG. If in the future, the CCG and public health agree that additional “enhanced” services should be provided by public health, the funding for these would need to be met by the CCG.

2.3 Regulations will prescribe that (population healthcare) advice can only be given by appropriately skilled public health specialists. This includes Faculty of Public Health accredited specialists and qualified multi-disciplinary public health specialists.

3.0 Functions, roles and responsibilities

Population Healthcare

3.1 The Health and Social Care Act establishes CCGs as the main local commissioners of NHS services and gives them a duty to continuously improve the effectiveness, safety and quality of services. Public health will have a key role in providing information and advice to the CCG to support their commissioning decisions.

3.2 In line with DH guidance, PH will provide information that has a largely strategic population focus, synthesising data from a wide range of sources and applying public health skills to analyse the data. It is expected that Central Southern Commissioning Support Unit (CSCSS) will focus more on commissioning processes and clinical systems, including analysis of referrals and activity, procurement and business process. To limit overlap, public health will not provide NHS activity data to the CCG (e.g. number of hospital admissions or outpatient appointments), other than that included within health needs assessments undertaken by the team.

Public Health will:

PH information and analysis to support strategic planning
• Oversee the production and development of the Joint Strategic Needs Assessment, which CCGs can use to inform their commissioning plans. • Produce locality/practice "Health Profiles" to inform commissioning plans. • Provide health needs assessments for particular conditions/disease groups, where they have been identified as a priority area. • Provide ad-hoc advice on methodologies to develop and analyse data and achieve data quality. • Support commissioning practice towards the reduction of local health inequalities and the specific needs of vulnerable and marginalised groups by: - Supporting GPs to collect improved inequalities data, and - by highlighting any inequalities/vulnerable groups within the Health Profiles (as far as possible with the data available). • Advise on the appropriate use of geo-demographic profiling (to identify associations between need and utilisation and outcomes for defined population groups), and use within Health Profiles and the JSNA as appropriate. • Carry out and advise on Health Equity Audits and Health Impact Assessments.
PH information and expertise to support the prioritisation and allocation of resources
• Produce a Programme Budgeting report, making use of appropriate economic analysis (i.e. marginal analysis, return on investment) as appropriate, to support priority setting and decision-making. • Support commissioners to identify areas for disinvestment through use of the Programme Budgeting Report and economic appraisals made available by Avon, Public Health England and organisations such as NICE. • Advise clinical commissioning groups on prioritisation processes, governance and best practice. • Provide support to respond to individual funding requests, including conducting evidence reviews and developing policy guidelines.
PH information and expertise on clinical effectiveness to support commissioning

- Provide public health specialist advice on:
  - The clinical and costs effectiveness of interventions and medicines.
  - Evidence based care pathways, service specifications and quality indicators.
  - Medicines management.

- Identify and assess the population impacts of implementing NICE guidance.

- Design monitoring and evaluation frameworks, and give advice on their use.

- Provide advice on relevant aspects of modelling and capacity planning.

Engagement – public and partners

- Through objective analysis, provide the evidence base for why difficult decisions (that affect members of the public) may have to be made.

- Support the CCG to progress joint commissioning and provision plans with the local authority and other organisations to maximise health gain.

B&NES CCG will:

Support strategic planning

- Consider Public Health data including health inequality data in planning.

- Contribute data and intelligence to the production of the JSNA and other priority needs assessments.

- Work with PH on the development and delivery of the Health and Wellbeing Strategy.

- Incorporate the JSNA and Joint Health and Wellbeing Strategy into NHS commissioning plans.

- Review how well the commissioning plan has contributed to the delivery of the Health and Wellbeing Strategy and to share this review with the Health & Wellbeing Board.

Other areas

- Consider how to incorporate specialist public health advice into decision making processes, in order that public health skills and expertise can inform key commissioning decisions.

- Use information on effectiveness, cost effectiveness and acceptability to inform policy decisions on the commissioning of services in order to

maximise health gain and reduce health inequalities.

- Work in partnership with providers and research partners to develop the evidence base for important innovations.

- Share details of arrangements in place with CSCSU and inter-dependencies with public health as they become confirmed (to enable public health to limit overlap in services provided).

Health Improvement

3.3 The Health and Social Care Act gives B&NES Council a statutory duty to improve the health of the population from April 2013. B&NES CCG also has duties to secure continuous improvement and reduce inequalities in the outcomes achieved by health services. This will require action along the entire care pathway from prevention to tertiary care. In addition the local NHS QIPP programme is predicated on successful implementation of preventive measures to reduce the burden of disease including from smoking, alcohol, obesity and falls.

3.4 B&NES Council and CCG therefore have a collective interest in health improvement:

Public Health will:

Health improvement
• Refresh the strategy and action plans for improving health and reducing health inequalities, and seek CCG input into these. Strategies and plans will include those that focus on particular groups and communities (i.e. traveller community), settings, and behaviours and lifestyles (i.e. obesity, smoking, alcohol, injury prevention, sexual health, mental health). • Develop (or advise on the development of) a set of metrics in addition to the Public Health Outcomes to allow the progress and outcomes of preventive measures to be monitored, particularly as they relate to delivery of the NHS QIPP programme. • Commission a range of health improvement services (i.e. lifestyle services and Health Checks), and engage the CCG in the commissioning cycle. • Support the development of best practice clinical pathways and specifications in collaboration with others (i.e. healthy weight specifications, drug and alcohol intervention specifications, consideration of collaborative tobacco control activity).

- Work with the Council to embed ownership and leadership of health improvement.

- Support the embedding of public health and wellbeing initiatives into frontline services, to improve outcomes and reduce demand on treatment services.

- Facilitate partnership working between the CCG, local partners and residents to integrate and optimise local efforts for health improvement and disease prevention.

B&NES CCG will:

Health improvement
• Contribute to the strategy and action plans for improving health and reducing health inequalities and lifestyle issues. • Encourage primary care practices to maximise their contribution to disease prevention and reducing health inequalities by making 'every contact count' to help address behaviours such as smoking, alcohol misuse, and obesity, and by optimising management of long term conditions. • Ensure that early intervention, primary and secondary prevention is incorporated into commissioning plans and care pathway (re)design. • Utilise contracts with providers to embed reduction of, and the monitoring of, health inequalities and the promotion of health and wellbeing priorities. • Support and contribute to locally driven public health campaigns. • Support the process of joint working on common outcome framework indicators.

Health Protection

3.5 The Health and Social Care Act 2012 will be followed by regulations which are likely to give B&NES Director of Public Health a series of responsibilities in respect of health protection, on behalf of Public Health England. These will include strategic leadership for public health protection including preventing and responding to outbreaks of communicable disease, planning for and mitigating the effects of public health incidents and environmental hazards, and assuring NHS resilience.

3.6 The Act designates CCGs as Category 2 responders and bestows on them a duty to co-operate with other responders and to share information both in the planning for and response to major incidents affecting their responsible population. These duties are intended to ensure that CCGs are properly prepared to deal with relevant emergencies. The Secretary of State retains emergency powers to direct any NHS body to extend or cease functions, and is likely to discharge these through the NHS Commissioning Board.

3.7 Therefore, to ensure robust health protection arrangements:

Public Health will:

Emergency planning and response:
Be responsible for the exercising of Local Authority functions that relate to planning for, and responding to, emergencies that involve a risk to public health[1]. This will include implementing robust integrated emergency management and health protection principles to ensure that: • National and local threats and hazards likely to impact on the health of the local population are understood and captured. This includes working in collaboration with the Local Health Resilience Partnership (LHRP) and Local Resilience Forum (LRF) to develop a risk register (i.e. the Community Risk Register). • Local strategic plans are in place for the protection of the local population's health and wellbeing (from relatively minor outbreaks to full scale emergencies), and for responding to the full range of principle risks identified in the national and local risk registers. Plans will include setting out the core elements to local arrangements, such as local arrangements for a 24/7 on-call rota of qualified personnel (currently delivered through the Director on Call rota system and a fully equipped Incident Room), arrangements for the stockpiling of essential medicines and supplies, and escalation protocols and arrangements for setting up incident/outbreak control teams. • Plans are adequately tested, exercised and subject to peer review. • Debriefing for real incidents is undertaken and learning points are captured and incorporated into future training requirements and plan revisions. • The capacity and skills are in place to co-ordinate the response to major incidents and emergencies, through strategic and tactical command and

[1] See new section 73A(1)(d) of the NHS Act 2006, as inserted by section 30 of the Health and Social Care Act 2012.

control arrangements.

- Staff are appropriately trained or have access to externally provided or accredited training to be able to expedite specific roles and responsibilities during the repose to major incidents and emergencies or communicable disease outbreaks.

Wider health protection:

Public health will:

- Provide advice to the clinical community on health protection and infection control issues (via Public Health England where appropriate).

- Help ensure that the Local Authority and local partners are supporting preventative services that tackle key threats to the health of local people e.g. may involve advising on preparation of cold weather plans, developing local initiatives to raise awareness of risks of infectious diseases based on population needs identified through the local JSNAs etc.

- Provide public health input for developing a Sustainable Development Management Plan against nationally recognised indicators, and for commissioning criteria related to sustainable development.

- Prior to April 2013: Remain responsible for ensuring that adequate public health support is in place for the safe commissioning of screening and immunisation programmes. Post April 2013: Ensure that plans are in place to protect the population, including through screening and immunisation. This will include providing independent scrutiny and challenge of the plans of the NHS Commissioning Board, Public Health England and providers.

- Provide surveillance and public health intelligence relating to childhood and adult immunisation campaigns. This includes feedback and reporting to the CCG, especially where potential risks to public health are identified due to inadequate coverage.

(Discussions are on-going with regards to the roles and responsibilities of public health and the CCG in relation to infection control. The MOU will be updated once these are agreed).

B&NES CCG will:

- Fulfil their duties as a Category 2 responder by co-operating with other local responders and sharing information, both in the planning for and response to major incidents affecting their responsible population.
- Develop and maintain a plan to enable the CCG to implement an appropriate

response to local incidents.

- Participate in single or multi-agency exercises when requested to do so. This may include communication cascade tests, table top exercise participation and triennial live exercise participation.

- Ensure that staff required to respond to a major incident are familiar with Strategic (Gold) and Tactical (Silver) multi-agency command centres and procedures.

- Utilise contracts with providers to ensure they:
  - Have robust business continuity plans in place.
  - Include clauses related to infection prevention and control.

- Encourage constituent practices to have business continuity plans in place to cover action in the event of the most likely business continuity incidents. Plans should include how the general practice will contribute to an emergency response, including the provision of medical support to rest centres and the treatment and triaging of minor injuries.

- Use Public Health information to support immunisation programmes, working together to reach high coverage.

- Contribute to and formalise an organisational Sustainable Development Management Plan.

3.8 The health protection section of this MOU reflects guidance issued by the Department of Health in September 2012[i]. It will be updated to reflect any further guidance from the DH, in light of public health regulations to be made under the 2006 Act as amended by the Health and Social Care Act 2012.

4.0 Annual work programme

4.1 Although the MOU is helpful in outlining the scope of public health services that can be provided to the CCG, as public health capacity is limited, it will be important to focus public health resource on those functions and projects that are priority for both the CCG and public health. An annual work programme will be developed for this purpose.

4.2 The annual work programme will outline the priority projects and functions that public health will provide to the CCG, and the key responsibilities of

the CCG back to public health. The work programme will also set out the key deliverables, outcomes, timescales for delivery, and the named public health lead for each project/function.

4.3 The annual work programme will be agreed by the Public Health and CCG Steering Group, and reviewed at least every 6 months (see section 6).

5.0 Quality of the service

5.1 DH guidance states that public health advice to the CCG should be obtained from an appropriately qualified and skilled public health specialist team. The functions required of CCGs include domains where significant public health science skills are required to perform tasks competently.

5.2 In response to this B&NES Council will ensure that:

- The public health advice is given by a team led by a Faculty of Public Health accredited Director of Public Health, supported by Faculty approved and accredited Consultants in Public Health, and an appropriately qualified and experienced multi-disciplinary public health team.
- The lead public health specialist for the population healthcare ("core offer") aspect of the service will be fully qualified with the Faculty of Public Health (FPH) and subject to all existing NHS clinical governance rules, including those for continued professional development.

6.0 Accountability and governance

6.1 A Public Health and CCG Steering Group will meet every 6 months (every 3 months during the transition period) to oversee the delivery of the MOU and annual work programme. The role of the Steering Group will include providing active direction, periodically reviewing progress against the work programme, acting as a forum for decision making, and identifying actions required to ensure that the service delivers its stated outputs.

6.2 The Steering Group will include representation from (at least) one CCG GP, the CCG Chief Operating Officer, the lead PH Consultant, and the PH Information Analyst.

6.3 The DPH will report to the Health and Wellbeing Board[2] on any key business issues reported by the Steering Group. The Director of Public Health and CCG will also jointly present a brief annual report to the Health & Wellbeing Board, setting out how the service had been provided that year. This will cover the process for engaging with public health expertise, whether the deliverables set out in the work programme have been met, key achievements, and key learning and priorities for the next year.

6.4 The Steering Group will link with (though not report to) other interested committees/forums such as the JSNA Steering Group.

7.0 Legal status

7.1 Whilst this MoU is not legally binding, it reflects current national guidance under which the Local Authority is mandated to provide public health advice and support to the CCG. The CCG as a statutory partner of the Health & Wellbeing Board also requires sound public health advice on which to base its recommendations.

8.0 Reconciliation of disagreement

8.1 Disagreements will normally be resolved amicably at the working level. If this is not possible, any concerns that the CCG have regarding support from the PH service, should be brought to the attention of the DPH. Likewise, if public health staff have concerns relating to CCG work, this should be brought to the attention of the DPH, who will seek to reconcile concerns/disagreements through liaison with the Chief Operating Officer.

8.2 If the issue requires escalation within the Council, this should be to the Strategic Director in the first instance, and then if required, to the Chief Executive of the Council.

8.3 Where disputes cannot be agreed at the local level, the formal mechanism being developed by the Department of Health[3] (and which is due to be set

[2] The purpose of the Health & Wellbeing Board is to provide leadership and direction across agencies that deliver services to improve the health and wellbeing of the residents in B&NES. Both PH and the CCG are statutory members of the Health & Wellbeing Board.

[3] The mechanism will be included in this MOU once it has been published by the Department of Health.

out in regulations[ii]) should be used. Final referral should be to the Local Government Ombudsman.

9.0 Review of Memorandum of Understanding

9.1 This Memorandum will be reviewed initially after six months, and thereafter on an annual basis.

9.2 Proposed review date – February 2013

Memorandum of Understanding Signatories:

Signature:_____	Signature: _____
Date:_____	Date: _____
Paul Scott B&NES Director of Public Health	Dr. Ian Orpen B&NES Clinical Commissioning Group Lead
Signature:_____	Signature:_____
Date:_____	Date:_____
Jo Farrar B&NES County Council Chief Executive	Ed MaCalister-Smith NHS B&NES Chief Executive

[i] Department of Health. 2012 (September). *Health protection and local government.* http://www.dh.gov.uk/health/2012/08/health-protection-guidance/

[ii] Department of Health. 2012 (June). *Healthcare Public Health Advice to CCGs.* Accessed at: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_132760

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Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Equality Impact Assessment / Equality Analysis

Title of service or policy	**Memorandum of Understanding between B&NES Clinical Commissioning Group and Public Health in B&NES Council**
Name of directorate and service	Currently Public Health within B&NES PCT. Due to move to B&NES Council from April 2013.
Name and role of officers completing the EIA	Amy McCullough, Public Health Specialty Registrar
Date of assessment	August 2012

Equality Impact Assessment (or 'Equality Analysis') is a process of systematically analysing a new or existing policy or service to identify what impact or likely impact it will have on different groups within the community. The primary concern is to identify any discriminatory or negative consequences for a particular group or sector of the community. Equality impact Assessments (EIAs) can be carried out in relation to service delivery as well as employment policies and strategies.

This toolkit has been developed to use as a framework when carrying out an Equality Impact Assessment (EIA) or Equality Analysis on a policy, service or function. It is intended that this is used as a working document throughout the process, with a final version including the action plan section being published on the Council's and NHS Bath and North East Somerset's websites.

1.	**Identify the aims of the policy or service and how it is implemented.**	
	Key questions	**Answers / Notes**
1.1	Briefly describe purpose of the service/policy including • How the service/policy is delivered and by whom • If responsibility for its implementation is shared with other departments or organisations • Intended outcomes	• The purpose of the Memorandum of Understanding (MOU) is to establish a framework for working relationships between B&NES Clinical Commissioning Group (CCG) and the public health team (due to be located with B&NES Council from April 2013), and to set out the scope of the service (i.e. functions) that public health will provide to the CCG. It also outlines the reciprocal responsibilities of the CCG in receiving these services. • The services that public health will provide to the CCG, includes the domain of *population healthcare*, which is informed by "core offer" guidance by the Department of Health. The MOU also outlines those services that will be provided under the other domains of public health: *health improvement* and *health protection*, so that all public health services provided to the CCG are captured in one MOU. • Responsibility for implementation of the MOU is shared between public health (and so B&NES Council from April 2013) and the CCG. • Intended outcomes are: An MOU that clearly defines the working

		relationship between public health and the CCG, the services/functions that public health can provide to the CCG and the CCGs reciprocal responsibilities, and arrangements to support the implementation of the MOU i.e. development of an annual work programme, governance arrangements. The overall outcome is an MOU that supports the delivery of a high quality specialist public health service to the CCG (from October 2012).
1.2	Provide brief details of the scope of the policy or service being reviewed, for example: • Is it a new service/policy or review of an existing one? • Is it a national requirement?). • How much room for review is there?	• The provision of public health advice, information and expertise to CCGs is a national requirement (from April 2013), stipulated under the under the Health and Social Care Act. • The Department of Health published guidance in February 2012 (updated in June 2012), encouraging CCGs and public health teams to develop an MOU, which will support CCGs in making best use of public health expertise. • The MOU is not a legally binding document, although the provision of specialist advice is mandatory. The CCG as a statutory partner of the Health & Wellbeing Board also requires sound public health advice on which to base its recommendations. • The services outlined under the *population healthcare, health improvement, and health protection sections* are informed by DH guidance, and the provision of specialist advice and some key public health functions (i.e. health protection, and immunisation/screening responsibilities) will be made mandatory by the Health and Social Care Act. However, there is local flexibility to prioritise which services are provided to some extent, and/or provide additional services.
1.3	Do the aims of this policy link to or conflict with any other policies of the Council?	• Links with the Council's responsibility to provide specialist public health advice to the CCG from April 2013.

2. Consideration of available data, research and information

Monitoring data and other information should be used to help you analyse whether you are delivering a fair and equal service. Please consider the availability of the following as potential sources:

- **Demographic** data and other statistics, including census findings
- Recent **research** findings (local and national)
- Results from **consultation or engagement** you have undertaken
- Service user **monitoring data** (including ethnicity, gender, disability, religion/belief, sexual orientation and age)
- Information from **relevant groups** or agencies, for example trade unions and voluntary/community organisations
- Analysis of records of enquiries about your service, or **complaints** or **compliments** about them
- Recommendations of **external inspections** or audit reports

	Key questions	**Data, research and information that you can refer to**
2.1	What is the equalities profile of the team delivering the service/policy?	To be addressed in workforce strategy.
2.2	What equalities training have staff received?	General equalities awareness training; training on undertaking EIAs; service-specific equalities training; managing equalities.
2.3	What is the equalities profile of service users?	The provision of advice to the CCG could potentially affect the health and wellbeing of the local community as a whole, as well as specific service groups or users. For example, the CCG may use specialist public health advice to inform the commissioning arrangements for a health promotion service aimed at the general public, or for a service aimed at a specific group such as adolescents with a combination of weight management and mental health problems. The Joint Strategic Needs Assessment for Bath and North East Somerset sets out the profile of the local community, as well as the

		profile of specific groups and service users.
2.4	What other data do you have in terms of service users or staff? (e.g results of customer satisfaction surveys, consultation findings). Are there any gaps?	N/A – as the MOU is not aimed to meet the needs of a specific group of service users. However, under the MOU, data on customer satisfaction surveys and consultation findings will be provided to the CCG (i.e. as part of the JSNA or specific needs assessment and data requests).
2.5	What engagement or consultation has been undertaken as part of this EIA and with whom? What were the results?	Discussion internally (i.e. within public health).
2.6	If you are planning to undertake any consultation in the future regarding this service or policy, how will you include equalities considerations within this?	Internal consultation within B&NES PCT, B&NES Council and the CCG has been undertaken. External stakeholders will not be consulted on the MOU document, though specific projects undertaken by public health as a result of the MOU (and outlined in an annual work programme) will include consultation with external stakeholders and use of engagement processes and forums such as Bath and North Somerset Local Involvement Network. These will include a consideration of equalities as appropriate.

3. Assessment of impact: 'Equality analysis'

	Based upon any data you have considered, or the results of consultation or research, use the spaces below to demonstrate you have analysed how the service or policy: • Meets any particular needs of equalities groups or helps promote equality in some way. • Could have a negative or adverse impact for any of the equalities groups		
		Examples of what the service has	**Examples of actual or potential negative or adverse impact and**

		done to promote equality	what steps have been or could be taken to address this
3.1	**Gender** – identify the impact/potential impact of the policy on women and men. (Are there any issues regarding pregnancy and maternity?)	The MOU will promote equality across all groups by stipulating the following: Public health will: • Support commissioning practice towards the reduction of local health inequalities and the specific needs of vulnerable and marginalised groups by: - Supporting GPs to collect improved inequalities data, and - By highlighting any inequalities/vulnerable groups within the Health Profiles (as far as possible with the data available). • Use information on effectiveness, cost effectiveness and acceptability to inform policy decisions on the commissioning of services in order to maximise health gain and reduce health inequalities. • Refresh the strategy and action plans for improving health and reducing health inequalities, and seek CCG input into these. Strategies and plans will include those that focus on particular groups and communities (i.e.	No negative or adverse impacts are anticipated. On the contrary, the MOU provides an opportunity for public health to support the CCG in promoting equality and diversity through the provision of public health intelligence and advice.
3.2	**Transgender –** – identify the impact/potential impact of the policy on transgender people		
3.3	**Disability** - identify the impact/potential impact of the policy on disabled people (ensure consideration of a range of impairments including both physical and mental impairments)		
3.4	**Age** – identify the impact/potential impact of the policy on different age groups		
3.5	**Race** – identify the impact/potential impact on different black and minority ethnic groups		
3.6	**Sexual orientation -** identify the impact/potential impact of the policy on lesbians, gay, bisexual & heterosexual people		
3.7	**Religion/belief** – identify the impact/potential impact of the policy on people of different religious/faith groups and also upon those with no religion.		
3.8	**Socio-economically disadvantaged** – identify the impact on people who are disadvantaged due to factors like family background,		

	educational attainment, neighbourhood, employment status can influence life chances	traveller community), settings, and behaviours and lifestyles (i.e. obesity, smoking, alcohol, injury prevention, sexual health, mental health). The CCG will: • Contribute to the strategy and action plans for improving health and reducing health inequalities and lifestyle issues. • Encourage primary care practices to maximise their contribution to disease prevention and reducing health inequalities by making 'every contact count' to help address behaviours such as smoking, alcohol misuse, and obesity, and by optimising management of long term conditions. • Utilise contracts with providers to embed reduction of, and the monitoring of, health inequalities and the promotion of health and wellbeing priorities. • Consider Public Health data including health inequality data in planning.	
3.9	**Rural communities** – identify the impact / potential impact on people living in rural communities		

4. Bath and North East Somerset Council & NHS B&NES
Equality Impact Assessment Improvement Plan

Please list actions that you plan to take as a result of this assessment. These actions should be based upon the analysis of data and engagement, any gaps in the data you have identified, and any steps you will be taking to address any negative impacts or remove barriers. The actions need to be built into your service planning framework. Actions/targets should be measurable, achievable, realistic and time framed.

Issues identified	Actions required	Progress milestones	Officer responsible	By when
Ensure that (in)equalities are given due consideration when developing the annual work programme that will set out which services/projects (within the MOU) will be considered priority and delivered to the CCG in the oncoming year.	Consider equalities within discussions on the annual work programme, and ensure addressed.	Equalities are explicitly referred to in the annual work programme.	Amy McCullough	October 2012

5. Sign off and publishing

Once you have completed this form, it needs to be 'approved' by your Divisional Director or their nominated officer. Following this sign off, send a copy to the Equalities Team (equality@bathnes.gov.uk), who will publish it on the Council's and/or NHS B&NES' website. Keep a copy for your own records.

Signed off by: Paul Scott, Director of Public Health
Date: September 2012

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Bath & North East Somerset Council

MEETING:	Health and Wellbeing Board (Shadow)
MEETING DATE:	19th September 2012
TITLE:	Joint Strategic Needs Assessment Update
AN OPEN PUBLIC ITEM	
List of attachments to this report: JSNA Update Briefing	

1 THE ISSUE

1.1 This report provides an update to the Joint Strategic Needs Assessment based and summarises findings of recent research conducted on the Bath and North East Somerset community.

2 RECOMMENDATION

The Board is asked to:

2.1 Note the findings of the report and consider the impact of any new findings on local policy.

2.2 Consider any other research or intelligence activity we should be including and who else should be informed.

2.3 Promote the JSNA web-site www.bathnes.gov.uk/jsna

3 FINANCIAL IMPLICATIONS

3.1 There are no direct resource implications of this report, however the findings will be included in data used to supplement the Equalities Impact Assessment of council budget proposals.

4 THE REPORT

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4.1 As agreed at the November 2011 board meeting, Policy and Partnerships and Public Health have managed the production of a Joint Strategic Needs Assessment.

4.2 The aim of the JSNA is to create a single strategic evidence base for understanding local lives, local communities and local services. This means we are broadening the traditional scope of the JSNA to look beyond trends in health and social care to examine the broader social and environmental determinants of wellbeing.

4.3 The JSNA has tried to get a balance between statistical data and information from consultation and engagement activity as well as reflecting local performance.

4.4 In April a Health and Wellbeing workshop noted the initial findings of the Joint Strategic Needs Assessment. That published document has been used as the foundation of the emerging Health and Wellbeing Strategy and to inform the CCG plan. We are also working with colleagues in Planning Policy to integrate the JSNA and the Local Development Framework Evidence base. In the shorter term, it will also be used as part of the Equalities Impact Assessment of the Councils' 2013/14 budget proposals.

4.5 In addition, an intention is to use the JSNA to a vehicle the transparency and community empowerment agenda, the main JSNA documents can be found on the Council's public web-site at www.bathnes.gov.uk/jsna as well as underlying source material.

4.6 It was also agreed that the main JSNA 'technical summary' would be updated on a rolling basis with briefings to be provided to the Health & Wellbeing Board as appropriate.

4.7 A briefing note detailing notable updates to our knowledge and an assessment of how they change what we already know are attached as Appendix 1.

5 RISK MANAGEMENT

5.1 A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

6 EQUALITIES

6.1 Findings from this update increase our knowledge about the needs associated with a range of equalities characteristics:

(1) Age – Particularly younger people (generally positive health outcomes with regards diabetes, epilepsy and asthma, updated childhood obesity data and

hospital stays for alcohol) and Student-age population (increased information about their approach to neighbourhoods)

(2) Socio-economic inequality – Increased understanding about the role of this factor as a significant underlying issue in health and wellbeing

6.2 In addition, an explicit Equalities Summary is produced alongside the JSNA annual summary. This document will shortly be available from the JSNA web-site.

7 CONSULTATION

7.1 *Cabinet Member; Staff; Other Public Sector Bodies; Section 151 Finance Officer; Chief Executive; Monitoring Officer*

7.2 Consultation has been made in line with corporate guidance and has also been sought from the multi-agency JSNA and Health & Wellbeing Strategy Steering Group.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Customer Focus; Sustainability; Young People; Human Rights; Corporate; Health & Safety; Impact on Staff; Other Legal Considerations

9 ADVICE SOUGHT

9.1 The Council's Monitoring Officer (Divisional Director – Legal and Democratic Services) and Section 151 Officer (Divisional Director - Finance) have had the opportunity to input to this report and have cleared it for publication.

Contact person	Jon Poole, Research & Intelligence Manager
Background papers	**JSNA 2-page summary** **JSNA 15-page plain English Summary** **JSNA 'Technical Summary'** **All can be downloaded from www.bathnes.gov.uk/jsna**
Please contact the report author if you need to access this report in an alternative format	

New Research, Facts & Figures

(JSNA Update – Dated 31/08/12)

News

The Joint Strategic Needs Assessment is online – visit www.bathnes.gov.uk/jsna for all the JSNA documents and lots more. Over the next few months we will be releasing a summary of equalities data and also data relating to smaller geographical areas.

The Census is here! – On Census day, our population was 176,000. A separate briefing note is available. This data will change a lot of what we know about the area, and more updates will be following as we fully learn what the data means for the area. If there is anything in particular you want to know about the Census, please get in touch– research@bathnes.gov.uk

Coming soon… - Other work on the horizon includes the House Conditions Survey, more detailed release of Census data and analysis of the local labour market…

New Research

Reports will be shortly available online, but if you would like a copy of any of the underlying data or reports, please contact research@bathnes.gov.uk

Health Profile 2012

The new health profiles for England are out; they show how Bath and North East Somerset compares to the rest of the country for top-level health data:

- On the whole **Bath and North East Somerset remains considerably healthier** than most areas, with a small number of exceptions:

- There are higher rates of **malignant melanoma (skin cancer**) than nationally. Numbers are very low (37 cases and 9 deaths in 2011/12), but as with the rest of the country they have been rising over time.

- **Hospital stays for under 18s** which are specifically related to alcohol are higher than national levels, but only represent 27 cases a year. These numbers only relate to people whose conditions are wholly caused by alcohol and so would not include someone admitted after a fight.

- **Hospital stays for self-harm** are significantly higher than nationally and whilst it has been suggested that this may represent better diagnosis and monitoring by health professionals further analysis has shown that there is a significant relationship between self-harm and economic inequality.

- In addition, the level of **excess winter mortality** is no longer significantly higher than national rates.

How does this change what we already know?
Where there is variation the numbers of cases are often very small in real terms and may still be subject to statistical chance. The increase in malignant melanoma will be discussed in more detail in the forthcoming review of Cancer data and alcohol related incidents amongst young people have already been raised as a gap for further enquiry.

The relationship between self-harm and economic inequality adds more to our local understanding of economic inequality as a key causal factor to health outcomes.

Hospital Admissions for children with diabetes, epilepsy and asthma

New data on this subject has been made available, and in all cases rates are either better than or in line with national levels.

How does this change what we already know?
This confirms our view that the health of children and young people in Bath and North East Somerset is generally better than the average.

Child Measurement Data – Healthy Weight

In 2010/11 a greater proportion of children measured in Bath and North East Somerset were of an unhealthy weight than the England average in reception year, while fewer children are of an unhealthy weight in year six (although this is rising).

Overall 30.6% of children in year six are of an unhealthy weight and 24.1% of those at reception year. There appear to be relationships between unhealthy rate and social inequalities in particular, those who experience social inequalities and who live in rural areas.

How does this change what we already know?

This information continues to demonstrate the extent of unhealthy weight amongst children in Bath and North East Somerset. Whilst the relationship with social inequality and rural areas confirms that these issues are likely to be important causal factors in health outcomes.

University Challenge: Students and Local Environmental Quality:

Research conducted by Keep Britain Tidy in Bath, examining the relationship between students and their local community, discovered that students consider themselves strongly influenced by friendship groups.

How does this change what we already know?
This research suggests us ways to engage with Students and explains how they may think about their local community.

Subjective Wellbeing

The government have released new data relating to the subjective wellbeing of the population. The wellbeing data was collected using four survey questions relating to life satisfaction, worthwhile activities, general happiness and general anxiety.

For the first three 'positive' wellbeing measures, the area scores significantly higher than the England and South West scores and is ranked second highest in the South West (just behind Cornwall) on the life satisfaction measure. Conversely, local people were more likely to consider themselves 'anxious' than both South West and England averages and is the third highest in the South West.

How does this change what we already know?
This re-affirms our view that the population generally has a high level of good health and wellbeing although higher levels of anxiety may align with other data on mental health issues in the area. It is, however, still very early days in terms of understanding what impact this data may have in terms of influencing government policy.

IS YOUR RESEARCH MISSING? – If you know of any new research about Bath and North East Somerset (on any subject) that we're missing, please get in touch
research@bathnes.gov.uk

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Health and Wellbeing Board (shadow)	
MEETING DATE:	19 September 2012
TITLE:	Strategic priorities
AN OPEN PUBLIC ITEM	
List of attachments to this report: None	

1 THE ISSUE

1.1 The Health and Wellbeing Board is responsible for developing a set of strategic priorities that deliver the Boards aim to:

- Reduce health inequalities and improve health and wellbeing in Bath and North East Somerset

1.2 This report seeks agreement on 7 strategic priorities. These priorities have been developed by a task group of the Board and are based on the Joint Strategic Needs Assessment (JSNA) update 2012.

1.3 These priorities will form the foundations of the Joint Health and Wellbeing Strategy (JHWS), as well as inform the Boards work programme over the next 3 years.

2 RECOMMENDATION

The Board is asked to:

1) To agree the 7 strategic priorities set out in this report (point 4.4). *(in agreeing these priorities the board should consider the feasibility of aligning these 7 strategic priorities and commissioning/delivery plans)*

2) To agree to review the strategic priorities in 15-16 in line with the 3 year duration of the CCG Plan.

3 FINANCIAL IMPLICATIONS

3.1 There are no direct financial implications arising from this report. However, implementation of the priorities may require service areas to consider service design / allocation of resources to ensure the Board delivers priority outcomes.

4 MAIN REPORT

4.1 *'Joint health and wellbeing strategies should prioritise the issues requiring the greatest attention, avoiding the pitfalls of trying to take action on everything all at once. They will not be a long list of everything that might be done; they will focus instead on key issues that make the biggest difference'.* ***(DoH draft JHWS guidance)***

4.2 On 28 May and 2 July a task group of the HWB, chaired by Cllr Simon Allen, began thinking on a set of strategic priorities for the B&NES Health and Wellbeing Board. Discussions were informed by the JSNA update 2012. The output from these sessions is 7 strategic priorities.

4.3 To ensure public and patient input into the development of the strategic priorities the Link were part of both task group sessions.

4.4 The 7 strategic priorities are:

- Improve outcomes for people who experience mental health problems
- Improve the outcomes of families experiencing complex needs
- Improve the outcomes of vulnerable groups
- Improve the outcomes of people with long term conditions (including end of life)
- Improve the outcomes of our aging population
- Reduce economic inequality (linked with poor health outcomes)
- Develop healthy and sustainable places and communities

4.5 The priorities will offer the Board the opportunity to be clear about what it wants to achieve locally. They will create a strong local voice which will enable the Board to influence decisions locally and nationally; including the NHS commissioning board. They should underpin commissioning plans and service delivery in order to improve health outcomes.

4.6 ***The national versus local context***

National versus local outcomes frameworks continue to be a debate that Health and Wellbeing Boards and CCGs are struggling with nationally. There is concern that JSNAs and JHWS(including local priorities) will become 'interesting reads' unless real consideration is given to local priorities in the design, commissioning and delivery of services. The DoH is clear that national outcomes frameworks give:

'commissioners freedom to decide how to improve quality and outcomes in ways that are most important for their local populations' ('levels of ambition, NHS Outcomes Framework).

4.7 It will be important for each HWB partner to strike a balance between the national and the local context; as without a common strategic vision - through this set of locally informed strategic priorities - there is a risk to partnership integration. To achieve this, these 7 strategic priorities will need to find a way of setting themselves against national outcomes frameworks. This will be a challenge that will require a commitment from partners to shape commissioning and delivery plans against these priorities as well as national outcomes frameworks. *(The HWB has a duty to ensure that commissioning plans take proper account of these priorities and the Joint Health and Wellbeing Strategy.)*

4.8 ***In the context of the economic climate***

Feedback at the 13 June HWB on the strategic priorities was that there needed to be more recognition of the current economic, commissioning and political context. The following has been added as an introduction to the strategic priorities:

In the context:

- *Of the **tough economic climate**, which is creating many challenges for the public sector. Our financial capacity to deliver services in the same way as the past is being put under pressure. These priorities offer the Board the opportunity to be clear about what it wants to achieve and where commissioning plans and resources should be targeted.*
- *Priorities and outcomes will be delivered in the context of the existing financial and **commissioning** framework.*
- *Of the **local political environment**. The priorities will help create a strong local voice which will help the Board to influence locally and nationally, including local commissioning plans*

and the NHS commissioning board. It will also enable the Board to be clear about what it is going to do and what it is not going to do.

4.9 The task group was also keen that the Board adopted principles of operation that would ensure focus and attention is given to ill-health prevention, system integration and community engagement. The following has been added as an introduction to the strategic priorities:

Principles of operation:

- *Strengthen the role and impact of ill-health* ***prevention***
- *A commitment to* ***add value*** *through a 'whole system approach' and through* ***integrating*** *the NHS, social care and public health systems.*
    - *Influence planning, transport, housing, environment, economic development and community safety in order to address the wider determinants of health and wellbeing.*
- ***High quality*** *service delivery* ***within the resources available****. Including low cost and no cost options, and reducing waste through a whole system approach.*
- *A commitment to* ***public, patient and provider engagement.*** *.*

4.10 The task group was keen to recognise that there is already a wealth of activity taking place across the health and wellbeing sector that is aready contributing to the delivery of the 7 strategic priorities. An initial mapping exercise will be undertaken to set out this activity. The aim of this exercise will be to better understand what we are doing now.

4.11 The task group was also clear that to add value, delivery of the 7 strategic priorities should not simply be the coordination of existing activity but a re-think of the key outcomes and activity against the 7 priorities This should ensure a meaningful focus on better outcomes for people, a whole system view of service delivery (such as housing, the economy and the environment), as well as identifying gaps and opportunity for better service integration.

4.12 Duration

The CCG have agreed a 3 year term for the CCG Plan (with 12–13 being year 1). It is recommended that the duration of the Boards priorities, and subsequently the Joint Health and Wellbeing Strategy, is aligned with the duration the CCG Plan. This will mean that the 7 strategic priorities and the JHWS will be reviewed in 14-15. (DoH draft guidance leaves the duration of the JHWS up to local determination).

4.13 Next steps

The 7 strategic priorities will form the foundations of the JHWS. It is also recommended that the Board selects just 2 of these priorities to really focus on in12 – 13. To identify the top 2 priorities for 12 – 13 the task group will conduct a prioritisation exercise and report back to the November HWB Board.

4.14 Once the top 2 priorities are agreed a process will be undertaken to identify the key outcomes against the priorities, and to shape future commissioning and delivery accordingly.

5 RISK MANAGEMENT

5.1 Risk will form a key consideration in the delivery of the Boards priorities.

6 EQUALITIES

6.1 Inequality is a key part of the JSNA framework. To reduce health inequality is a key ambition of the Board – around which the priorities are framed.

7 CONSULTATION

4.2 The emerging priorities have been developed in consultation with:

a. *Cabinet Member; Staff; Other B&NES Services; Service Users; Local Residents; Community Interest Groups; Stakeholders/Partners; Other Public Sector Bodies;*

8 ISSUES TO CONSIDER IN REACHING THE DECISION

a. Select from: *Social Inclusion; Customer Focus; Sustainability; Human Resources; Property; Young People; Human Rights; Corporate; Health & Safety; Impact on Staff; Other Legal Considerations*

9 ADVICE SOUGHT

a. The Council's Monitoring Officer (Council Solicitor) and Section 151 Officer (Divisional Director - Finance) have had the opportunity to input to this report and have cleared it for publication.

Contact person	*Helen Edelstyn (x7951)*
Background papers	*NA*
Please contact the report author if you need to access this report in an alternative format	

Bath & North East Somerset Council	
MEETING:	Health and Wellbeing Board (Shadow)
MEETING DATE:	19th September 2012
TITLE:	NHS Bath & North East Somerset CCG's Strategic Plan
AN OPEN PUBLIC ITEM	
List of attachments to this report: Attachment 1 : CCG's Draft Strategic Plan	

1 THE ISSUE

1.1 Each Clinical Commissioning Group is required as part of the CCG Authorisation process to develop an integrated plan. The integrated plan includes:

- *A high level strategic plan for the 3 year period to 2014-15*
- *The CCG's Operational Plan for 2012/13*
- *Draft commissioning intentions for 2013/14*

1.2 This paper sets out the CCG's draft high level strategic plan to the period 2014-15.

1.3 At the June Health and Well-being Board meeting the CCG shared an overview of it's draft strategic service priorities. The CCG is sharing the fuller draft plan of its strategic plan with Health and Well-being members for their consideration.

2 RECOMMENDATION

2.1 The Board is asked to review the latest version of the CCG's Strategic plan.

3 FINANCIAL IMPLICATIONS

3.1 Section 10 of the plan describes the 3 year financial planning assumptions for the CCG. Based on current information available this highlights that locally NHS budgets are likely to grow by no more than 2% per annum, we can anticipate inflationary pressures of 3.5% and efficiency requirements of 4%. This will require the CCG to develop an annual set of initiatives to create recurring efficiency savings in the region of £10.5m over a two period.

4 THE REPORT

4.1 The plan is enclosed at Attachment 1. The plan describes:

- An overview of the CCG
- The national and local context and how this has shaped the CCG's plans
- An overview of local health needs (based on B&NES' local Joint Strategic Needs Assessment)
- The linkages to the emerging themes we have been discussing as part of the Health and Well-being Strategy
- Service level priorities by area of care
- The financial planning assumptions for the next 3 years
- How the CCG will deliver on its plan

5 RISK MANAGEMENT

5.1 Section 11 of the plan describes the CCG's overall approach to risk management, our assessment of some of the key risks for the CCG and the actions we will take to mitigate against these.

6 EQUALITIES

6.1 An Equality Impact Assessment (EqIA) has been completed. This identified that there were further opportunities to draw upon local sources of information about the needs of our local population.

6.2 EqIAs will be completed in the future in relation to key service changes identified in the plan e.g.local proposals to review and re-design the urgent care system.

7 CONSULTATION

7.1 A series of stakeholder events took place during May and July where the CCG tested some of its proposals. This included engagement with local providers, including voluntary and third sector organisations, Councillors and members of the public.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 The CCG's plan sets out how it will respond to national and local priorities and therefore relates to a range of issues including :- Social Inclusion; Customer Focus; Sustainability; Human Resources; Human Rights and Impact on Staff.

9 ADVICE SOUGHT

9.1 The Strategic plan has been reviewed by the CCG's Clinical Commissioning Committee and members of the PCT's Cluster Board.

Contact person	Tracey Cox, Chief Operating Officer (Interim) Contact telephone number : 01225 831736
Background	Towards Establishment:- Creating responsive and accountable

papers	clinical commissioning groups http://www.commissioningboard.nhs.uk/files/2012/01/NHSCBA-02-2012-6-Guidance-Towards-establishment-Final.pdf
Please contact the report author if you need to access this report in an alternative format	

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Bath & North East Somerset Clinical Commissioning Group

Integrated Commissioning Plan

September 2012

Foreword

Healthier, Stronger, Together

v.7 (12 September 2012)

From April 2013, Clinical Commissioning Groups (CCGs) will become the statutory bodies responsible for commissioning local health services in England. In preparation for this, Bath & North East Somerset (B&NES) CCG is currently working in shadow form and is taking on a greater degree of accountability for managing NHS budgets and developing commissioning plans.

This document is our integrated plan for the period 2012/13 to 2014/15. It has been developed by the CCG with the purpose of outlining our vision for local health services and to set out our strategic priorities and key initiative for the next three years. The plan is set out in three parts:

Part 1 – A high level strategic plan for the period 2012/13 to 2014/15
Part 2 – Our Operational Plan for 2012/13
Part 3 – Our draft Commissioning Intentions for 2013/14

Underpinning the plan is a recognition that clinician involvement and accountability are central to the reforms set out in the Health and Social Care Act. In keeping with its philosophy, we have developed our current structure from the bottom up and have achieved a level of engagement with our colleagues and practices that we fully aim to build on. We will continue to develop our local structure working across 5 practice cluster groupings to ensure excellent clinical engagement. We will maintain flexibility in order to accommodate nationally mandated structural changes as and when they occur.

We recognise that joint commissioning with the local authority and significant public health involvement will be fundamental to the success of Clinical Commissioning Groups. To this end, we have worked with Local Authority colleagues to develop a Joint Working Framework: this describes our joint commissioning arrangements and commitment with which the CCG and B&NES Council will work together for the benefit of local people.

It goes without saying that effective relationships with our local stakeholders will be pivotal and our ethos will be to put the needs of patients and the local population at the centre of everything we do. It is through this meaningful engagement with local stakeholders, including clinicians from primary, secondary and community care, the public and the Local Authority that we believe we can add value to the commissioning process. We aim to do this by working both at strategic and practical levels, closely linking to all colleagues and stakeholders, keeping the commissioning process relevant to those implementing our commissioning plans and the public at large.

Dr Ian Orpen, Chair, B&NES Clinical Commissioning Group

Document structure

This document is structured to reflect the domain requirements of the CCG Authorisation process, *"A clear and credible integrated plan which includes an operating plan for 2012-13, draft commissioning intentions for 2013-14 and a high level strategic plan until 2014-15."*

The document has three parts:

Part 1 – A high level strategic plan which runs to 2014/15

Part 2 – Our Operational Plan 2012/13 which describes our plans and financial arrangements in more detail

Part 3 – Our draft Commissioning Intentions for 2013/14. (The detailed operational plan for 2013/14 will be available later this year).

Contents

PART 1

Strategic Plan 2012/13 to 2014/15

Healthier, Stronger, Together

v.7 (12 September 2012)

1. Executive Summary

1.1 Level of GP involvement and support

Over the past 18 months, there has been a clear commitment from all of the clinical leads on the governing body to work with their respective commissioning lead manager to help develop and implement our QIPP (Quality, Innovation, Productivity and Prevention) plans. This has been apparent when the CCG has been discussing its plans with various stakeholder groups and in particular, when CCG leads have presented pathway and service development plans to our member practices, through the regular GP forums and practice cluster group meetings.

Our plan has therefore had close involvement of the GP leads in their QIPP programme areas, working with lead commissioning managers across the QIPP work streams. The on-going involvement of the clinical leads in monitoring progress with our QIPP plans is enacted through monthly feedback and progress to the CCG governing body at the monthly clinical commissioning meetings. The Shadow Clinical Accountable officer, with his counterpart from the Wiltshire CCG co-leads the QIPP performance management meetings hosted monthly by the Strategic Health Authority and co-chairs, with the chair of the Wiltshire CCG the local QIPP programme Board, which brings together all the main providers in BANES and Wiltshire to a forum where priorities and actions for QIPP are discussed and signed up to.

1.2 Clinical added value

All the CCG clinical leads took a leading role in our consultation programme when we engaged with local community stakeholders at a number of events held in B&NES. We have a number of regular forums where we meet with local providers, the public, the local authority and the member practices of the CCG. In all of these interfaces, the CCG clinicians take a leading role in communicating the tasks and challenges ahead of us: maintaining and improving quality of services and outcomes and living within the tight financial constraints we have to face in the future.

Our plan gives more detailed information of the areas where we feel we have given added value: for example, taking a leading role in the development of the hip and knee pathway; involvement in our mental health board and helping to shape and give direction to future mental health services; leading the Urgent Care Network, which brings together all the main providers involved in urgent care in our area; the implementation of the 111 project has involved a significant amount of input from our urgent care lead, who has been undertaking this work on behalf of both B&NES and Wiltshire; leading on long term conditions, particularly involvement in our dementia care strategy; leading in medicines

management, for example the plan to rationalise prescribing of anti-psychotics in patients with dementia and the prescribing of gluten free products in patients with coeliac disease- these latter have involved consultation exercises, which have been led by CCG clinicians.

1.3 Joint Working arrangements with the Local Authority

B&NES CCG is in the enviable position of having inherited from the PCT a very effective joint working arrangement with the Local Authority. Through a project group, this has now culminated in a more formal joint working partnership agreement which has been taken through our PCT board and the council leaders for approval.

The joint working arrangements have been developed in mental health, urgent care, long term conditions, learning difficulties and continuing health care. Joint budgets and shared risk arrangements have helped underpin an ethos of joint working. The Clinical Accountable Officer (designate) and the Strategic Director for People and Communities both have a place on each other's senior management teams, which helps to bring the operational day to day management of the two organisations even closer together.

We see that commitment to the joint working culture of the two organisations is vital in order for us to be able to meet the demands of the future. This is well demonstrated by our consistently good performance of managing delayed transfers of care (DTOCs) from our local acute provider. The issues resulting in DTOCs are complex and cut across health and social care. A joint approach, from both a commissioning and providing perspective, has clearly brought dividends in this area, and forms a critical part of our approach in managing the urgent care agenda and it is our intent to develop into the future more integration of our respective organisations, a greater level of pooled budgets and co-location.

1.4 Stakeholder Engagement

As mentioned in the introduction, clinicians and senior commissioning managers have been involved in leading a number of important stakeholder events, which have helped shape this plan. We have held meetings with our local providers, including acute care trusts, community providers, our mental health services provider and the third sector. Consultation events with the public and our membership practices have all been led by clinicians working with our managers. The CCG chair and shadow clinical accountable officer also presented the outline plan to our Health and Wellbeing Board.

1.5 Committed staff

It goes without saying that no matter how good our plans and strategy are on paper, the team of individuals that make up the CCG governing body and the member practices of the CCG will be instrumental in helping to deliver the strategy into meaningful outcomes for the people of Bath and North East Somerset. There is a clear commitment and high level of enthusiasm inherent in all the individuals we are very fortunate in having work with us: this gives us the best possible chance of success. We are at the start of what will be a challenging and exciting journey: our culture of working together with all of our stakeholders will stand us in good stead. The leadership provided by the clinicians and commissioning managers and all those that support us will give us the best possible chance of changing local health and social care services to meet the future demands of demographic change, rising expectations and a financially challenging environment.

Dr Simon Douglass, Clinical Accountable Officer (designate), B&NES Clinical Commissioning Group

2. Introduction

2.1 Overview

This document is our integrated plan for the period 2012/13 to 2014/15. It has been developed by the CCG, with the purpose of outlining our vision for local health services and to set out our strategic priorities and key initiatives for the next three years.

The plan describes:

- The context of the developing B&NES CCG and the challenges of dealing with the financial environment facing the local NHS over the next three years. The plan pays particular attention to the ownership and delivery of the QIPP agenda and the crucial importance of engagement with local stakeholders in managing the increasing demands that will be placed on local social and health services, caused by future demographic pressures.

- The structural, budgetary and operating arrangements for the Clinical Commissioning Group, including a description of our local mandate and the proposed methods of local clinical engagement. This will be pivotal in ensuring the success of the CCG.

- Clinical added value: where we see our roles in ensuring the success of the CCG and building on the impressive inheritance that has been delivered by the outgoing PCT. Crucially, success will be based on the effective engagement with the public, the Local Authority, local clinicians and other stakeholders. The full ownership and delivery of the QIPP agenda will be at the centre of everything we do, with quality of services being our number one priority: to this end, the CCG's engagement with the Quality Agenda will also be a significant part of the work plan.

- Governance arrangements, including accountability arrangements and relationships.

In developing the plan, we have worked closely with our member GP practices and partners including the Local Authority and Health & Wellbeing Board and B&NES LINK. We also sought contributions from the public, clinical colleagues in local provider organisations (NHS and private sector) and voluntary sector leads.

We held a series of stakeholder events to provide an opportunity to present our priorities and emerging plans to various stakeholder groups. This provided us

with some valuable feedback, elements of which have been incorporated within the plan.

The plan begins with an introduction to the CCG and its vision and values. It then sets out the national and local context within which the plan was developed and a number of themes which influenced the decision making around the key priorities for this plan period. The document then goes on to describe the priorities and high level plans for each of the service areas. The final sections summarise the commissioning arrangements which will support delivery; the financial plans and an outline of how we will measure our performance.

2.2 B&NES Clinical Commissioning Group

Bath & North East Somerset Clinical Commissioning Group (CCG) consists of 28 member practices. We cover the city of Bath, the towns of Radstock, Midsomer Norton, Paulton, Keynsham and the Chew Valley and we have a registered population of approximately 195,000. The CCG covers the full geographic area of NHS Bath & North East Somerset PCT and its geographic boundaries are co-terminous with B&NES Local Authority. Individuals elected by our member practices fill 7 seats on our Governing Body.

		Service Lead for:
Ian Orpen	GP Partner, CCG Chair	Prescribing
Simon Douglass	GP Partner, Clinical Accountable Officer	Mental Health services
Ruth Grabham	GP Partner, Clinical Director	End of Life Care & Long Term Conditions
Jim Hampton	GP Partner	Elective Care
Liz Hersch	GP Partner	Non-Elective Care
Shan Mantri	GP (Sessional)	Learning Disabilities
Roger Stead	Practice Manager	

Working arrangements are based on 5 geographic clusters of practices and each Practice Cluster is supported by a Governing Body member acting as Cluster Commissioning Lead.

	Cluster Name	**Number of practices**	**Registered population**
Cluster 1	**Norton Radstock**	7	48,703 patients
Cluster 2	**Chew/Keynsham**	5	38,140 patients
Cluster 3	**Bath East**	5	30,680 patients
Cluster 4	**Bath West**	5	39,656 patients

Cluster 5	**Bath Central**	6	38,646 patients

The Cluster Commissioning Leads hold regular Practice Cluster meetings and the wider GP Forum is held on a monthly basis. All practices are invited to the GP Forum for educational sessions and to share learning and best practice around commissioning and clinical pathway performance management. The Forum is well established and currently has three main functions:

- Commissioning – presentations on topical issues and group work
- Education – presentations by local consultants about new clinical pathways and commissioning focused discussion
- GP business – presentations by the primary care provider group on topical issues in practice.

2.3 Governance Arrangements

During the transitional year 2012/13, the Clinical Commissioning Committee (CCC) is the shadow CCG Governing Body. This is a formal committee of the PCT Board, established in September 2011, working within an agreed Scheme of Delegation. Its principal functions are to oversee the development of the B&NES Primary Care Trust's (PCT) commissioning strategy, clinical policy development and the PCT's annual operating plan, on behalf of the Board.

The key features of the Clinical Commissioning Committee (CCC) are:

- Clinicians have a majority membership
- There are two lay members. One is a champion of 'Patient & Public Involvement' and the other of 'Governance and Audit'. (The latter is also a Non-Executive Director of the PCT Cluster Board).
- The PCT Cluster Chief Executive is not a member but is in attendance
- The Chair of the CCC is a full member of the PCT Cluster Board
- Its line of accountability is to the Board but also has representation on the B&NES Health & Wellbeing Board recently established by the Local Authority.

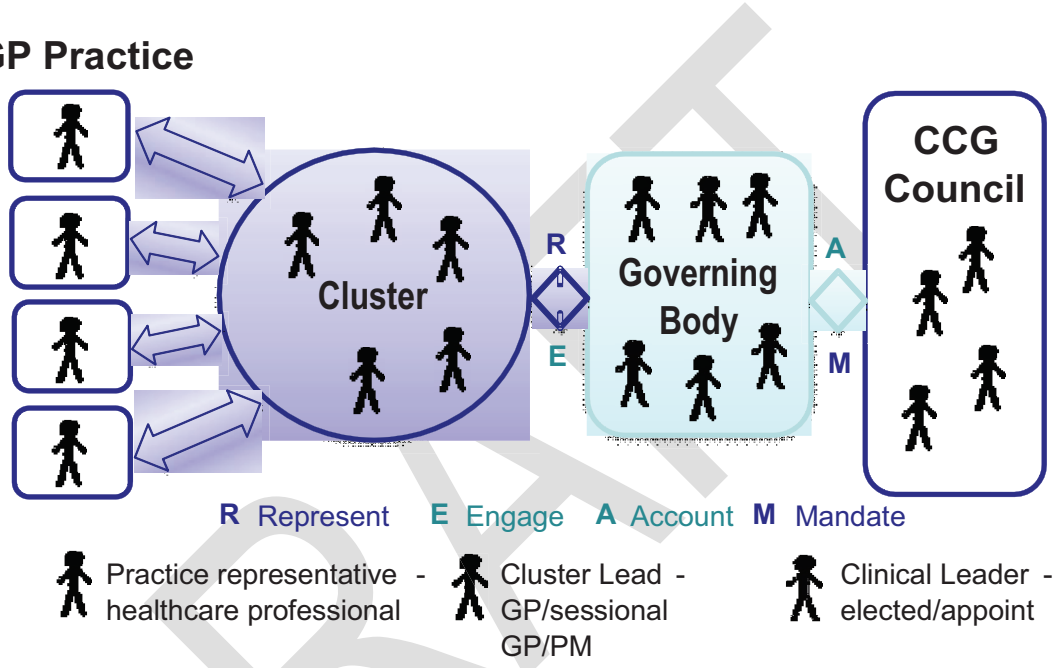
From 1 April 2013, the CCG will be established as a statutory body and this will require a step change in function and responsibility. We have been working with the Foresight Partnership and DAC Beachcroft to develop new governance arrangements in accordance with good practice and the NHS Commissioning Board guidance on authorisation. This includes:

- 'Towards Establishment', February 2012
- CCG Governing Board committees: terms of reference, March 2012
- CCG Governing Body members: role outlines, attributes & skills, April 12

- Model Constitution Framework, April 2012
- The Function of Clinical Commissioning Groups, Department of Health, June 2012

A governance model has been developed and a consultation exercise was carried out on the proposed governance structure during July 2012. The new governance arrangements are summarised in the diagrams below.

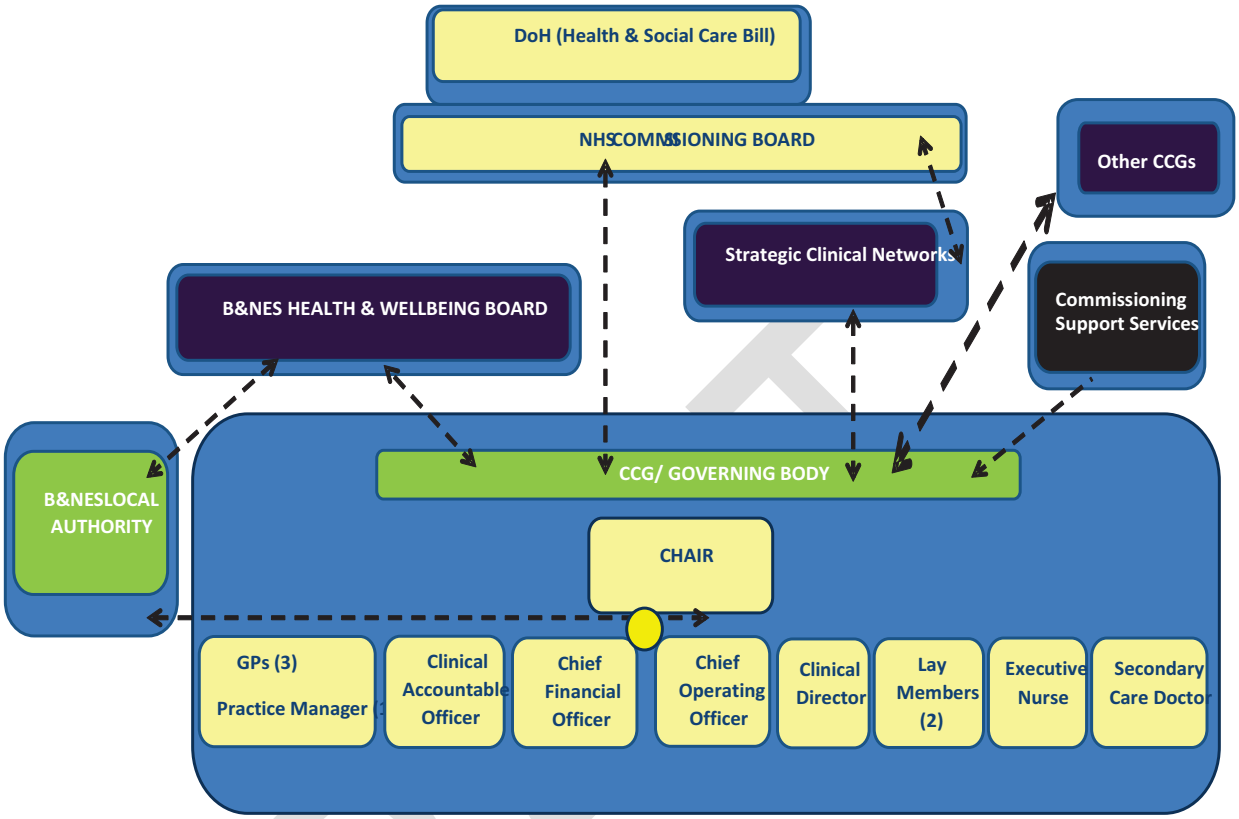
Proposed CCG governance structure from April



Governing Body membership:

5 voting non-clinicians	8 voting clinicians
1 Patient/Public Adviser (Lay)	1 Chair (GP)
1 Vice Chair / Audit & Governance Advisor (Lay)	1 Clinical Accountable Officer (GP)
1 Chief Financial Officer	1 Clinical Director (GP)
1 Chief Operating Officer	2 GP Cluster Leads
1 Practice Manager, Cluster Lead	1 Sessional GP Cluster Lead
	1 Secondary Care Clinician
	1 Registered Nurse

The diagram below summarises the CCG/Governing Body relationships with organisations in the local health system, including the B&NES Local Authority's Health & Wellbeing Board and the NHS Commissioning Board.



For further information, please see the proposed CCG Constitution document (add hyperlink when finalised).

Recruitment to the governing body structure is well underway with Designate appointments to the roles of Chair, Clinical Accountable Officer, Clinical Director, Chief Financial Officer, Chief Operating Officer and Lay members taking place during September 2012.

Appointment of the Registered Nurse and Secondary Care Doctor role will be made during October.

During October and November, the remaining roles in the CCG structure will be appointed to. The final CCG structure is expected to have circa 28 members of staff.

3. Mission, Vision and Values

Our Mission

- To commission high quality, affordable, integrated patient centred care which respects and responds to the needs of our local population.
- In doing so, we will harness the strength of clinician led commissioning and empower our patients to improve their health status

Establishing the CCG's Mission, Vision and Values was an early organisational development priority. These have been developed jointly between the Clinical leadership team and commissioning staff and have been shared and tested widely with member practices and local stakeholders including the Health and Wellbeing Board, local provider organisations including non-statutory bodies and members of the public.

The key change resulting from the reforms set out in the Health and Social Care Act is the shift to clinical leadership, with support from expert management. This has created an energy locally which we intend to build on as the basis for delivering the challenging targets we all face.

We will work with our colleagues so that they understand their involvement in this process and our belief that we are able to carry through the changes required. We have already started working on engagement with key stakeholders through:

- The early election of Governing Body members from practices through an election
- All Governing Body GP members have linked practices and all practices have been visited
- GP Forum Plus – monthly educational/commissioning focused afternoons
- Regular meetings with secondary care colleagues to agree focus and work on key clinical pathways and the establishment of a Commissioning Reference Group.
- The development of a draft Memorandum of Understanding to describe how we will work collaboratively with our Wiltshire CCG colleagues on commissioning arrangements with the RUH.
- Monthly meetings between the Chair of the CCG and Chief Executive of the Council
- Meetings with LINK and Health Watch as the latter takes over the statutory role of providing public scrutiny of commissioned services.

- A series of engagement events with stakeholders on our plan (these are described more fully in section 7).

The engagement with clinicians in primary care is crucial and practice visits have been helpful in establishing this. There is a recognition that we need to avoid the disconnect that sometimes occurred with Practice Based Commissioning. We are aware of the need to be open and transparent with our colleagues about their new responsibilities as members of the CCG and how the Governing Body will work on their behalf. Looking ahead, the development of our working relationship with the 5 practice Clusters will be critical to the delivery of this. We are developing, as part of our organisational development plan, our approach to cluster working and securing a high level of practice engagement.

The ongoing Quality agenda for engagement will be based on our local proposals for improving the effectiveness and value for money of services including our QIPP programme and ensuring we meet the targets we are required to. The priorities identified through discussions with commissioners and providers will drive the agenda for the engagement process. All QIPP areas have Governing Body GP members allocated as leads to be responsible for overseeing their application and to work closely with CCG commissioning staff.

We believe this clinical input will add value to the commissioning process by helping to establish both the clinical and evidential basis for service redesign and changing priorities. With this will come greater acceptance from clinicians and an increased likelihood of successful delivery of the changes that the QIPP agenda demands. We believe the key to success is to harness this clinical leadership with the expertise of the senior commissioning team.

Our Vision

'Healthier, Stronger, Together'

It is our vision to raise the awareness to all colleagues in primary, secondary and community care of our collective responsibilities of being involved in delivering high quality cost effective and efficient health care to our population. We recognise the vital importance of joint working with the local authority to deliver high quality and effective social care, which will have a positive impact on reducing more costly downstream health interventions. There is a need for all to understand that we, meaning the public and health and social care colleagues are all involved with this and that we all pull in the same direction.

It is by ensuring colleagues understand their pivotal roles in delivering our plans and strategy and how they work with and support their peers in terms of performance, for example admission and referral rates that we aim to ensure

improved outcomes for the population of B&NES: it is critical that GP practices understand their accountability in all of this. We have already started to work with B&NES GP practices in a number of areas and the following examples show where clinical involvement has added value to the commissioning process.

Example 1: Hip and knee pathway

The CCG reviewed the hip and knee pathway following an assessment of the programme budgeting data and the Atlas of Health Variation. This identified that B&NES had higher than benchmark orthopaedic activity and spend, particularly for hip and knee replacements. It also highlighted that patient symptoms and levels of disability prior to treatment were less severe in B&NES compared to other areas.

The CCG established a hip and knee pathway group to review existing practice and NICE guidance. It became clear that referral practice was variable across and within GP practices and in some cases, patients were being referred and treated before conservative management had been tried. The group developed and agreed a pathway which sets out comprehensive management in primary and community services, with greater scope for treatment and improvement without surgery. The pathway also includes revised follow up arrangements which will give patients care closer to home, in line with clinical protocols agreed with orthopaedic consultants and will reduce the overall number of follow ups in secondary care.

The CCG negotiated with the local community physiotherapy provider to offer patients a 12 week physiotherapy-led hip and knee programme within existing contractual arrangements. This supports patients in the early stages of the pathway, achieving better use of available resources and improved access for patients.

Example 2: Implementation of Clinical Priorities Policy

The CCG recognises that there are difficult decisions ahead about the use of NHS resources and that these must be based on robust evidence of clinical benefit. Putting in place strong clinical ownership of the issues and principles will support future decision-making and ensure that resources are being used where they will deliver most benefit to patients. The CCG therefore decided to focus on working with GPs and secondary care consultants to develop a more comprehensive Clinical Priorities Policy. The regular GP Forum meetings were used to inform local GPs about how spending on low benefit procedures affects overall availability of resources, and to benchmark and review activity by practice.

The policy was reviewed and developed through the QIPP Clinical Leadership Group which includes CCG GPs and clinicians from the local health community. The policy covers treatments and procedures for which there is either no

evidence of clinical benefit for our patients, or for which there is little clinical benefit (health gain) for certain forms of treatment. Secondary care involvement and 'buy in' was a very important element in developing the policy, as the programme is designed to reduce secondary care activity overall: this will allow consultants to focus on patients with more complex and urgent conditions and therefore a greater need and chance of benefitting form health interventions..

A comprehensive Clinical Priorities Policy document was produced and published both as a printed booklet and desk top electronic version for all GPs to use as a referral document in their practices. This was published in October 2011. The publication of a printed document, which sits alongside the Bath prescribing Formulary as the local clinical reference documents, has meant GPs have immediate access to the policies and can use the document in consultations with patients to identify what treatments are of clinical benefit for which patients.

The involvement of a broad group of clinicians including secondary care clinicians has meant there is wide ownership of the principles of prioritising based on clinical evidence, as well as acceptance of the individual policies within the document, even though it is reducing secondary care activity. Practices that have been shown to be outliers have worked with the CCG to identify patterns in activity and developed action plans to reduce low benefit activity.

Please see our 'Case Studies' (add link) for further examples.

Our Values

- We will focus on continually improving the quality of services
- We will be credible, creative and ambitious on behalf of our local population
- We will work collaboratively and be respectful of others
- We will be focused, committed and hard working
- We will be alert to the needs of all our population, particularly those who are most vulnerable
- We will operate with integrity and trust

4. National and local context

This section briefly describes the context within which the CCG is operating and identifies the key trends and factors which need to be reflected in our plans.

4.1 Demographics

The Population at a glance

There were 179,900 residents in Bath and North East Somerset (B&NES) in 2010, an increase of 1.1% (2000 people) from 2009, which is slightly greater than regional and national levels. The population increased by 7.7% between 1981 and 2009 (from 161,000 to the current figure). This is greater than the national increase but lower than the regional. This has been largely due to 'migration and other' factors in particular, the number of students in the two Universities doubled between 1995 and 2009.

The age and sex profile remains largely consistent compared to previous years, with a 49%/51% male/female split. The age profile is also largely consistent with the UK as a whole, except for the 20-24 age range which represents the significant student population.

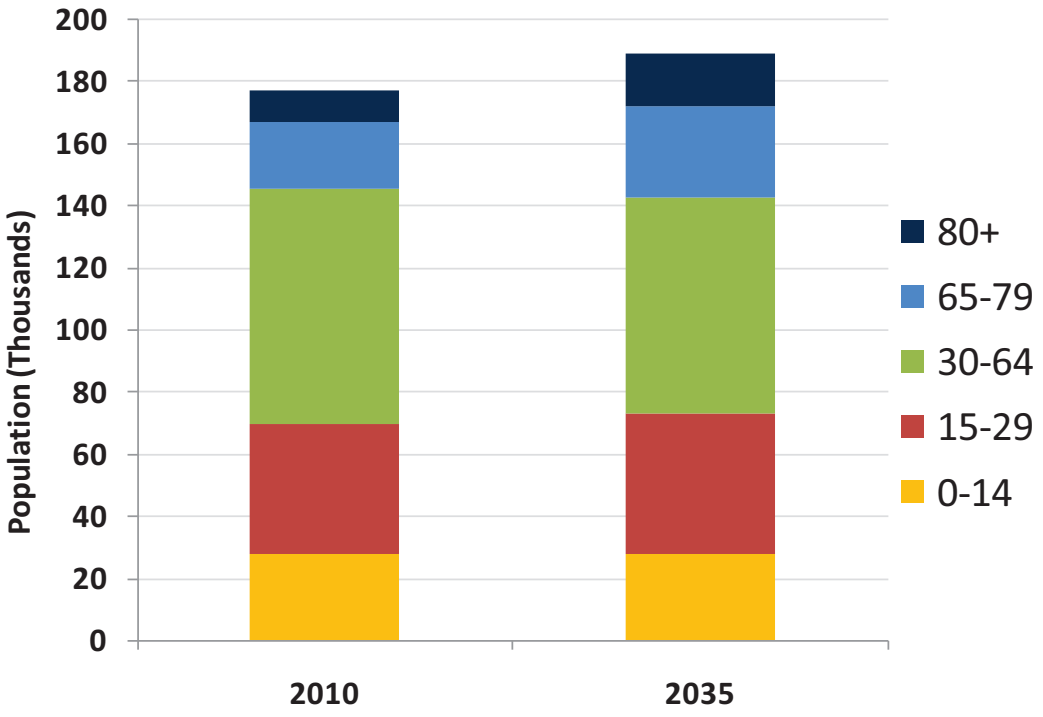
Bath and North East Somerset is less ethnically diverse than the UK as a whole but more so than the South West. 88% of residents are likely to define their ethnicity as White British. 'White other' (3.66%) is the most significant non-white British ethnicity by volume which is likely to include EU Accession state residents, followed by "Asian Indian" (1.97%), "Other ethnic background" (0.96%) and "Black African" (0.9%)

Demographic change

The Office of National Statistics (ONS) projects that the population of B&NES will increase to 198,800, by 2026. This increase is expected to be mainly in the older age groups; in particular the 80+ population is projected to increase by 40% from 9,900 in 2010 to 13,900 in 2026.

The age profile of B&NES is similar to the national average and growing older:

- In 1981, **5,600** people were 80 years or older
- In 2010, **9,900** people were 80 years or older



Mortality and life expectancy

The health of people in Bath and North East Somerset is generally better than the England average. Over the last 10 years, annual mortality rates for all causes have fallen. All-cause mortality has decreased from 731 per 100,000 in 1993 to 495 per 100,000 in 2010, (32% reduction). This downward trend is reflected in England and similar authorities. Female life expectancy is three years longer than men and women experience lower mortality rates.

Mortality from treatable conditions is also significantly lower than the England average. In addition, all-cause mortality has decreased in the under 75s, and the current rate for the area is lower than national, regional and comparator areas. Infant mortality rates are similar to the England average (however numbers are very small) and child mortality rates are lower.

Causes of mortality

The leading causes of mortality in B&NES are conditions of the heart, cancer, lungs, and diseases of the bowels, liver, kidney, stomach. These are also the four leading causes of mortality for England and Wales. Mortality rates for all these conditions are lower than England and South West rates.

Health profile at a glance

Deprivation	Deprivation is lower than average, however about 4,000 children live in poverty.
Life expectancy	Life expectancy is higher than the England average for both women and men. Life expectancy is 5.7 years lower for men and 4.5 years lower for women in the most deprived areas of B&NES compared to the least deprived areas.
Mortality rates	Over the last 10 years, annual all cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen and is better than the England average.
Cancer	Cancer incidence is increasing. However, mortality from cancer is decreasing. The incidence of malignant melanomas is higher than average. Colorectal and breast cancer rates are also increasing in line with the national position.
Disability and Long Term conditions	7% of the population has a physical disability, 12% sensory impairment, 1% autism and 16% have a mental health condition. The prevalence of diabetes is significantly lower than national rates. Emergency hospital bed days and smoking levels are both low amongst people with Long Term Conditions.
Mental Health	Prevalence of mental health conditions is generally lower or in line with national rates and suicide rates are low. BME population identified as at risk of mental health problems Self-harm and depression prevalence high (1000 more depression cases than expected) The prevalence of reported dementia in 2010/11 is slightly lower (0.4%) than the national average but there is likely to be significant under-reporting. The number of cases is expected to rise by 23% for females and 43% for males between 2010 and 2025.
Children	About 16.9% of Year 6 children are classified as obese. This is lower than the England average but both are rising. The rate in children from reception to Year 6 is also rising. The level of alcohol-specific hospital stays among those under 18 is worse than the English average. Levels of teenage pregnancy are better than the England average. Higher than average rates of asthma amongst young people.

4.2 Benchmarking information

NHS Commissioning Board CCG Profile

The NHSCB recently provided a profile of the CCG's activity, spend and outcomes. The profile included a range of measures to highlight variations in activity levels between CCGs and the link between spend and outcome. The table below summarises some of the measures. The key points to note are:

- the CCG had higher than average growth in non-elective admissions over the period 2007/8 to 2010/11
- the GP referral rate was slightly higher than the average in 2010/11

Non- elective admissions per 1,000 population (2010/11) Lower than average at 93 compared to 114 nationally **Growth in non-elective admissions between 2007/8 and 2010/11** Higher than average growth at 11% compared to 7% average national rate
GP referral rates per 1,000 population (2010/11) Slightly higher than average first outpatient attendances following a GP referral – 194 compared to 192 nationally **GP referral growth between 2007/8 and 2010/11** Lower than average growth at 19% compared to national average growth of 21%
Elective admissions per 1,000 population (2010/11) Lower than average at 100 compared to 121 nationally **Growth in elective admissions between 2007/8 and 2010/11** Lower than average growth at 7% compared to a national average of 16%
Prescribing spend rates per 1,000 population for the four biggest prescribing programmes in primary care in 2010/11 *(Circulation, Respiratory, Endocrinology and Mental Health)* Lower than average spend at £67,104 compared to £79,662 **Growth in prescribing spend rates for the 4 biggest programmes between 2007/8 and 2010/11** Lower than average growth at 1% compared to national average growth of 3%

Disease prevalence

A comparison of the prevalence of diseases covered by the QOF (Quality & Outcomes Framework) for the CCG practices during 2010/11 indicates that the B&NES population has higher rates of the following diseases compared to the England average:

- Stroke or Transient Ischaemic Attacks

- Cancer
- Asthma
- Heart Failure
- Atrial Fibrillation
- Depression (over 18 years old))

Health Profile 2012, Department of Health

The Department of Health has developed health profiles for each of the local authorities in England. The key points from the B&NES profile are:

- The health of people in B&NES is generally better than the England average
- Deprivation is lower than average but 4,000 children live in poverty
- Life expectancy is higher than the England average
- All cause mortality rates have fallen over the last 10 years
- Lower than average obesity in children
- Lower levels of teenage pregnancy
- Estimated levels of physical activity better than average
- Hospital stays for alcohol related harm higher than average for under 18s

The profile highlights three priorities for B&NES:

- Reducing hospital admissions for self-harm
- Reducing alcohol harm
- Reduce levels of overweight and obesity

4.3 Joint Strategic Needs Assessment

We have been working closely with our colleagues in the Local Authority in the development of the latest Joint Strategic Needs Assessment (JSNA). A number of priorities have been identified through this process and these are likely to be reflected in the Joint Health & Well Being Strategy (JHWS) currently under development. The key priorities identified are:

- Improve outcomes for people who experience mental health problems
- Improve the outcomes of families experiencing complex needs
- Improve the outcomes of vulnerable groups
- Improve the outcomes of people with long term conditions (including end of life)
- Improve the outcomes of our aging population
- Reduce economic inequality (linked with poor health outcomes)
- Develop healthy and sustainable places and communities

- **Complex families** – it is estimated that there are 220 families in B&NES with a range of a range of complex needs including unemployment, poor school attendance, domestic violence, mental health problems and anti-social behaviour.

- **An aging population** – the increase in life expectancy will create significant changes to our local population. The demand for appropriate housing including residential and nursing homes will grow. The profile of disease and cause of death will change, with increased prevalence of physical and mental fragility leading to pressure on public, private and voluntary care provision.

- **People with multiple conditions/needs (co-morbidity)** – people experiencing mental and physical disabilities are at risk of associated disorders and conditions. For example, 46% of people with a mental health problem also have a long term condition (LTC).

- **Social and economic differences** – despite relatively low levels of social inequality, there are small geographical areas with notable issues. These areas are largely comprised of social housing estates. Five areas are within the 20% most notable in the country across a range of data and indicators. Issues include lower life expectancy, higher prevalence of LTCs, alcohol misuse, increased risk of premature births, increased hospital admissions for self harm, poor dental health.

- **Rural areas** – people living in rural areas relying on oil-fuelled transport and heating have been identified as being at high risk of fuel poverty.

For further information on the B&NES Joint Needs Assessment please see

http://www.bathnes.gov.uk/communityandliving/ResearchAndIntelligence/Pages/default.aspx

4.4 National and local priorities for improving services

The NHS Constitution

We recognise our obligations to patients as set out in the NHS Constitution. Our patients have a right:

- To non-emergency treatment starting within a maximum of 18 weeks from referral
- To be seen by a specialist within a maximum of two weeks from GP referral for urgent referrals, where cancer is suspected
- To a choice of a number of hospitals for elective care
- To view personal health record

- To be treated with dignity and respect, including single sex accommodation
- To have complaints dealt with efficiently and investigated properly.

For further information on the NHS Constitution please see http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/nhs-constitution-interactive-version-march-2012.pdf

The Operating Framework for the NHS 2012/13

The 'Operating Framework for the NHS in England 2012/13' describes the planning, performance and financial requirements for NHS organisations and sets out four key themes:

- Putting patients at the centre of decision making
- Development of the new system of delivery
- Quality, innovation, productivity and prevention (QIPP)
- Maintaining and improving performance

The Framework also identifies a number of key priorities for 2012/13 including:

- Dementia and the care of older people
- Carers
- Military and veteran's health
- Health visitors and Family Nurse Partnerships

In addition there is a strong focus on Quality, safety and user experience measured and assessed through a range of indicators including:

- Waiting times
- Hospital Standard Mortality Rates
- Patient Experience
- Mixed Sex accommodation
- Healthcare Associated Infection rates
- VTE
- CQUIN schemes

The plans for meeting these standards and commitments during 2012/13 are set out in **Part 2 Operational Plan for 2012/13.**

The NHS Outcomes Framework

The NHS Outcomes Framework describes the health outcomes required from NHS organisation under 5 domains:

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

These requirements are reflected in the CCG and JSNA priorities for the plan period and various initiatives have been developed to help achieve these outcomes. Section 8 describes our key priorities and initiatives by service area.

The NHS Mandate

The Government's first draft mandate to the NHS Commissioning Board is currently out to public consultation. The mandate sets out the Government's objectives for the Board for the period from April 2013 to March 2015. It also sets ambitions for improving outcomes over five and ten years, to provide continuity for the NHS commissioning system.

We expect to see the outcome measures incorporated within the 2013/14 Operating Framework guidance later this year.

http://mandate.dh.gov.uk/2012/07/04/mandate-consultation/

Innovation, Health and Wealth

In December 2011, the Department of Health published its paper *Innovation, Health and Wealth*: Accelerating Adoption and Diffusion in the NHS. Innovation is defined as 'an idea, service or product, new to the NHS or applied in a way that is new to the NHS, which significantly improves the quality of health and care wherever it is applied'.

We will adopt, implement and extend each of the six high impact innovations set out in the paper and will ensure that QIPP plans reflect the high impact changes.

High Impact Innovation	CCG Plans for adoption and spread
Assistive technologies	We have a scheme using telecare in 2012-13. In 2013-14, we plan to extend the use of this scheme for patients with Long Term conditions.

Fluid Management monitoring system	Scheme running in 2012-13. Depending on the outcomes of this, extend use with more clinical conditions.
Child in a chair in a day	Work with current wheelchair providers to meet this guidance and ensure incorporated within the AQP procurement process.
International and commercial activity	Work with NHS Improvement body once further guidance is available
Digital by default	We have schemes using digital technology in 2012-13, and will extend the schemes into 2013-14
Carers for people with dementia	We are using CQUIN in 2012-13 to identify carers of people with dementia. We will review provision for carers with our local integrated provider of health and social care, to ensure we are improving support available.

4.5 Local Provider Landscape

The CCG will commission and influence the quality of service provision from a large number and wide range of providers. The following are some of the most significant (in terms of financial value/proportion of services).

4.5.1 Primary Care Provision

General Practice

There are 28 GP practices within the CCG area; all lists are open, signifying that supply is at least matching demand. Provision is evidenced as being high quality through annual QUOF scores and by our low exception reporting rate. There is a narrow range between best / worse QUOF scores for 2011/12 of2.4%. This indicates that performance is reliably high. There are a high number of training practices and recruitment is not considered a problem locally. The recently produced CCG Quality Profiles (July 2012), indicates that B&NES CCG performance for the ability to see a GP fairly quickly indicator is worse than the national picture by a degree that is unlikely to be explained by random chance. However, the ability to book ahead for an appointment indicator is better than the national picture. The link for the CCG quality profiles is: http://www.mego.nhs.uk/OurProjects/PracticeQualityProfiles/CCGQualityProfiles.aspx

Dental Services

There are a high number of dental practices for our population size: 32 practices including 1 corporate group and a range of independents. There is no overall market domination by any single group. Given the number of practices we have very good geographical spread. Dental services benchmark high against the vital signs quality indicators. Building & estates are of variable quality.

Pharmacists
We have 38 local pharmacists spread across our local communities with no overall market domination. We currently have 100 hour pharmacy and other applications in progress. There is aspiration and capacity to increase the role of the community pharmacist in health promotion and early intervention in minor illness.

Opticians
We have 22 high street opticians, a relatively high number for our population size.

4.5.2 Urgent & Elective Secondary Healthcare Provision

Royal United Hospital Bath NHS Trust for major acute hospital services
Our main provider of local secondary acute hospital care and held in high affection by local people. The Trust is currently progressing through its Foundation Trust application and is currently with Monitor. It is anticipated that the Trust will achieve Foundation Trust status by early 2013. The RUH also provides more specialist tertiary services in certain specialties. Historically performance against key targets has been challenged, particularly for A&E and waiting time targets. The Trust is in its final year of Debt repayment supported through long standing but time limited financial support from commissioners.

North Bristol NHS Trust and University Hospitals Bristol NHS Foundation Trust for patient choice in secondary care and for more specialised tertiary services
North Bristol is also seeking FT status with an aspiration to complete its application by early 2013. The Trust's Long Term Financial Model and Integrated Business Plan are due to be submitted to the Department of Health in September 2013.

UHB is the main university and teaching hospital providing the majority of tertiary services to the population of NHS B&NES. In conjunction with North Bristol NHS Trust, University Hospitals Bristol NHS Foundation Trust has established a project to look at the future of Bristol Acute Services, as part of the next phase of the Bristol Health Services plan. A project team has been established to bring back recommendations to both boards regarding the future of services. The recommendations would include consideration of the most appropriate way to deliver the service plan, which could mean a single acute trust for Bristol.

Royal National Hospital for Rheumatic Diseases for rheumatology and head injury services (though not majority user)
Provider of secondary care rheumatology services for B&NES, and a more specialist head injury service with a national reputation. The RNHRD was an early Foundation Trust and is now struggling to demonstrate financial viability

and the option to join with the RUH once it has successfully passed through its FT application is now proposed. Reaching agreement on a viable service model for the future represents a potential risk to the CCG. The CCG is therefore a key member of the Programme Board overseeing the process to decide on future service arrangements.

Independent Sector Treatment Centres (ISTC), Bath BMI and Circle, Bath
There is a rich local market for choice of elective care in Bath. The CCG continues to commission activity from centres at Emerson's Green and Shepton Mallet as well as elective activity from BMI Bath and Circle, Bath.

The CCG is commissioning up to £8.6m of services from these providers, although this includes significant under-utilisation of approximately £1m of the guaranteed contract value with ISTCs.

4.5.3 Mental Health Provision

Avon and Wiltshire Mental Health Partnership NHS Trust for specialist Mental health services
This is the CCG's main provider of specialist in patient and community mental health services. The Trust has been challenged both financially and in service terms but is now working closely with CCGs to review local service specifications and models of care. The Trust is currently reviewing its timescale to progress into the Foundation Trust pipeline.

4.5.4 Community Health and Social Care Provision

Sirona Care and Health Community Interest Company (CIC)
Sirona is the main provider of community health and social care services. Formed in October 2011 following the requirement for PCT's to divest themselves of their provider functions, the CIC provides integrated model of care and a wide range of services including District Nursing teams, community health and social care teams, Community Resource Centres and Community Hospitals in Bath and Paulton. As well as being an integrated community health & social care provider, Sirona is a community interest company which means they have to invest any surplus in local services for the benefit of the B&NES population.

The PCT agreed a 5-year contract with this provider, but with scope to give 12 months notice on individual service areas after an 18-month period of operation. The contract agreement being a tri-partite agreement between the PCT, local authority and the provider and delivers a range of integrated services.

4.5.5 Maternity Provision

Great Western Community Healthcare Services for maternity services

Provides maternity services for B&NES residents on the RUH and Paulton hospital sites and in the community.

4.5.6 Housing Provision

Curo Housing
Formed as a result of the transfer of council housing stock, this organisation is highly entrepreneurial and has a strong reputation locally. It has refurbished and brought back into use a significant number of local properties.

Approximately £4m is spent on housing related support services commissioned through Third Sector and £3m is spent on community-funded services providing social care commissioned from the Third sector.

4.5.7 The Third Sector

B&NES CCG is fortunate in that there is a vibrant third sector market in B&NES, albeit noting that this sector is particularly challenged in the current economic climate. The CCG already seen the benefits that these organisations can bring to local service arrangements through our local stakeholder events and there is a desire to continue to draw upon these organisations in support of our strategic service aims.

4.6 Financial Assumptions for the next three years

4.6.1 The Economic Context

Over the next three years the economic climate is likely to have a significant impact on the health and well being of local people as well as on the resilience of the local public, private and third sector organisations to respond to these additional challenges. A prolonged period of reduction in public expenditure is inevitable to address the deficit in the national finances. The high reliance of the economy in Bath on the public sector could become a disadvantage.

The financial planning assumptions for the CCG reflect the likely impact of this on the allocation available to B&NES. Income growth is expected to be at a minimum level, with provider inflation covered through the delivery of significant efficiency gains. Growth in excess of planned volumes and investment to improve services will need to be funded through the delivery of QIPP schemes.

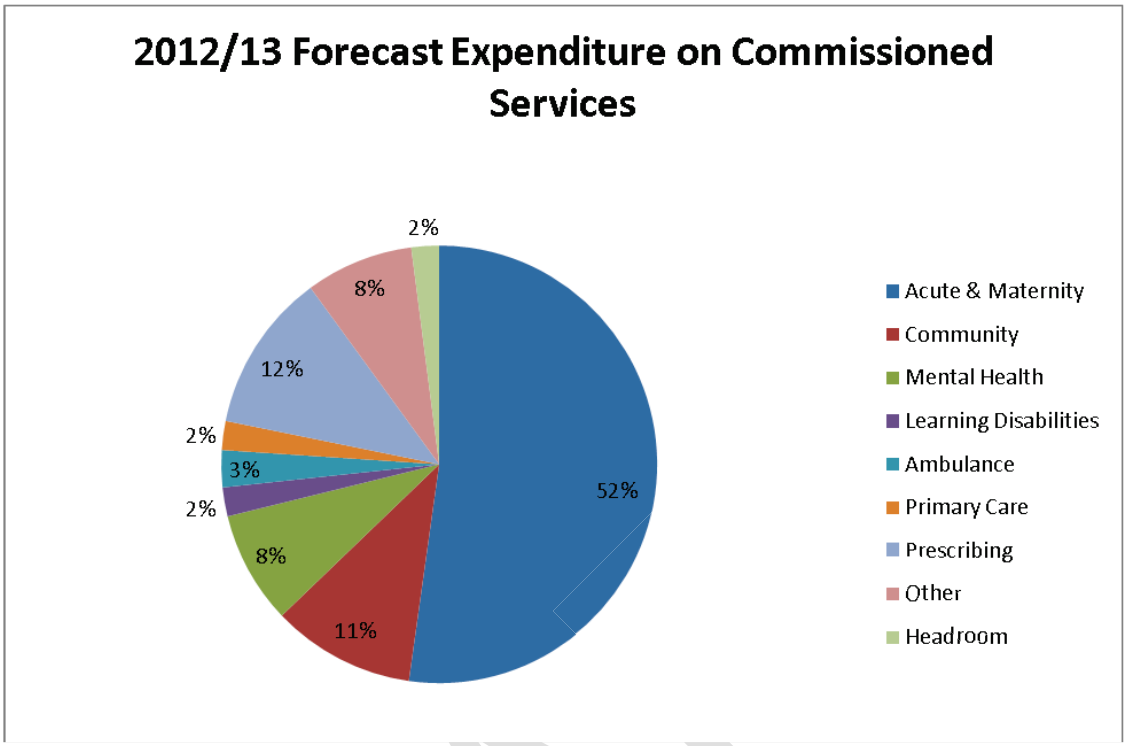
The CCG has developed a three-year financial plan which builds on the established 2012/13 to 2014/15 PCT medium term financial plan. The NHS Operating Framework underpins the priorities and financial assumptions. This is shown at summary level in the following table:

	2012/13 Forecast Outturn	2013/14 Plan	2014/15 Plan
	£000	£000	£000
Sources of Funds:			
Revenue Resource Limit	(218,979)	(223,891)	(227,642)
Total Sources of Funds	**(218,979)**	**(223,891)**	**(227,642)**
Applications of Funds:			
Commissioned Services	210,844	216,781	221,002
Running Costs	5,372	4,670	4,670
Total PCT Revenue Expenditure	**216,216**	**221,451**	**225,672**
Net Income & Expenditure Position	**(2,763)**	**(2,440)**	**(1,970)**

Please see Section 10 for further information on the Financial Plan.

4.6.2 How the budget will be allocated by type of service

The pie chart below shows how the budget is allocated by type of service.



4.7 QIPP

The national Quality, Innovation, Productivity and Prevention (QIPP) programme aims to improve the quality and delivery of care whilst making £20bn efficiency savings over the period 2011/12 to 2014/15. These savings can be reinvested in order to deliver year on year quality improvements and manage the pressure on services. These pressures include:

- **Increasing demand for services** - particularly from an ageing population with fewer people of caring age to support older people. There is also an expectation that the level and quality of services will continue to rise.
- **Increasing costs** – particularly from developments in technological treatments and the rising cost of medicines.
- **Improving quality standards** – there is an expectation that improvements in the quality and provision of services will continue to be made, regardless of the need to make efficiency savings
- **Managing key health challenges** – for example, obesity and dementia.

For the period of this plan, the CCG expects to be commissioning services with minimal funding to cover growth. The expected value of recurring QIPP savings required over the three-year period of the plan is £16.3m.

The CCG has worked with the PCT to further develop the four-year QIPP programme which began in 2011/12. The programme is intended to help deliver the efficiency savings whilst at the same time, delivering high-quality care. This will be achieved by:

- developing pathways that improve effectiveness and enhance the patient experience
- supporting innovation in clinical practice
- improving primary and secondary prevention
- early identification of disease and interventions
- reducing avoidable admissions to acute hospitals
- moving the focus of care away from acute hospitals to a community setting
- strengthening services in the community with access to services 7 days a week
- giving patients a greater role in the management of their health and any conditions they may have
- improving partnerships between primary, community and secondary care to support people with long term conditions
- increasing the use of new technologies to enable people to be cared for in their own homes

The projected QIPP programme savings for the period of this plan are summarised in section 10.5.

For further information on our QIPP programme see (add document title and hyperlink when finalised).

5. Key themes

The previous section described the national and local context within which the plan was developed. It highlights a number of key themes and factors relating to the current and future health needs of the B&NES population, which we will need to focus on. These include:

- A growing population – 12% increase by 2026
- An ageing population – 40% increase in >80s by 2026
- A significant student population
- Cancer incidence is increasing
- Higher than average rates of stroke and heart failure
- Higher than average growth in the rate of non-elective admissions
- High rates of asthma amongst young people
- Increasing number of people with a physical disability
- The prevalence of self harm and depression is higher than average
- BME population identified as at risk of mental health problems
- Dementia – increase of 23% in females and 43% in males by 2026
- A need to improve outcomes for people with mental health problem

We have also identified a number of strengths and weakness in the local health system which are summarised in the following table, together with the opportunities and threats.

STRENGTHS	WEAKNESSES
• GP leadership and commitment to new ways of working • History of strong financial management • CCG is relatively small – able to respond quickly and flexibly • High level of GP and practice support and involvement in CCG development • History of successful integrated working with the Local Authority • Integrated commissioning team already in place • Close working arrangements with Wiltshire CCG • Good working relationship with LINK • Clinical links with local secondary care clinicians already in place and work underway to re-design care pathways • Developing a strong relationship with the local H&W Board • Sirona - provider of community health & social care services • Longstanding excellent clinical engagement in quality agenda	• Organisation is in transition during Year 1 of the plan • CCG is relatively small – capacity to respond to challenges, risks and national requirements • Waiting times in some specialities • High referral rates for some specialities • High growth rate for non-elective admissions compared to the England average • A&E and patients attending inappropriately • Complex local urgent care system
OPPORTUNITIES	**THREATS**
• Local secondary care providers in transition – opportunity to influence future service configuration and provision • Opportunity to reduce referral rates through pathway re-design • Opportunity to reduce inappropriate emergency admissions e.g. management of people with LTCs • ISTC capacity not fully utilised • Relatively high spend on Free Nursing Care – opportunity to review and potentially reduce costs • Reduce use of secondary care beds and shift more care to the primary/community care setting, with integrated care teams • High level of opportunity to increase clinical added value through development of Cluster relationships • Opportunity to re-define and re-develop engagement mechanisms with the local public	• Growing population with increasing demand for health services • Aging population (40% increase in >80s by 2026) • Increase in LTCs, disabilities, mental health issues and dementia • Local secondary care providers in transition – possibility of deterioration in operational performance during transition phase • QIPP plans not fully realised • Affordability of the commissioning support services • Retention of key members of the CCG • Increasing cost of new drugs and technologies having an impact on managing budgets • Local Authority savings plans may impact on capacity of local social services

5.1 Commentary on SWOT Analysis

Building on Strengths

The CCG will use the skills and reputation of its clinical leaders and commissioning staff to sustain and further build upon a set of effective working relationships with our partners, with the public, patients and their carers. Section 9 of the plan provides an overview of the CCG's Organisational development plan which will be critical in ensuring that we are a highly effective organisation. We intend to remain an organisation with a strong quality focus aimed at continuously improving performance.

Addressing Weaknesses

There have been some historical issues with waiting times and pressures within the urgent care system. The CCG has a good awareness and understanding of the areas that it needs to address and our plans for the future reflect the need to continue to develop strategies to manage these issues. These are covered in the following section.

Whilst the CCG is in the year of transition during year 1 of our plan and there are many changes to respond to, we are fortunate in that we have a strong team of commissioning support staff with the right skills and organisational memory to support us through the transition period.

Taking Opportunities

Our greatest opportunities are to bring clinical added value to the commissioning process and to re-define and further develop our engagement processes with the local public and other stakeholders. We intend to fully pursue these as they will be instrumental in determining how successful we can be.

Managing Threats

Responding to the growing demands of an aging population, increasing demand for services and managing a period of austerity are threats that are common to most CCGs. If we fully utilise the opportunities that are available to us through clinical leadership and improved engagement on service plans with local people we stand a good chance of responding to these issues. Succession planning in terms of clinical leader in the future has been recognised as a key issue for the CCG as part of our organisational development plan and we will be developing a strategy to respond specifically to this issue.

6. Strategic Priorities

6.1 Strategic objectives

Sections 4 and 5 highlighted a number of key trends and themes for the local population and provision of health services. This information, together with our experience as clinicians working in the local health system has enabled us to identify the key strategic aims that we will need to address during this plan period and beyond. These aims are set out below as six strategic objectives for the CCG:

- Responding to the challenges of an aging population
- Improving quality and patient safety
- Promoting healthy lifestyles and wellbeing
- Improving the mental health and wellbeing of the population
- Improving access and consistency of care
- Reducing inequalities and social exclusion

6.2 CCG Service Priorities

In developing our strategic objectives, we have identified four key service priorities which we believe are critical to the achievement of our strategic objectives and to the long term success of the CCG. These priorities are:

- Re-design of urgent care
- Services for people with Long Term Conditions
- End of life care
- Dementia care

The strategic plans for each of these priority services are set out in Section 8 but the following describes the overall aims that we expect to achieve by 2014/15:

- To have integrated (health and social care) community teams proactively managing urgent care
- A streamlined urgent care system which includes the Emergency Department front door and Minor Injury Unit at Paulton Community Hospital
- Use of assistive technology including telecare and telehealth embedded and used to its full potential
- Patients receiving appropriate rehabilitation and re-ablement before assessment for longer term care

- Patients with long term conditions having access to psychological therapies
- Patients feeling supported and confident in managing their long term conditions
- To further increase the proportion of patients who are able to die in their place of choice
- Improving dementia assessment services in the community
- Increasing the "menu" of community support opportunities for people with dementia

6.3 Alignment with JHWS priorities

As noted in section 4.3, the Joint Health & Wellbeing Strategy (JHWB) is currently under development. The table below shows where these priorities align with the CCG's objectives and priorities

ALIGNMENT OF CCG AND JHWB PRIORITIES	
Aligned priorities:	
CCG priorities	**JHWB priorities**
Responding to the challenges of an aging population	Improve the outcomes of our aging population
Improving the mental health and wellbeing of the population	Improve outcomes for people who experience mental health problems
Promoting healthy lifestyles and wellbeing	Develop healthy and sustainable places and communities
Reducing inequalities and social exclusion	Improve the outcomes of vulnerable groups
	Reduce economic inequality (linked with poor health outcomes)
Services for people with Long Term Conditions	Improve the outcomes of people with long term conditions (including end of life)
End of Life care	
CCG only priorities:	
Improving quality and patient safety	
Improving access and consistency of care	
Re-design of urgent care	
Dementia care	
JHWB only priorities:	
Improve the outcomes of families experiencing complex needs	

6.4 Links to the QIPP programme

The following table summarises the links between the strategic objectives and priorities and the relevant elements of our QIPP programme.

Strategic Objectives	Outcomes	QIPP programme
Responding to the challenges of an aging population	**Long Term Conditions & Frail Elderly** • Role of primary care is geared towards the proactive management of patients with long term conditions, supported by a multi-disciplinary approach • Patients with long term conditions feel empowered and confident to self-manage their condition • Personalised care plans are seen as the norm for patients with long term conditions • People with dementia receive a timely diagnosis to enable them to feel in control of their lives • Caring for frail older people is seen as a rewarding career • Carers feel supported in their caring role • Post diagnostic support and intervention provided in primary and community care for people diagnosed with dementia in order to delay or avoid the need for specialist mental health services	**Unplanned Care and Long Term Conditions Care pathway** • Step up beds at Paulton Hospital • Community Geriatrician model (linked with risk stratification & case management) • Diabetic pathway • Expansion of Telehealth to support people with diabetes, COPD & heart failure
Improving quality and patient safety	• Virtual wards – patients being held safely in the community where they want to be with the support of carers. • All the primary healthcare team to act as care co-ordinators navigating and tracking patients through the system and removing blocks • Clinically effective and safe use of medicines with good clinical outcomes • Patients have good understanding of how to get the best from their medicines • CCG uses robust contracting and governance procedures to ensure that adults with LD are safeguarded • Safeguarding - healthcare settings demonstrate good knowledge and use of procedures such as MCA, DOL's, best interest decision making	**Medicines Optimisation** • Improve quality of Clinical Medicines Reviews for our most vulnerable (2012-15) • Utilising best practice to "invest to save" in high cost medicines through improved audit and monitoring. • Implement dedicated Medication Review in Nursing Homes • Improved procurement of medicines within our health community and appropriate use of dressings, SIPs, catheters, anti TNF pathway and Gluten Free products • Mental Health - initially looking at rolling out work on reducing Benzodiazepine prescribing • Reviewing the utilisation of stoma care products

		• Reviewing the Continence care pathway
Promoting healthy lifestyles and wellbeing	• Change in culture to support prevention and self care (patients and the primary healthcare team) including use of information relating to health care • Closer working between community services and GP practices • Maximising use of technology	• Risk stratification tool embedded in each practice – helping to prevent unnecessary hospital admissions
Improving the mental health and wellbeing of the population	• Far greater understanding in the community about how to maintain mental health and wellbeing and challenge the stigma attached to having mental health problems. • People with common mental health problems or signs of psychological distress - including those where these problems are secondary to a long term physical health condition - can access a range of talking therapies and support in Primary Care to prevent escalation into, and extended use of, health and social care services. • Providing high quality care and support for people who become acutely mentally ill and need specialist in-patient and community services (specialist or generic services). • People with mental health problems remain in or as near to B&NES as they wish in a genuine home with support to remain in or get employment/meaningful occupation • Staff working with people who have mental health problems are recognised as doing a valuable job.	• Maximise the potential of early intervention in psychosis, assertive out-reach, flexible crisis resolution and home treatment options for people with serous mental health problems. • Review and rationalise out of area treatments and expenditure for specialist and non specialist placements – including the social care funded placements in order to develop a proper pathway
Improving access and consistency of care	**Urgent Care re-design** • Primary care is able to provide a same day service for patients with a perceived urgent care need • Patients who access urgent care services receive a consistent and seamless approach and as a result are not passed from one service to another • Patients with an emergency ambulatory care condition receive same day access to diagnostics	• Urgent Care Redesign Project

	and treatment • Patients who need to be admitted stay in hospital for no longer than is necessary	
	End of Life Care • Patients are able to die in their preferred place of death • An emergency hospital admission for someone who has chosen to die elsewhere is seen as a failure • Patients are treated with dignity and respect of their wishes at end of life • Patients die pain free and with good symptom control • Carers and families have a positive experience of dying and death of their loved one • All providers are confident and skilled in the management of people at end of life	**End of Life Care** • End of Life care (EoLC) co-ordination service • EoL pathway for heart failure patients
	Planned Care • More care delivered within localities with primary and community support for patients and reduction in number of treatments carried out in acute care settings • Clinicians and patients reviewing and redesigning pathways • Greater use of Patient Recorded Outcomes Measure (PROMS) and patient satisfaction • Regular use of benchmarking • Patients will receive seamless care in line with best practice no matter where they are seen with variation around patient needs not the system • Patients supported and proactively managed in primary and community settings with cluster based GP specialists • GPs can access multi-disciplinary expertise with access to range of diagnostics and advice from specialists to avoid unnecessary appointments and	**Planned Care:** • Rheumatology - new service model to deliver a more community based model • Advice and guidance – paediatrics • Advice and guidance and referral management – dermatology • Increasing utilisation of ISTCs by ensuring choice offered • Pain pathway and back pain pathway • Reduction in variation in GP referrals • Home delivery of cancer drugs • Prostate cancer pathway - intermittent hormone treatment • Reduction in low priority procedure referrals

	admissions for patients	
	Primary Care • Practices working collaboratively together to improve access, share specialist skills within primary care • Supporting GPs in their initial assessment of a patients need by tapping into consultant expertise in a timely manner • Patients can access medicines when they need them	
Reducing inequalities and social exclusion	• Far greater understanding in the community about how to maintain mental health and wellbeing and challenge the stigma attached to having mental health problems. • All healthcare settings can provide equitable access to services and improved patient outcomes for people with learning disabilities. • People with LD do not experience discrimination or barriers to treatment as a result of their additional needs. • Primary care is well supported to provide annual health checks to adults with LD and ensure access to screening programmes • People with complex health needs have person centred health action plans as part of whole system approach (health and social care) to meeting individual needs • Adults with LD who have mental health needs appropriately supported by local community and inpatient services, avoiding the need for out of area (specialist commissioning) placements • CCG works in partnership with local authority to promote joint commissioning approaches to providing person centred support • Implementation of AQP for wheelchair services	**Learning Disabilities** • Complete development of new service spec. • Develop Avon wide Aspergers / Autism strategy • Identify service users in supported accommodation • Manage transition demand • Ordinary Residence Benefits • Resource Allocation / Transformation - personal budgets

7. Stakeholder Engagement

Having identified our strategic priorities, the next step was to test them with local stakeholders and partners. During May to July 2012, we arranged a series of events and meetings for our local stakeholders. These were well attended and generally very well received

We held four separate planning events involving members of the public, Local Authority representatives, Councillors, provider organisations, voluntary and third sector organisations, commissioners and GPs. The aim of these events was to inform the community about the CCG priorities and to seek their feedback and involvement.

- Planning Event with partner organisations
- Stakeholder Event (open invitation to providers and public)
- Member's Governance and Constitution Meeting
- Further public Stakeholder Event (evening meeting)

Stakeholders were asked to provide feedback in three different ways:

- **Evaluation Forms**- handed to each individual stakeholder
- **Message Boards**- stakeholders were asked to write their views on post-it notes and add them to one of several message boards.
- **Verbal Feedback**- GPs and Commissioners engaged in discussions with the stakeholders.

We received a high level of support for the four key priorities and for our outline service plans. The CCG was asked to consider further areas such as a greater focus on accessibility and on carers and their needs.

Some stakeholders requested further detail around specific goals, targets and pathways. This will be addressed with the development of the 2013/14 Operational Plan which will be available in the autumn.

From the number of comments, suggestions, praise and criticisms we received, it is clear that the public want to be engaged with the CCG and would like a repeat of this kind of event in the future. We are considering how best to do this and will incorporate it within our engagement plans.

For further information on the feedback from these events, please see the full Stakeholder Engagement Evaluation Report (add hyperlink when complete). The CCG also has a Communications and Engagement Strategy (add hyperlink when complete).

8. Service level priorities and plans

This section describes the priorities and plans for individual services. For each of the service areas listed below, there is a high level summary of where we want to be and how we plan to achieve this. These plans will be further developed over the coming months as we work on our Operational Plan for 2013/14. They will need to reflect the Operating Framework requirements for 2013/14 and our local Joint Health & Wellbeing Strategy which will be available in the autumn.

- Urgent Care
- Long Term Conditions & Frail Elderly
- End of Life Care
- Planned Care
- Mental Health
- Primary Care
- Medicines Optimisation
- Children's Services
- Maternity and newborn
- Learning Difficulties

Urgent Care

Strategic Priority	National guidance
• Simplify access to urgent care services • Redesign of clinical pathways to improve clinical outcomes, increase & ensure patient satisfaction • Achieve and sustain national and local performance	• Right treatment, right time, right place • Quality, Innovation, Productivity & Prevention (QIPP) • National Institute of Clinical Evidence (NICE) • The NHS Outcomes Framework • NHS Co-operation & Competition requirements • The Operating Framework for the NHS 2012/13

Where we want to be

- Primary care is able to provide a same day service for patients with a perceived urgent care need
- Patients who access urgent care services receive a consistent and seamless approach and as a result are not passed from one service to another
- Patients with an emergency ambulatory care condition receive same day access to diagnostics and treatment
- Patients who need to be admitted stay in hospital for no longer than is necessary

Our plans

- Use the out-of-hours re-procurement as an opportunity to include other 24/7 urgent care services, including GP-led health centre, Paulton MIU and ED front door
- Implement an urgent care local enhanced service
- RUH to revise pathways and re-launch the role of ambulatory care and the medical and surgical assessment units
- Embed the community IV therapy service
- Develop a robust all age mental health liaison service

How we will measure success

- New 24/7 urgent model of care is operational from April 2014
- Reduction in walk-in activity at the GP-led health centre
- Increase in the number of patients discharged the same day
- Primary care knows how to access emergency ambulatory care pathways
- Increased number of patients managed at home by the community IV therapy service
- Patient reported experience of accessing urgent care services
- Reduced emergency hospital bed days all ages

Long Term Conditions & Frail Elderly

Strategic Priority	National guidance
• Redesign of clinical pathways to improve clinical outcomes, increase & ensure patient satisfaction • Deliver care closer to home • Achieve national and local priorities	• Right treatment, right time, right place • Quality, Innovation, Productivity & Prevention (QIPP) • National Institute of Clinical Evidence (NICE) • The NHS Outcomes Framework • NHS Co-operation & Competition requirements • The Operating Framework for the NHS 2012/13 • National Dementia Strategy and Prime Minister's Dementia Challenge

Where we want to be

- Role of primary care is geared towards the proactive management of patients with long term conditions supported by a multi-disciplinary approach
- Patients with long term conditions feel empowered and confident to self-manage their condition
- Personalised care plans are seen as the norm for patients with long term conditions
- People with dementia receive a timely diagnosis to enable them to feel in control of their lives
- Caring for frail older people is seen as a rewarding career
- Carers feel supported in their caring role
- Post diagnostic support and intervention provided in primary and community care for people diagnosed with dementia in order to delay or avoid the need for specialist mental health services

Our plans

- Risk stratification tool embedded in each practice through a local enhance service
- Work with Sirona Care & Health, the RUH and primary care to develop the model of integrated care team around practices based on the output of the risk stratification tool
- GP training and education programme on shared-decision making and personalised care planning to be developed and delivered
- Refresh the dementia assessment and diagnosis pathway in light of national guidance
- Frail older people receive a comprehensive assessment and re-ablement following an acute episode of care to determine and reduce long term care needs
- Review the diabetes care pathway
- Develop role of dementia support workers in Primary Care

How we will measure success

- Patient reported experience of managing their long term condition
- Carer reported experience of feeling supported
- Patients newly diagnosed with a long term condition have a personalised care plan which is co-produced with their GP
- Patients with complex needs have a named case manager
- Reduced emergency admissions for the 19 ambulatory care sensitive conditions
- Older people's reported experience of treatment and care
- Reduced emergency hospital bed days for patients aged 75 and over

End of Life Care

Strategic Priority	National guidance
• Deliver improved care co-ordination for people at end of life • Achieve and sustain national and local performance	• Right treatment, right time, right place • Quality, Innovation, Productivity & Prevention (QIPP) • National Institute of Clinical Evidence (NICE) • The NHS Outcomes Framework • NHS Co-operation & Competition requirements • The Operating Framework for the NHS 2012/13 • National End of Life Care Strategy

Where we want to be

- Patients are able to die in their preferred place of death
- An emergency hospital admission for someone who has chosen to die elsewhere is seen as a failure
- Patients are treated with dignity and respect of their wishes at end of life
- Patients die pain free and with good symptom control
- Carers and families have a positive experience of dying and death of their loved one
- All providers are confident and skilled in the management of people at end of life

Our plans

- Electronic Palliative Care Coordination System (EPaCCS) is embedded across all organisations to ensure patients are managed appropriately
- Evaluate the nursing care home local enhanced service with a view to continuation and potentially expanding into residential care homes
- All end of life patients to have an advanced care plan in place
- All end of life patients to have do not attempt pulmonary resuscitation (DNAR) orders in place

How we will measure success

- Continual increase in the percentage of patients who die in their preferred place of death
- Reduced conveyance of patients at end of life to hospital
- No emergency admissions to hospital for people at end of life from a nursing home
- Reduced emergency hospital bed days
- Carer and family reported experience of the death of a loved one
- Staff reported experience of dying and death for patients and carers/families

Planned Care

Strategic Priority	National guidance
• Reduction of variations • Redesign of clinical pathways to improve clinical outcomes, increase & ensure patient satisfaction • Achieve national and local priorities	• Right treatment, right time, right place • Quality, Innovation, Productivity & Prevention (QIPP) • National Institute of Clinical Evidence (NICE) • The NHS Outcomes Framework • NHS Co-operation & Competition requirements • The Operating Framework for the NHS 2012/13 • Cancer Reform Strategy

Where we want to be

- More care delivered within localities with primary and community support for patients and reduction in number of treatments carried out in acute care settings
- Clinicians and patients reviewing and redesigning pathways
- Greater use of Patient Recorded Outcomes Measure (PROMS) and patient satisfaction
- Regular use of benchmarking
- Patients will receive seamless care in line with best practice no matter where they are seen with variation around patient needs not the system
- Patients supported and proactively managed in primary and community settings with cluster based GP specialists
- GPs can access multi-disciplinary expertise with access to range of diagnostics and advice from specialists to avoid unnecessary appointments and admissions for patients

Our plans

- To review patient pathways based on benchmarking which shows there are inefficiencies in current services and where patients are travelling to an acute hospital for treatments and support that can be delivered closer to home. Priorities are hip and knee, pain, rheumatology in 2012
- Direct access diagnostics from 2012
- Advice and guidance from consultants starting with paediatrics in 2012
- Working with GPs and secondary care clinicians to develop multi-disciplinary care and access to specialisms within clusters
- Shared care and primary care support for cancer patients. Increasing focus on support after treatment and long term follow up arrangements
- Clinical Priorities Policy understood in primary care and within providers updated in line

How we will measure success

- Reduction in the number of admissions and outpatient attendances
- Increased range of care offered in primary care and community settings
- Patient experience of primary and community support (measured by surveys)
- Reduced length of hospital stay and number of bed days
- Reduction in the number of low priority procedures
- Reduced variation in activity and number of referrals between practices
- Practice use of data tool and referrals information

Mental Health Services

Strategic Priority	National guidance
• Reconfiguration in Adult Mental Health inpatient services • Review care pathways and services to improve health and social care outcomes • Achieve national and local priorities • Improve mental health and wellbeing in Primary Care	• Right treatment, right time, right place • Quality, Innovation, Productivity & Prevention (QIPP) • National Institute of Clinical Evidence (NICE) • The NHS Outcomes Framework • The Operating Framework for the NHS 2012/13 • The Autism Act (2009) • Fulfilling & Rewarding Lives (2010) • NHS Co-operation & Competition requirements • Talking Therapies - A Four Year Plan • No Health Without Mental Health

Where we want to be

- Far greater understanding in the community about how to maintain mental health and wellbeing and challenge the stigma attached to having mental health problems.
- People with common mental health problems or signs of psychological distress - including those where these problems are secondary to a long term physical health condition - can access a range of talking therapies and support in Primary Care to prevent escalation into, and extended use of, health and social care services.
- Providing high quality care and support for people who become acutely mentally ill and need specialist in-patient and community services (specialist or generic services).
- People with mental health problems remain in or as near to B&NES as they wish in a genuine home with support to remain in or get employment/meaningful occupation
- Staff working with people who have mental health problems are recognised as doing a valuable job.

Our plans

- To work with public health and mental health/community providers to increase local targeted campaigns, increase self care and challenge stigma – by October 2013
- To use the talking therapies procurement process to design care pathways that increase choice and flexibility in Primary Care whilst maintaining close relationships with GPs – from July 2013
- Commissioners will review acute care pathways and service specifications as part of pre-procurement exercise – October 2012 in order to either tender for new services or review current contracting and commissioning arrangements with existing provider – March 2013.
- To develop a robust all age mental health liaison service – March 2013

How we will measure success

- Active and visible public mental health messages as part of World Mental Health Day, October 2012 with ongoing programme of public information across the next year.
- Maintenance of performance against quality indicators for people in specialist mental health services in settled accommodation and employment
- More people access talking therapies (15% of estimated prevalence), 50% recovery rates for people at clinical scoring threshold and improved social functioning outcomes for everyone accessing a service
- Patient reported experience of specialist mental health services.
- Reduced emergency and hospital bed days all ages for people with mental health problems.

Primary Care

Strategic Priority	National guidance
• Waiting time targets • Redesign of clinical pathways to improve clinical outcomes, increase & ensure patient satisfaction • Achieve national and local priorities	• Right treatment, right time, right place • Quality, Innovation, Productivity & Prevention (QIPP) • National Institute of Clinical Evidence (NICE) • The NHS Outcomes Framework • NHS Co-operation & Competition requirements • The Operating Framework for the NHS 2012/13 • Primary Care Development

Where we want to be

- Change in culture to support prevention and self care (patients and the primary healthcare team) including use of information relating to health care
- High quality services
- Supporting other work streams – Urgent Care and Long Term Conditions.
- Closer working between community services and practices – integration
- Virtual wards – patients being held safely in the community where they want to be with the support of carers.
- All the primary healthcare team to act as care co-ordinators navigating and tracking patients through the system removing blocks
- Supporting GPs in their initial assessment of a patients need by tapping into consultant expertise in a timely manner
- Practices working collaboratively together to improve access, share specialist skills within primary care and share back office functions
- Maximising use of technology

Our plans

- Implement local enhanced services
    - Urgent Care
    - Nursing Home
    - Health checks
    - Risk stratification
- Better sharing of information about patients between practices, community and secondary care. This will be facilitated by hosted GP IT systems and use of the End of Life Register.
- Practices beginning to collaborate
    - Access especially in delivering urgent care
    - Back office functions via Practice Manager network
    - Harnessing specialist skills in primary care
    - Consistency in LTC management
    - Purchase of supplies and equipment
- Continue to support practices by sharing best practice on QOF, audits & NICE guidelines to reduce variation.
- Work with the LA to influence the Health and Wellbeing Strategy and play a part in its implementation.

How we will measure success

- Reduction in referrals for conditions relating to known harmful lifestyle choices e.g. smoking, alcohol, weight.
- Maintain and increase QOF scores as they become more challenging
- New patient pathways that result in a shorter time in the system – LOS, return to work/education, less cancelled operations
- Patients feeling supported along their pathway and managing their expectations
- Minimise avoidable hospital admissions
- Better worked up referrals demonstrated by benchmarking conversion rates, referral rates, New/Fup rates

Medicines Optimisation

Strategic Priority	National guidance
• Redesign of clinical pathways to improve clinical outcomes, increase & ensure patient satisfaction • Achieve national and local priorities	• Right treatment, right time, right place • Quality, Innovation, Productivity & Prevention (QIPP) • National Institute of Clinical Evidence (NICE) • The NHS Outcomes Framework • The Operating Framework for the NHS 2012/13

Where we want to be

- **Clinically Effective use of Medicines:**
  a. Good clinical outcomes from medicines
  b. Safe use of medicine
- **Cost Effective use of medicines so we can invest in innovation and quality improvement:**
  a. Maintain low prescribing growth in primary care and secondary care
  b. Low levels of wastage medicines
- **Great patient experience in access and medicines management services high**
  a. Patients have good understanding of how to get the best from their medicines
  b. Patients can access medicines when they need them

Our plans

- Improved **benchmarking information** for prescribers for GPs (Oct 2012) and RUH (Oct 2013)
- Improve quality of Clinical **Medicines Reviews** for our most vulnerable (2012-15)
- Implement **risk/ gain share** arrangement on High Cost Drugs **with RUH** (contract round 12/13)
- **Reduce unnecessary trips** to RUH to collect specialist medicines
- Have a **well-respected medicines discharge system** which provides good quality information about medicines on discharge in a timely manner (December 2012)
- **Maximise the benefits** of Medicines Optimisation Services in **Community Pharmacy** (2013 -15)

How we will measure success

- Benchmarking - to be in top quartile - for all **quality and safety** indicators available
- **GP** prescribing growth and cost of **weighted prescribing** - to be in bottom quartile
- **Secondary care prescribing costs** for PBR excluded drugs – to be in the bottom quartile
- High uptake of **community pharmacist medicines review** services – to be in top quartile
- Over performance on delivery of the QIPP **savings programme**
- Good benchmarking from Community Pharmacy and secondary care medicines **patient experience surveys**

Children's Health Services

Strategic Priority	National guidance
• Ensure all services meet safeguarding & clinical standards • Waiting time targets • Redesign of clinical pathways to improve clinical outcomes, increase & ensure patient satisfaction • Achieve national and local priorities	• National Institute of Clinical Evidence (NICE) • Working together to safeguard children (2012) • Healthy Child Programme (2009) • Getting it right for Children and Young People (2010) • Achieving Equity and Excellence for Children (2010) • The NHS Outcomes Framework (2012/13) • The Operating Framework for the NHS (2012/13)

Where we want to be

Children, young people and their families

- Are satisfied with the services they receive and are able to contribute to and engage with service development and evaluation in a manner which is empowering and convenient to them.
- Experience high quality, evidence based services.
- Experience clear paediatric pathways in which primary care, community and acute clinicians, including mental health, work together to offer care closer to home where possible.
- Experience a multidisciplinary approach to assessment and care, receiving early intervention as necessary.
- Transition seamlessly to adult services.
- Are seen promptly and in a child or young-person friendly environment.
- Receive all appropriate immunisations and screening.
- Are empowered to stay healthy, safe and emotionally resilient, narrowing the gap for morbidity, mortality and life outcomes.

Our plans

- Maintain high uptake rates for breastfeeding, newborn screening and immunisations.
- Implement pilot for GPs to access paediatric advice/guidance to reduce non-urgent outpatient appointment.
- Consider a pilot of a "virtual ward" community nursing service, including clarifying pathways.
- Diabetes pathway commissioned with new Best Practice Tariff from Sept 2012.
- CQC action plan being implemented to address safeguarding issues (by April 2013).
- New model of service for Looked After Children's health assessments (by Aug 2012).
- Smooth transition of contracts to be commissioned nationally (e.g. School Nurses, Health Visitors, immunisations, screening, Tier 4 CaMHS).
- Pilot of speech and language therapy services to Youth Offending Team and pilot extension of Early Years' provision.
- Work with education and social care to consider the implications of the SEND White paper, including development of personal health and education plans.
- Review of therapy services, including resolution of capacity issues.
- Implementation of AQP for wheelchair services by Dec 2012.

How we will measure success

- Improved outcomes for children and young people.
- Improved service and outcomes for children following CQC and Ofsted inspection of Looked After Children and Safeguarding services.
- Reduction in hospital admissions and length of stay.
- High uptake of screening, immunisations and breastfeeding.
- High satisfaction with services.
- Improvements in experience and waiting times for wheelchairs.
- Improved patient engagement with services.

Maternity and Newborn

Strategic Priority	National guidance
• Improved outcomes for mothers and babies • Achieve national and local priorities	• Right treatment, right time, right place • National Institute of Clinical Evidence (NICE) • The NHS Outcomes Framework • The Operating Framework for the NHS 2012/13 • Commissioning maternity services: resource pack to support CCGs

Where we want to be

- Excellent links between maternity services, health visitors and GPs to ensure patients and families have multidisciplinary care
- Additional needs understood early and support put in place
- Range of choices available, based on clinical needs of mother and baby to include supporting community birth centres and home births, and secondary dare
- Each mother to have a named midwife to support care
- Staffing ratios in line with national guidance

Our plans

- Work with providers, GPs & health visitors to agree and implement pathways ensuring close communication
- Work with providers, GPs and health visitors to identify additional needs and ensure services available to meet them
- Support provided to all women in the antenatal and postnatal period e.g. improved breastfeeding advice and guidance pre/post birth, parent craft classes, early identification of antenatal depression
- Review of ambulance transfers and transfers from community centres to hospital care
- Use of tariff packages to support move to coherent package of antenatal, birth and postnatal care based on complexity

How we will measure success

- Decreasing Caesarean section rates
- Decreasing rate of transfers from community and home birth to hospital care
- Access to home births and community birthing centres for local women
- Appropriate range of options including supported community birth centres
- Appropriate support services available and easily accessible for women (stop smoking midwife, family support, young parent support, breastfeeding support, VBAC clinic)

Learning Difficulties

Strategic Priority	National guidance
• Achieve national and local priorities	• Right treatment, right time, right place • Quality, Innovation, Productivity & Prevention (QIPP) • National Institute of Clinical Evidence (NICE) • The NHS Outcomes Framework • The Operating Framework for the NHS 2012/13

Where we want to be

- All healthcare settings can provide equitable access to services and improved patient outcomes for people with learning disabilities. People with LD do not experience discrimination or barriers to treatment as a result of their additional needs.
- Primary care is well supported to provide annual health checks to adults with LD and ensure access to screening programmes
- People with complex health needs have person centred health action plans as part of whole system approach (health and social care) to meeting individual needs
- Adults with LD who have mental health needs appropriately supported by local community and inpatient services, avoiding the need for out of area (specialist commissioning) placements
- CCG works in partnership with local authority to promote joint commissioning approaches to providing person centred support
- CCG uses robust contracting and governance procedures to ensure that adults with LD are safeguarded
- Healthcare settings demonstrate good knowledge and use of procedures such as MCA, DOL's, best interest decision making

Our plans

- Primary Care to continue to offer annual health checks to adults with LD (supported by LD nurses)
- Embed commissioning of LD mental health services (Assessment and Treatment beds, forensic community support) into mainstream contracting with AWP, rather than the existing separate arrangement
- Develop joint working protocols between Sirona and AWP through contracting processes
- RUH to implement CQUIN for patient with LD – implemented from April 2012
- CCG to maintain joint commissioning arrangements with LA as lead commissioner, utilising pooled budget
- Ensure that recommendations arising from Winterbourne View serious case review (due to be published in September 2012) are implemented locally with clear actions and lead responsibilities

How we will measure success

- Number of patients with LD receiving Annual Health check and follow up Health Action Plans
- Patient reported experience of accessing range of health care services – primary/acute/community
- Evidence of MCA and best interest decision making processes
- Limited admissions to mental health services
- Improved patient outcomes and evidence of take up of screening programmes
- Carer satisfaction
- Increase in number of people living in their own homes and gaining paid employment (indicators of social inclusion and independent living)

9. Delivery

This section describes the arrangements we are putting in place to support CCG commissioning from 2012 onwards.

9.1 Commissioning Support Services

The CCG intends to purchase a range of support services from Central Southern Commissioning Support Services (CSCSS) including the provision of IM&T support, business intelligence and health care procurement. CSCSS is working with 14 CCGs within the four geographical PCT Clusters covering Bath & North East Somerset and Wiltshire, Berkshire, Buckinghamshire and Oxfordshire, and Gloucestershire and Swindon.

The CCG signed a Heads of Agreement with CSCSS in July 2012. This sets out an in-principle agreement and basis for proceeding to the development of a service level agreement. A formal contract offer was received in August 2012 and over the coming months we will finalise the service specification and negotiate and refine the final agreement with the intention of signing an SLA by no later than 31 December 2012. The initial contract length is expected to be for a three-year period from April 2013 to March 2016 (subject to any specific instructions from the Department of Health or legal advice).

Both parties recognise the benefits of collaborative commissioning and the relationships established through this agreement will be complemented through the "sister" arrangements that the CCG puts in place with partner commissioning arrangements including but not limited to: local authorities; public health; other CCGs; other parties

The CCG's Organisational Development Plan sets out our plans for formally procuring commissioning support by 2016.

9.2 Joint Working Framework (B&NES Council)

B&NES Council and the local NHS have a long history of constructive joint working. Each organisation has its own constitution and separate accountabilities but we have a common interest in the health and well- being of local people. There is a recognition that closer working between our two organisations can secure additional benefits by aligning the use of resources and planning services to enable.

- Integrated commissioning that delivers joined up services
- Better value for money through the avoidance of duplication and economies of scale

The CCG is currently working with the Local Authority to draw up a Joint Working Framework. This framework builds on but supersedes previous arrangements in place between the council and the PCT. It reflects the aspiration and commitment of the CCG and B&NES Council to maximise the benefits of joint working, and sets out our intentions and the mechanisms by which we will achieve this. It also describes our joint ambitions around common goals and shared working practices and includes specific legal employment and financial agreements in support of joint management of commissioning.

The commitment to partnership working covers the full extent of both organisations responsibilities and the range of services covered by the CCG and the B&NES Council's People and Communities Directorate (including Public Health). The scope of the Framework also relates to delivering the aims and objectives of the Health & Wellbeing Board.

We intend to achieve the aims of the Framework through a process of alignment and joint working, rather than through the appointment of a lead body with delegated functions, or through a single formal contract for commissioning services. Under these arrangements, each organisation will retain their statutory functions and no responsibility or authority will be delegated from one party to the other.

Aims of the JWF

- Alignment of strategy, service plans and use of resources
- Commissioning, managing and delivering high quality services which understand and respond to the needs of individual service users and their carers
- Ensuring integrated delivery of seamless care through effective commissioning
- Making the best use of management, professional skills and knowledge
- Efficiency and value for money

Expected outputs

- Shared strategy and priorities
- Delivery of the JSNA
- Joint development and investment plans
- Aligned business planning and performance management arrangements
- Commissioning interface with stakeholders

- Efficiency savings

Expected outcomes

- Better services for local people and reduced bureaucracy
- Clearer and more efficient communication with stakeholders
- Greater opportunities to influence

To be achieved through:

- An integrated leadership structure and joint management teams
- Alignment of systems and policies
- Building on positive relationships
- Sharing space and support services

9.3 Joint Health and Wellbeing Strategy

The B&NES Health and Wellbeing Board is responsible for overseeing, monitoring and making recommendations in respect of the development of strategy and performance management of health and social care and public health for the local population.

The Board is also responsible for developing the strategic priorities that will reduce health inequalities and improve health and wellbeing in B&NES. These strategic priorities will form the basis of the Board's Joint Health and Wellbeing Strategy and will inform its work programme for the next few years.

As noted earlier in section 4.3, a number of strategic priorities have been identified through the Joint Strategic Needs Assessment process. These are likely to be reflected in the Joint Health & Well Being Strategy (JHWS) which is currently being developed.

The CCG is committed to working with the Health and Wellbeing Board to help deliver the JHWS priorities. Section 6.3 of this plan illustrates how the CCG priorities align with those of the Health and Wellbeing Board.

9.4 Memorandum Of Understanding with Wiltshire CCG

From April 2013, B&NES CCG and Wiltshire CCG will have a formal collaborative commissioning arrangement in place, covering the commissioning of services from the Royal United Hospital Trust, Bath.

B&NES CCG has agreed to take on the role of commissioner on behalf of Wiltshire CCG, with the mutual understanding that each CCG remains individually accountable and responsible for their commissioning decisions. This arrangement will be underpinned by a Memorandum of Understanding agreement

The MOU sets out:

- the principles of collaboration between the CCGs
- the governance structure that the CCGs will put in place and,
- the respective roles and responsibilities the CCGs

A Joint Forum will be established with representatives from both CCGs. The Forum will review and agree the range, quantity and nature of the services to be commissioned by B&NES CCG on behalf of Wiltshire CCG. It will not have separate legal status or additional delegated authority and will operate based upon the delegated powers of its individual members, who will make decisions on behalf of their organisations as they consider appropriate.

9.5 Memorandum of Understanding with Public Health

Under the Health and Social Care Act, from April 2013 CCGs have a duty to access public health advice, information and expertise in relation to the healthcare services they commission. Public health teams based in local authorities will have a responsibility to provide specialist advice to CCGs.

A Memorandum of Understanding (MOU) setting out a framework for working relationships has been agreed between the CCG and Public Health. It sets out the scope of the specialist service that public health will provide and outlines the reciprocal responsibilities of the CCG. It covers the 3 domains of Public Health and the strategic planning functions that underpin the domains:

- **Population healthcare** – input to the commissioning of health services, evidence of effectiveness, care pathways.
- **Health improvement** - lifestyle factors and the wider determinants of health
- **Health protection** – preventing the spread of communicable diseases, the response to major incidents, and screening

The MOU will cover the period from October 2012 until March 2014, with the initial six months in shadow form. The Public Health Directorate will transfer from NHS B&NES to B&NES Council on 1 April 2013.

9.6 Memorandum of Understanding (MOU) with CCG Practices

The Health and Social Care Act 2012 establishes CCGs as clinically led membership organisations made up of general practices. Key elements of these arrangements are the creation of locality-based practice Clusters, clinical leaders and a Governing Body, with delegated authority to discharge many of the responsibilities of the CCG.

We have developed a Memorandum of Understanding (MOU) with CCG practices, to establish a set of mutual commitments which will enable the member practices of the CCG to work together, and with the Governing Body of the CCG, to discharge their commissioning responsibilities in the most effective way.

The MOU is an essential supporting document to the governance arrangements set out in the CCG's Constitution. It sets out what member practices can expect of each other and of the Governing Body, and the process for resolving any disputes. For further information please see (add link)

9.7 Organisational Development plan

The CCG has produced its third Organisational Development Plan to cover the period June 2012 to June 2013. The purpose of the plan is to set out the further actions the CCG needs to take to ensure it has the right skills and resources to be able to take on full statutory functions from April 2013, and to support the CCG to continue to develop throughout 2013/14 and beyond.

The plan reflects the development journey the CCG has been on since its initial inception and highlights the key organisational development priorities and actions going forward, based on our most recent assessment of how we are performing against the 6 domains set out within the CCG Authorisation Framework:-

- Clinical focus and added value
- Engagement with patients and communities
- Capacity and capabilities
- Collaborative arrangements
- Leadership capacity and capability

The plan will continue to be monitored and reviewed by the CCG Governing Body on a quarterly basis, to ensure that the CCG's development is continuously refreshed. (insert hyperlink to OD plan document)

9.8 Human Resources

The CCG has established its organisational structure which sets out the 'in – house' roles that will support delivery of our commissioning agenda. The CCG is confident that it has a structure that has the right level of senior commissioning expertise to support our strategic service aims, backed up by a range of support functions provided from Central Southern Commissioning Support Services (CSCSS). End- to end support for human resource activities will be provided directly from CSCSS to cover the whole range of transactional activity from recruitment through to developing training staff, performance management, employee relations, workforce changes and turnover.

9.9 Equality & Diversity Strategy

The CCG is committed to eliminating all forms of discrimination and providing equality of opportunity for everyone. We recognise and value the diversity of our communities and believe that equality is pivotal to the commissioning of modern, high quality health services.

We have recently launched the CCG's first Equality and Diversity Strategy which outlines our overall approach to equality, diversity and human rights in our capacity as an employer and a health commissioner. This strategy sets out how the CCG will:

- Develop a governance structure for equality and diversity;
- Ensure all staff have the necessary skills to commission services in line with the Equality Act 2010 and Public Sector Equality Duty under this act.
- Complete Equality Analyses/Equality Impact Assessments (EAs/EIAs) to identify potential impacts on and outcomes for patients
- Use the results of EA/EIA as an integral part of our decision making and commissioning processes
- Ensure that our communications and engagement activities are inclusive, that is to say that they are reaching effectively to people from all protected groups, including carers and seldom heard or marginalised communities
- Work with our statutory and voluntary sector partners on equality issues and to tackle health inequalities
- Ensure that our Human Resources policies are fair and transparent, and work in partnership with our staff and potential employees to improve working lives
- Monitor complaints, comments and compliments by protected characteristic
- Develop assurance mechanisms to satisfy ourselves that providers who are delivering services on our behalf including the Commissioning Support Service (CSS) are complying with the Equality Act 2010 - this will include for example completion of access audits to ensure services are accessible

The approaches outlined above apply to all of the 'protected characteristics' as defined by the Equality Act 2010. They include: age, disability, gender reassignment (transgender), marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender), and sexual orientation.

We recognise that the practical result of the Act is that we are legally required to consider how our policies, plans, procedures, projects, services and decisions will affect people (such as patients, carers, service users, communities and employees) with one or more of the protected characteristics.

The CCG's Governing Body will receive reports on complaints, concerns and compliments at least twice a year. These will include equality monitoring of access to services, plus analysis of any equalities trends that have arisen from both complaints received and the way they have been handled.

For further information please see the full strategy and action plan (add link).

An equality impact assessment of our integrated plan has been completed and is available on request. This process highlighted a series of issues for the CCG to consider as it implements its strategic intentions.

9.10 Communications and Engagement Strategy

As a CCG we recognise that good communication and engagement is essential to the success of these new ways of working in our area. We must communicate and engage in an effective, understandable and meaningful way with all our stakeholders, seeking their views to inform our plans, whilst maintaining confidence in local health services.

To help achieve this, we have developed a Communications and Engagement Strategy. This document looks at the work we have already done with our stakeholders to develop the CCG's vision for health, and sets out our strategy for communications and engagement over the next three years (2012/13 – 14/15). The full document is available at (add link).

For the purposes of our communication with our stakeholders and members of the public, we have developed some key messages about the CCG and the future delivery of health services locally:

- Decisions about health care in B&NES will be made by local GPs who know what patients need, this approach will bring benefits to local people
- Maintaining high quality care for patients is our top priority
- We will listen to what our patients, communities and partner organisations tell us and work with them to deliver the best possible services

- We have an ageing population which brings increasing financial pressures so to protect priority services, the CCG must look at changing the way some things are done
- We will make it easier for patients to access the services they need and work more closely with other organisations.

The success of our approach to communications and engagement will be measured by a number of factors including:

- Media analysis – on-going monitoring and assessment of national, local and specialist media coverage. We will look at the tone of coverage (positive / negative / neutral).
- Partner/member perception – surveys and other work to determine key partners' perception of the CCG as an organisation, and as a partner within the health community
- Public perception – regular surveying of the public and analysis of responses using web based tools and other approaches where appropriate; using national surveys too, where they exist.
- Public attendance at events.
- Staff survey – an internal communications survey looking at staff satisfaction.

9.11 Extending Choice

One of the key planks of the NHS reforms and the NHS Constitution is for CCGs to establish systems to convert insights about patient choice/s in practice consultations into plans and decision-making.

This has been recognised as development priority as part of the CCG's Organisational Development plan but our current systems and processes include:

- Feedback from practice representatives at practice cluster meetings and the CCG's GP Forum
- Hearing feedback from practices at peer review meetings on the Quality and Outcomes Framework
- Use of practice level patient participation groups to highlight any key issues and to use these forums to actively engage with on key issues
- Feedback from our ongoing engagement events with members of the public
- Review of issued raised via the PALS and complaints process

9.12 Procurement Framework

The NHS B&NES Procurement & Contestability Framework has recently been reviewed and substantially updated to incorporate the developments and requirements set out in:

- Health and Social Care Act 2012
- The Operating Framework for the NHS in England, 2012/13
- Procurement guide for commissioners of NHS-funded services, July 2010
- Principles and Rules for Cooperation and Competition (PRCC), July 2012
- The NHS standard contracts for acute hospital, mental health, community and ambulance services and supporting guidance, December 2011
- Cooperation and Competition Panel procurement dispute appeal guidelines October 2010
- Operational Guidance to the NHS - Extending Patient Choice of Provider, July 2011
- Public Contracts Regulations – 2006 (and subsequent revisions)

The document incorporates the DH *'Principles and Rules for Cooperation and Competition'* and confirms the CCG's position statement and principles relating to contestability of healthcare services and its commitment to Patient and Public Involvement.

The document also incorporates:

- procurement models covering Any Qualified Provider, renewals following contract termination or expiry; new service models and additional capacity

- the guiding procurement principles of transparency, proportionality, non-discrimination and equality of treatment .

The revised framework is designed to support the PCT's and CCG's approach to procurement to 31 March 2013 and to act as a policy framework that the CCG will adopt from 1 April 2013 onwards.

9.13 Quality Strategy

The Health & Social Care Bill (2012) requires CCGs to have a strong focus on improving quality and outcomes of care for patients and they will be held to account for effective commissioning and promoting improvements in quality.

Building on the PCT's legacy, we have developed an ambitious quality strategy to improve the outcomes for people living in Bath & North East Somerset. Using a process of quality assurance, quality improvements and working collaboratively

with key partners in the health community, we are aiming to reduce preventable morbidity and mortality by:

- Improving the safety of the services we commission
- Improving the effectiveness of the services that we commission
- Improving people's experience of health, social care & housing services

The quality strategy is based on our four quality objectives:

1. To ensure that services being commissioned are safe, personal and effective

2. To ensure the right quality mechanisms are in place so that standards of patient safety and quality are understood, met and effectively demonstrated

3. To provide assurance that patient safety and quality outcomes and benefits are being realised and recommend action if the safety and quality of commissioned services are compromised

4. To promote the continuous improvement in the safety and quality of commissioned services

Outcome measures

A number of outcome measures have been selected to demonstrate progress against our key aim of reducing preventable morbidity and mortality. These have been drawn from a variety of sources including the National Outcomes Frameworks for Health & Social Care, the B&NES JSNA and the Safer Care QIPP.

Safety outcomes
Reduce incidence of VTE
Reduce incidence of newly acquired grade 3 and 4 pressure ulcers across all providers
Part 1 Elimination of 'never events' and Part 2 Incremental reduction in rates of avoidable harm
Reduce the number of bed days occupied as a result of avoidable infection
Improve the quality of safeguarding practice by ensuring that lessons learned and actions agreed as a result of safeguarding intervention are implemented by agreed timescales
Effectiveness outcomes
Reduce emergency admissions within 30 days of discharge

Increase the number of social care providers (care homes and domiciliary care) who have completed a satisfactory Quality Assurance process
Improve the outcomes for people using mental health & learning disability services
Implementation of new QOF and impact on referral management
Implement vascular health checks programme
Patient / service user/ carer experience outcomes
Improve patient experience to top quartile and maintain when providers are in top quartile
Improvement in social care users experience of our services and related quality of life
Increasing the number of people who die in the place of their choice
Improving the quality of life for people with long term conditions

Achieving the outcomes

We will work with the B&NES Adult Health, Social Care and Housing Partnership to drive the implementation of minimum quality standards via the contracting process. Providers will need to work collaboratively, developing effective relationships across patient care pathways and making appropriate links to the QIPP programme. The key providers to deliver the quality outcomes for Bath and North East Somerset will be public health and our local service providers, together with support from primary care.

A Core Quality Team has been established which reports to the CCG and to the Health & Wellbeing Board via the Clinical Commissioning Committee. Members of the Core Team include the CCG's Clinical Accountable Officer and Clinical Director, the CCG's lead for Performance & Quality and the Public Health Director.

Members of the Core Team are responsible for determining the direction for quality assurances and improvements; monitoring achievement of quality standards and ensuring systems are in place to provide assurance to the CCC and the Health & Wellbeing Board on key quality issues and systems.

For further information please see our Quality Strategy document (add link).

9.14 Research Governance

The aim of research governance is to provide a quality assurance framework for all health-related organisations, individuals and stakeholders. In March 2001, the Department of Health published *A Research Governance Framework for Health & Social Care* which set out standards of best practice in research. At that time, the PCT developed a Research & Development policy which was last reviewed in 2010.

In preparation for CCG authorisation, the Joint Medical Director has revised the policy and procedures. The revision takes into account the change from PCT to CCG, and the presence of Sirona and other provider organisations in the research landscape.

The purpose of the policy is to ensure that the CCG complies with the standards and principles set out in the Government's Research Governance Framework, thus ensuring the quality, safety, and good conduct of all research activity led or hosted by the CCG. Under the new policy, personnel delivering research projects will not be directly employed by CCGs.

The need for a clearly identified, strong Research Governance lead (RGL) with delegated powers has been recognised and defined. The Clinical Accountable Officer will act as RGL from 1st April 2013.

The CCG understands and will comply with statutory responsibilities to promote research. The CCG is committed to following the policy of ensuring that the NHS locally meets the treatment costs for patients who are taking part in research funded by government and research charity partner organisations. This will be funded through normal arrangements for commissioning patient care, as set out in HSG (97)32.

NHS B&NES is currently part of a consortium with NHS Wiltshire and NHS Swindon and Bath University (Bath Research and Development, BRD) who provide planning, oversight, development and assurance of research to the PCTs. BRD has been successful in achieving a high rating for research and attracting capability funding to B&NES of £52,000 in 2012/13.

BRD receives £91,000 directly from the Western Research Network for the whole consortium, which now includes Sirona and Sequol. PCTs do not fund this service directly but have a simple SLA describing the services provided. The CCG intends to continue the arrangement with BRD under a new SLA.

During 2012/13, the BRD and the present Research Governance lead will liaise with Sirona and other provider organisations to ensure they have congruent research policies in place to deliver safety, quality and good conduct of research. (Link to Research Governance policy - add link).

9.15 Sustainability

The NHS Carbon Reduction Strategy *Saving Carbon, Improving Health* was launched in 2009 and contains key targets for the NHS to reduce its environmental impact:

- From a baseline of 2007 reduce carbon emissions by 10% by 2015
- Raise awareness at every level of the organisation.
- Review procurement of energy, food, water, waste, transport, travel, pharmaceuticals and commissioned services by performance management and setting targets for reduction.

The NHS Carbon Reduction Strategy seeks all NHS organisations sign up to the Good Corporate Citizenship Assessment Model.

Furthermore, the Social Value (Public Services) Act 2012 will be in force early in 2013 and will include a duty to consider social value, ahead of a procurement exercise involving public service contracts. The CCG will need to consider how to improve the economic, social and environmental wellbeing of the community through these contracts.

The CCG has decided to develop a Sustainable Development Management Plan to ensure sustainable development including carbon reduction is embedded in commissioning and corporate processes. The CCG will also sign up to the Good Corporate Citizenship Assessment Tool as part of its commitment to the NHS Carbon Reduction Strategy

10. Financial Plan

10.1 Context

When NHS B&NES CCG is formally established on 1st April 2013 it will be responsible for the majority of the expenditure on commissioned services currently managed by NHS B&NES PCT. The PCT has a history of achieving financial balance and delivering savings targets year on year, which the CCG would wish to continue. However, the CCG recognises that this will present a challenge given both the economic and demographic context and the fact that it will be responsible for those commissioned services which have historically carried the greatest financial risk.

10.2 Financial Strategy and Supporting Arrangements

The CCG has developed a high level financial strategy to support the achievement of its overall commissioning objectives, whilst meeting its statutory financial targets and duties. This is underpinned by a clear set of structural arrangements to facilitate delivery of the strategy.

The key elements of the CCG's financial strategy are:

- To plan realistically, taking into account risks and sensitivities, to meet statutory financial duties and targets and to maintain recurring financial balance whilst investing resources in the delivery of key commissioning objectives
- To maximise income both through anticipating and influencing issues impacting on NHS income, and through proactive identification of additional income sources
- To maximise the use of resource by ensuring costs incurred are those which deliver the safest and most effective care for patients at the best obtainable value, through the use of transformational and innovative schemes and continual testing of spend against strategic objectives
- To identify, quantify and act to avoid, manage or mitigate financial risk through high quality monitoring and forecasting, appropriate contingency planning, and the exploration of risk sharing or pooling opportunities
- To use headroom and other investment sources to support effective and timely change within the healthcare system, through structured testing and prioritisation of investment proposals and monitoring of outcomes
- To focus on intelligent analysis of comparative and other data to understand the key drivers of cost and to identify where actions will have maximum impact, and to exploit the benefits of intelligence derived directly from increased clinical engagement

- To develop a clear alignment between commissioning, activity, financial and workforce plans across the health community, ensuring they are effectively communicated within the CCG and to partner organisations and that responsibilities and intended impact are clearly understood
- To engage with practices, providers and other key stakeholders throughout planning and project delivery to maximise buy in to outcomes and opportunities for collaboration
- To sustain and explore opportunities to expand joint financial arrangements with B&NES Council where these provide mutual benefit and support joint commissioning
- To work effectively with the Local Area Team of the NCB in support of its duties in respect of primary care, ensuring coordinated and complementary approaches to the funding of service provision

The structural arrangements which support delivery of the strategy are:

- Reliable finance and information systems and processes which produce accurate and timely data in accessible formats
- Clear and practical financial policies and procedures
- Accessible training for non-finance staff and supported professional development for finance staff
- Appropriately qualified and skilled staff at strategic, technical and transactional level
- Customer-focussed finance expertise available to member practices and commissioning leads
- Strong strategic leadership of the finance function and commitment of the Governing Body and CCG as a whole to fulfilment of the CCG's financial responsibilities
- Positive and effective working relationships and collaboration with partner organisations

Where it is most beneficial in terms of cost, quality and resilience to do so, the CCG will secure these arrangements through commissioning support partners.

10.3 Development of the Medium Term Plan

The CCG's financial plan for the period 2012/13 to 2014/15 is based on those elements of the PCT's current budgets which were identified through the Baseline Exercise (July 2012) as transferring to the CCG in April 2013. These are the expenditure budgets currently delegated to the CCG by the PCT.

For 2012/13 an indicative Revenue Resource Limit has been extracted which reconciles fully to the Baseline Exercise, and expenditure projections are based on the forecast outturn for CCG delegated budgets as at Month 3.

For 2013/14 and 2014/15 the planning assumptions used for the PCT's Medium Term Plan at the start of 2012/13 have been reviewed and updated in the context of the 2013/14 commissioning intentions. Key assumptions for these two years are tabulated below.

Planning Area	Assumption for 2013/14 and 2014/15
Income growth	2% to reflect B&NES position as currently above target income for its population
Social care funding	In line with previously advised values and to be transferred in full to the Council via a s256 agreement
Running costs	Draft allocation as published by NCB, with spend at the same level as the allocation
Tariff and non-PbR uplift	Inflation at 3.5% less 4% efficiency
Primary care prescribing uplift	Inflation at 9% less 4% efficiency
Growth	Based on ONS 2010 mid-year population projections
Tariff excluded drugs and devices	10% growth above tariff uplift
CQUINs	Increase of 1% on previous year based on SHA advised assumption
Readmissions and re-ablement	Non-payment for readmissions invested at the same level in re-ablement
New investment	Investment at value of B&NES share of previously advised national assumption for carers, 'No Health without Mental Health' and cost shifting from other departments Further provision for investment for priorities yet to be advised but to include dementia and QIPP enabling
Headroom	2% of recurring baseline allocation to be set aside for non-recurring use
Surplus	Set at value of previously notified PCT surplus

10.4 Three-Year Income and Expenditure Position

The forecast CCG Income and Expenditure position for 2012/13 and the planned position for 2013/14 and 2014/15 are set out in the table below, showing the cumulative level of QIPP required to deliver financial balance following investment in commissioning priorities.

	2012/13 Forecast Outturn	2013/14 Plan	2014/15 Plan
	£000	£000	£000
Sources of Funds			
Revenue Resource Limit	(218,976)	(223,891)	(227,642)
Total Sources of Funds	**(218,976)**	**(223,891)**	**(227,642)**
Applications of Funds			
Commissioned Services			
Acute	105,728	104,522	105,612
Community	22,246	22,459	22,671
Maternity	3,788	3,825	3,862
Mental Health	17,485	17,644	17,804
Learning Disabilities	4,494	7,119	7,119
Ambulance	5,740	5,796	5,852
Primary Care	4,491	4,491	4,491
Prescribing	24,691	25,926	27,222
Other	16,756	19,415	19,115
Contingency/Investment to be allocated	1,128	7,665	13,324
Headroom	4,294	4,379	4,467
QIPP Requirement		(6,460)	(10,537)
Running Costs	5,372	4,670	4,670
Total PCT Revenue Expenditure	**216,213**	**221,451**	**225,672**
Net Income & Expenditure Position	**(2,763)**	**(2,440)**	**(1,970)**

In respect of running costs, the CCG will ensure that the total planned cost of their in-house structure and the net impact of services bought in from or provided to commissioning support providers, the Council and Wiltshire CCG, and of occupancy agreements with PropCo, do not exceed the allowance notified by the NHS Commissioning Board.

10.5 QIPP

The table below shows the scale of the annual QIPP challenge faced by the CCG in the next three years, for which the CCG will need to develop delivery plans which align with its vision for the future shape of services. The QIPP target is

very similar to that which the PCT planned to deliver against a budget some 25% larger.

Section 13 describes the service implications of current plans. In financial terms, the 2012/13 forecast position is that the target QIPP value will be delivered overall but several of the original plans for the year are not performing as expected. This is being mitigated by the development of new plans, by risk sharing arrangements with providers, and to some extent by the use of non-recurring solutions. The expected financial impact of plans for 2013/14 and 2014/15 has been reviewed in the light of current year experience and of continued analysis of and intelligence on the most influential cost drivers. At present gaps of £1,486k and £2,520k respectively still exist. Work continues to identify scope for the significant clinically led transformational change which will be required to deliver this level of saving.

A summary of the plans identified to date, the remaining gap, and of provider efficiency requirements showing the total savings challenge for the health community, is provided in the table below. Whilst provider efficiency requirements will be delivered through internal cost improvement initiatives, it is essential to ensure that these do not conflict with commissioner QIPP plans.

	2012/13 Forecast Outturn	2013/14 Plan	2014/15 Plan
	£000	£000	£000
Commissioner QIPP			
Shifting settings of care and urgent care	1,358	580	467
Optimising elective care pathways	1,293	1,052	310
Best practice care pathways for long term conditions	0	1,806	230
Improving medicines management	975	710	550
Improving primary and community care	660	470	
Improving mental health	470	220	
Improving learning disabilities	180	136	
Other schemes	874		
Schemes to be identified		1,486	2,520
Total Commissioner QIPP	**5,810**	**6,460**	**4,077**
Provider Efficiency	**7,380**	**7,152**	**7,319**
Total Health Community Savings	**13,190**	**13,612**	**11,396**

10.6 Balance Sheet and Cashflow

The CCG's balance sheet will be developed once clarification on the passing of assets and liabilities from PCTs to successor bodies is available.

Cashflow is expected to be manageable in accordance with current PCT practice, with most payments including those of the highest value being wholly predictable as they will comprise monthly contractual payments to providers, salaries, contractual payments for commissioning support services, and occupancy payments to PropCo. The CCG will plan to stay within its cash limit and to keep bank balances to an acceptable minimum.

10.7 Capital

The CCG does not expect to receive a capital allocation of any significance, as property related capital requirements will be managed by PropCo. The CCG will work with PropCo to ensure the revenue implications for the CCG of any capital decisions are understood fully.

The CCG will work with providers to provide evaluation and appropriate support for capital investment bids linked to service change, ensuring that these align with the strategic direction for commissioned services and meet commissioner affordability criteria.

10.8 Financial Risks

The following risks have been identified and work continues to quantify their potential impact in future years as further information becomes available:

- The CCG's Revenue Resource Limit is lower than expected following finalisation of all successor organisation allocations
- Demographic growth or complexity of casemix increases in excess of planned volumes
- High cost drugs volume or price inflation exceeds planned levels
- Tariff does not deliver the expected provider efficiencies locally
- The cost or volume of placements increases above expected levels
- Running costs are not contained within the notified allocation once commissioning support, Council and Wiltshire CCG charges are finalised
- QIPP plans do not deliver the expected activity shifts or reductions and corresponding cost release
- Providers do not release costs in response to QIPP schemes but seek instead to maintain income levels

- Non-recurring delivery of the 2012/13 QIPP target increases the challenge for subsequent years
- The introduction of mental health Payment by Results has an adverse impact

10.9 Mitigations

The following actions have been identified to avoid, manage or mitigate the impact of those risks which materialise. Work continues to quantify the potential value of these items and ensure it is sufficient. The CCG will:

- Maintain an appropriate level of recurring contingency
- Prioritise uncommitted spend to enable prompt and flexible response to either limitation or opportunity
- Identify non-recurring expenditure which can appropriately be funded from headroom
- Ensure savings plans are risk-adjusted so that expectations are based on the realistically deliverable value
- Link continued investment to delivery of expected outcomes, with clear processes for terminating ineffective investments
- Identify future year savings schemes which can be accelerated if required
- Enter into mutually beneficial risk sharing or pooling arrangements with partner organisations including the Council, other CCGs, providers and if offered by the NCB
- Market test outsourced commissioning support services

11. Risk Management

11.1 Approach to risk management

We recognise our statutory responsibility to patients, staff and the public to ensure that effective processes, policies and people are in place to deliver our objectives and to control any risks to achieving them. Our approach to risk management will be comprehensive, covering financial, organisational, clinical, project and reputational risks.

We intend to commission support for risk management services from Central Southern Commissioning Support Services under the contract arrangements described in section 9.1.but overall responsibility and accountability for risk will reside with the CCG.

11.2 Risk Strategy

We have identified a number of objectives which have formed the basis of our Risk Management Strategy:

- To promote awareness of risk management and embed the approach through all functions and management throughout the organisation;
- To ensure the CCG has and maintains the required level of risk management support to successfully manage its risks;
- To seek to identify, record, measure, control, report and monitor any risk that will undermine the achievement of objectives, both strategically and operationally, through appropriate analysis and assessment criteria;
- To protect the services, patients, staff, reputation and finances of the organisation through application of sound risk management;
- To provide the Governing Body with assurance that risk is being effectively managed through the establishment of appropriate risk management escalation mechanisms for the purposes of decision-making, coupled with proportionate monitoring and compliance with agreed processes.

The key elements of the Risk Strategy are summarised below and the full document is available at (add link)

11.3 Risk Management process

Risk Identification

The risk identification processes will include:

- A structured risk assessment process
- Adverse event report, including trends and data analysis
- Serious Incidents Requiring Investigation (SIRI)
- Claims and complaints data
- Business decision making and project planning
- Strategy and policy development analysis
- External/Internal audits findings

Risk Assessment & Measurement

Once risks have been identified, they will be assessed for significance and priority using the National Patient Safety Agency 5 by 5 likelihood and impact matrix to assign a risk score.

		Likelihood of Occurrence				
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
Impact	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

Risk Reporting and Monitoring

The lines of delegation and authority are summarised in the table below.

Level	Authority / Ownership	Action
Low risk 1-3	Individuals and Team Managers	Managed through normal local control measures. Acceptable level of risk.
Moderate risk 4-6	Managers	Review control measures through formal risk assessment, record on the Risk Register
High risk 8-12	Senior Manager	Above a normal tolerable level of risk. Action required to be taken, recorded on the Risk Register
Extreme	'Risk' Committee	Intolerable level of risk. **Immediate action** must be taken

risk 15-25		and the risk will be escalated to the Corporate Risk Register.

Roles and responsibilities

The Risk Management Strategy describes the roles and responsibilities of individuals and various committees including the Governing Body, the Audit Committee, the 'Risk' Committee and the Quality Improvement & Patient Safety Committee (QIPS).

The Clinical Accountable Officer is accountable for all risks relating to the operations of the organisation and will lead on determining the strategic approach to risk, establishing and maintaining the structure for risk management.

The Chief Financial Officer is accountable for internal financial control and financial governance

The Corporate Affairs Officer is responsible for ensuring that the Board Assurance Framework is developed, reviewed and reported to the 'Risk' Committee and Governing Body, and Audit Committee as appropriate. The Corporate Affairs Officer will also ensure that business continuity and disaster recovery plans are established and regularly tested.

11.4 Current Risk Issues

The major risks to which the CCG is currently exposed but seeking to mitigate:

1. Risk of not achieving financial targets in the light of future growth projections of no more than 2% and the need to identify significant cash release and the deteriorating financial forecasts
2. Risk of managing a number of highly complex issues through local engagement processes; these include the re-design of the local urgent care system and agreeing the future service arrangements for services currently provided by the RNHRD.
3. Risk of disengaging with or disempowering local practices and other local clinicians as pressures mount
4. A focus on performance reporting rather than performance management undermining our ability to intervene to improve on nay key areas of concern
5. Risk of transition to new commissioning support arrangements with a potential loss of direction and memory as key members of PCT staff move out of the system
6. Risk of non delivery of strategy due to the small size of the CCG restricted clinical and managerial management commissioning capacity,

In response to these issues, the critical success factors identified are as follows:

- An ongoing focus on the delivery and implementation of QIPP opportunities across B&NES to mitigate against future financial risks
- Need for senior clinical and managerial support, with clarity about the governance of any work programme, and the escalation process in the event that all does not go to plan
- Need for clarity of leadership and a clear audit trail of decisions made internally and agreements reached with partners and providers
- Early and broad engagement with the public and with service users in the identification of the need for a service and the specification
- Ongoing and a clear organisational development priority for developing cluster and practice level working arrangements including being clear about the benefits to the Practices as well as patients and carers
- Adherence to the CCG's contestability framework, to support all future commissioning decisions.
- Continued adherence to a good performance management system across the health and social care partnership

12. Performance Management

The CCG has inherited a good performance management system from the PCT locally known as "Intervening for Success". This system relies on a mapping of the local health system, mapping key performance or outcome indicators and identifying the system levers i.e. the issues that commissioners can have influence and control over in shaping and impacting on performance.

In addition to monthly exception reporting and monitoring of QIPP progress, performance management reviews are undertaken jointly with local authority commissioners on a bi-monthly basis. This facilitates a wider system of review and the identification of how one issue in a part of the system can be impacted upon, or to identify issues in other parts of the system.

The CCG plans to continue with this system for 2012/13 and to work collaboratively with our local authority partners to extend this process of performance management and review to other service areas such as Children's services.

13. Impact on the local health system (Incomplete)

13.1 Clinically Led Commissioning

Clinical Added Value:

- Two-way sharing of information on service provision directly between clinicians and patients, which will help inform planning and commissioning of services
- Clinically led pathway design involving primary, community and secondary care clinicians
- Clinically led service re-design, particularly in relation to the QIPP programme
- Clinically led commissioning decisions
- Increased involvement from patients, members of the public and partner organisations in planning and commissioning local services, achieved through effective engagement arrangements
- Multi-disciplinary community teams supporting primary care clinicians to manage patients in the community setting
- Continual improvement in quality and safety for patients as clinicians have greater involvement and responsibility for setting and monitoring quality and safety standards and service requirements
- Greater choice for patients including implementation of AQP for community services
- Improved use of technology, both in terms of clinical services and the use of medical technology such as telemedicine, and in the way we communicate with patients and the public through social media

13.2 Impact of changes on patients

Impact	As a result of:
Improved prevention and self-care	• Promoting health and wellbeing e.g. exercise, smoking cessation • Hip and knee exercise programme • Focus on managing obesity • Provision of condition-specific Information for patients • Improved medicines management
More likely to be managed in a community setting rather than in hospital – better management of Long Term Conditions, early management of patients with escalating conditions, fewer unplanned admissions	• Urgent care re-design • Pathway re-design with a focus on managing patients in the community • Multi-disciplinary community teams supporting primary care to manage people at home • Improved use of community beds –

	step-up and step-down • Managing OP referrals • Introducing a risk stratification tool • GP support to Nursing Homes • Medicine reviews • Improved End of Life care with more people dying in the place of choice
Improved experience of planned care	• Choice of provider • Referral management leading to appropriate OP referral to secondary care • Management of referrals for low priority procedures • Improved management of follow-up appointments • Consultant telephone consultations where appropriate • Use of telemedicine • Shorter length of stay with community support where required • Improved discharge procedures
Improved mental health services	• Early intervention e.g IAPT • Reduced use of acute beds with greater emphasis on community based service provision • Fewer out of area placements
Improved health services for people with learning disabilities	

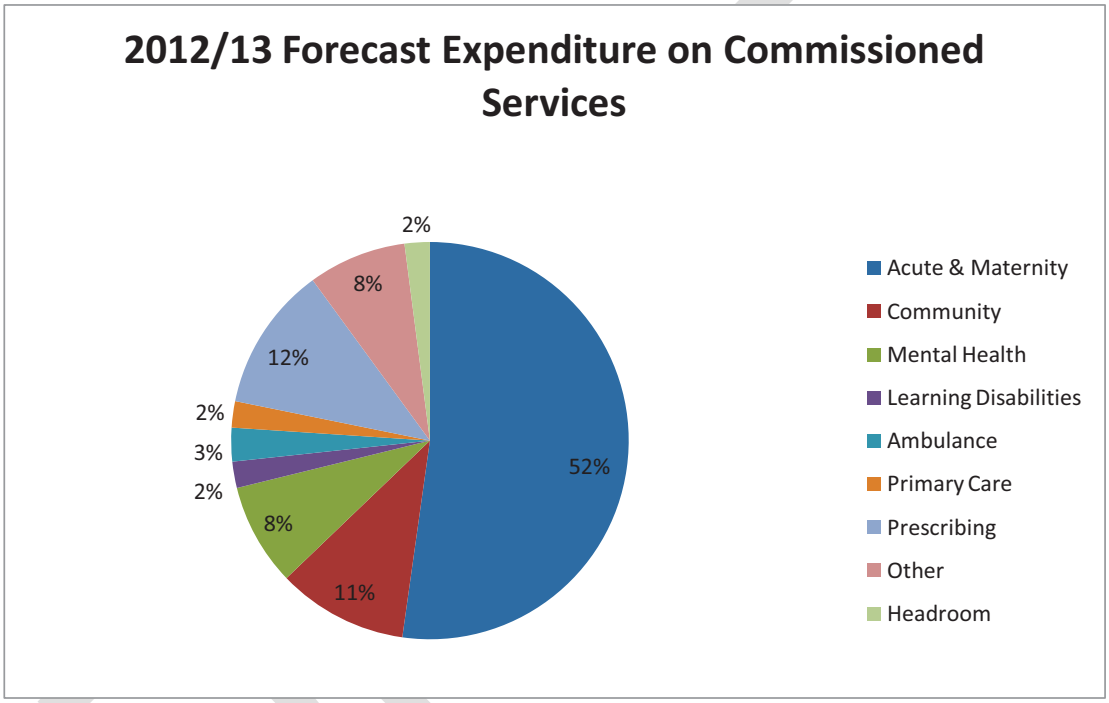
13.3 Impact on Providers

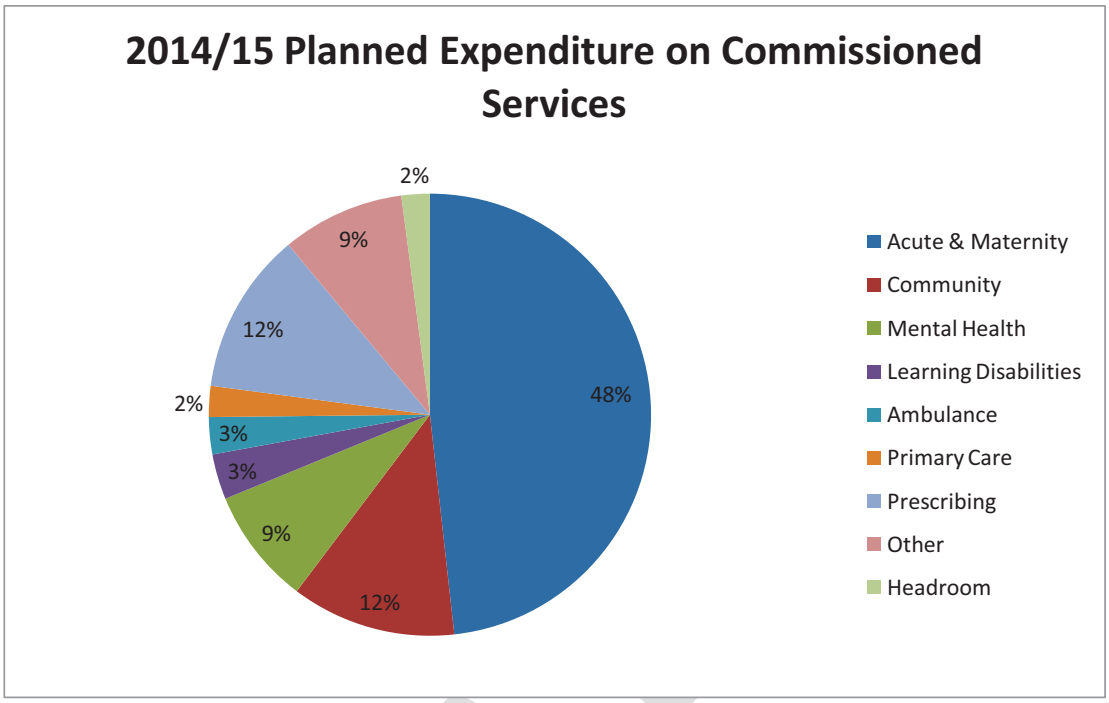
Impact of changes on activity:

- Reduction in unplanned admissions to hospital
- Reduction in planned admissions to hospital
- Reduction in mental health related admissions to hospital
- Reduction in outpatient referrals to secondary care
- Reduction in outpatient follow-up attendances
- Decrease in ambulance conveyance rates

- Reduction in inappropriate A&E attendances
- Increased use of community beds
- Increased demand for hospice provision
- Increased demand on community services (ageing population and increase in people with LTCs)
- Increase in the number of people diagnosed with dementia
- Increased demand for psychological therapies

13.4 Financial impact




2014/15 Planned Expenditure on Commissioned Services
2%
9%
12%
48%
2%
3%
3%
9%
12%
Acute & Maternity
Community
Mental Health
Learning Disabilities
Ambulance
Primary Care
Prescribing
Other
Headroom

NHS
Bath & North East Somerset
Clinical Commissioning Group

PART 2

Operational Plan for 2012/13

Healthier, Stronger, Together

v.7 (12 September 2012)

Xxxxxxxxxxxxxxxxxxxxxxxxxx

NHS
Bath & North East Somerset
Clinical Commissioning Group

PART 3

Draft Commissioning Intentions 2013/14

Healthier, Stronger, Together

v.7 (12 September 2012)

Bath & North East Somerset Council	
MEETING:	Health and Wellbeing Board (Shadow)
MEETING DATE:	19 September 2012
TITLE:	Community engagement
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1: Principles for community engagement	

1 THE ISSUE

1.1 Health and wellbeing boards have a duty to engage the public in their work. This report seeks to discuss and agree a set of principles that will establish a consistent and rigorous approach to community engagement.

2 RECOMMENDATION

The Board is asked to agree:

2.1 A set of principles for community engagement (attached as appendix 1).

FINANCIAL IMPLICATIONS

2.2 There are no direct financial implications as a result of this report.

3 THE REPORT

3.1 Health and wellbeing boards have a duty to engage the public in their work under the Local Government and Public Involvement in Health Act (2007), and this is recognised in the latest health reforms within the Health and Social Care Act (2012). This responsibility extends to the work of the clinical commissioning group represented on the board and the NHS Commissioning Board Authority.

'If the reforms are genuinely about shaping services around the needs of individuals and communities, then service users and the public must have real influence when big decisions are made' Department of Health

3.2 Good local engagement has a series of benefits and outcomes including:

- Can lead to new, more creative and often more cost effective solutions
- Better understanding of local community need
- Can provide insight into what is important locally
- Increase the sense of civic influence / empowerment (ownership of local initiatives)
- Better co-ordination of localised initiatives

3.3 Best practice suggests that engagement should take place from the start of the life of the board and woven through-out its work.

3.4 This report seeks to agree a set of principles for engagement for the B&NES Health and Wellbeing Board. These principles emerged from the Boards development session on the 3 September and are set out in appendix 1.

3.5 These principles will operate within the context of the Councils developing Local Engagement Framework (LEF).

3.6 The developing LEF will establish a minimum core 'offer' to all local communities for engagement with the Council. It will be coproduced with local stakeholders – particularly local public service agencies - and will be a more transparent, streamlined, innovative and integrated approach to engaging with local people, communities and other stakeholders. It will underpin the way community engagement is undertaken across the B&NES Partnership Framework of which the HWB is a part.

3.7 Through these principles – and a different way of approaching community engagement – the Board has the opportunity to be a pathfinder within the developing LEF.

3.8 Both the LEF and the Health and Wellbeing Board acknowledge that there will be different types and levels of engagement appropriate depending on the situation. However, it is important that there is a consistent and rigorous approach across the area; the principles set out in appendix 1 fit with the developing LEF.

3.9 There is also a clear connection between the presence of local elected members on the board and the public involvement agenda. Not only does this enhance the democratic legitimacy of the board and the decisions it takes, it also means that those members of the board come into regular contact with the public that they represent.

3.10 Healthwatch

Healthwatch will be in place from April 2013 and will have a formal role of involving the public in the work of the board. It is crucial that the board supports the development of local Healthwatch and their role on the board. However, public engagement is not purely the role and responsibility of the Healthwatch representative; all members of the board must assure themselves that appropriate public and user engagement is taking place in relation to the work of the board.

3.11 The following sets out our vision for local Healthwatch. This vision complements the Boards ambition for engagement.

3.12 *Our vision for local Healthwatch is:*

To embed the public and consumer voice within the day-to-day business of the HWB. The aim is to give citizens and communities a stronger voice and an independent voice to influence and challenge how health and social care services are commissioned and provided. And Local Healthwatch will establish itself as the coordinator of engagement in all aspects of health and social care and has the real potential to grow into an effective and powerful local leader.

3.13 Its specific role and scope can be described through six key areas. Healthwatch will:

1. Deliver three core operational functions: Influencing the planning and provision of health and social care, signposting people to information about health and social care services and assisting people by taking issues forward with health and social care commissioners and providers.

2. Act as an involvement network working proactively to bring together and enhance the existing infrastructure of local engagement and support drawing input and participation from it and coordinating common outputs.

3. Implement powerful communications promoting an active, dynamic and ongoing public conversation through web and social media. Operating within the broader local engagement framework proactively outreach to communities utilising innovative and effective methods of communication that are inclusive and accessible to all groups.

4. Work successfully alongside partners achieving excellent professional relationships and working systems within which to present challenge to ensure the views and experiences of patients, carers and other service users are heard and taken into account with commissioners and providers.

5. Establish a common agenda of priorities within the framework of the joint health and wellbeing strategy take up membership on the Health and Wellbeing Board and contribute a credible and proactive representation of the consumer voice within the Health and Wellbeing Board.

6. Ensure that the views and experiences of patients, carers and other service users are taken into account when local needs assessments and strategies are prepared, such as the Joint Strategic Needs Assessment.

3.14 The council will begin the procurement process for a Local Healthwatch on 1 October 2012, and will appoint the winning bidder by the end of this year 2012.

3.15 The new body will commence delivery of B&NES Local Healthwatch from 1 April 2013, when it becomes a statutory requirement for local authorities to make this provision.

4 RISK MANAGEMENT

4.1 A risk assessment related to the issue and recommendations will be undertaken as part of each engagement activity.

5 EQUALITIES

c) An EqIA has not been completed for the following reasons… EqIAs will be undertaken in the planning of each engagement activity.

6 CONSULTATION

6.1 Select from: *Ward Councillor; Cabinet Member; Staff; Other B&NES Services; Service Users; Local Residents; Community Interest Groups;; Stakeholders/Partners; Section 151 Finance Officer; Chief Executive; Monitoring Officer*

6.2 These report seeks to embed public and patient engagement within the day-to-day business of the health and wellbeing board.

7 ISSUES TO CONSIDER IN REACHING THE DECISION

7.1 Select from: *Social Inclusion; Customer Focus; Sustainability; Human Resources; Property; Young People; Human Rights; Corporate; Health & Safety; Impact on Staff; Other Legal Considerations*

8 ADVICE SOUGHT

8.1 The Council's Monitoring Officer (Divisional Director – Legal and Democratic Services) and Section 151 Officer (Divisional Director - Finance) have had the opportunity to input to this report and have cleared it for publication.

Contact person	*Helen Edelstyn 7951*
Background papers	
Please contact the report author if you need to access this report in an alternative format	

Health and Wellbeing Board principles for good public engagement:

Commitment to:
Proactively embed good public and patient engagement within the day-to-day business of the Board to improve the health and wellbeing outcomes of the B&NES population. This includes the intelligence, design, commissioning and delivery of services.

Principles:
Responsibility for good public engagement
All members of the board must assure themselves that appropriate public and patient engagement is taking place in relation to the work of the board.

Clarity about purpose
To ensure that there is a clear purpose and outcome from the start of the engagement activity. This should include what can change as a result of the engagement.

Harnessing a range of engagement methods
To harness a range of traditional and innovative ways of engaging with people including those who may be seldom heard.

Engaging with everyone
To take a proactive approach to engaging all parts of the local population / service users and seldom heard groups.

Cultural change
To develop a leadership style and meeting culture that is visible and accessible through, for example, a creative approach to the style and location of Board meetings.

Access to information
To provide (and allow access) to relevant information that allows people to engage in an informed way.

In partnership
Each agency represented on the Board has a separate responsibility for public engagement however where possible public engagement should be planned and delivered in a joined up way across the partnership and Local Engagement Framework.

Feedback
To ensure that service users and the public feel that engagement has been meaningful there should be feedback on how engagement has influenced the development of priorities and actions (even if there has been no influence as a result of the engagement).

Local HealthWatch
All members of the board must support the development and inclusion of Local HealthWatch so that they can sufficiently represent the public views within the day-to-day business of the Board.

Evaluation
To undertake evaluation of engagement activity to demonstrate transparency and accountability of outcomes achieved. Evaluation should also inform future engagement activity.

Outcomes:
- Improve the health and wellbeing outcomes of the B&NES population
- Improve the quality and efficiency of services
- Adds value to the work of the Board
- Public feels empowered