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:

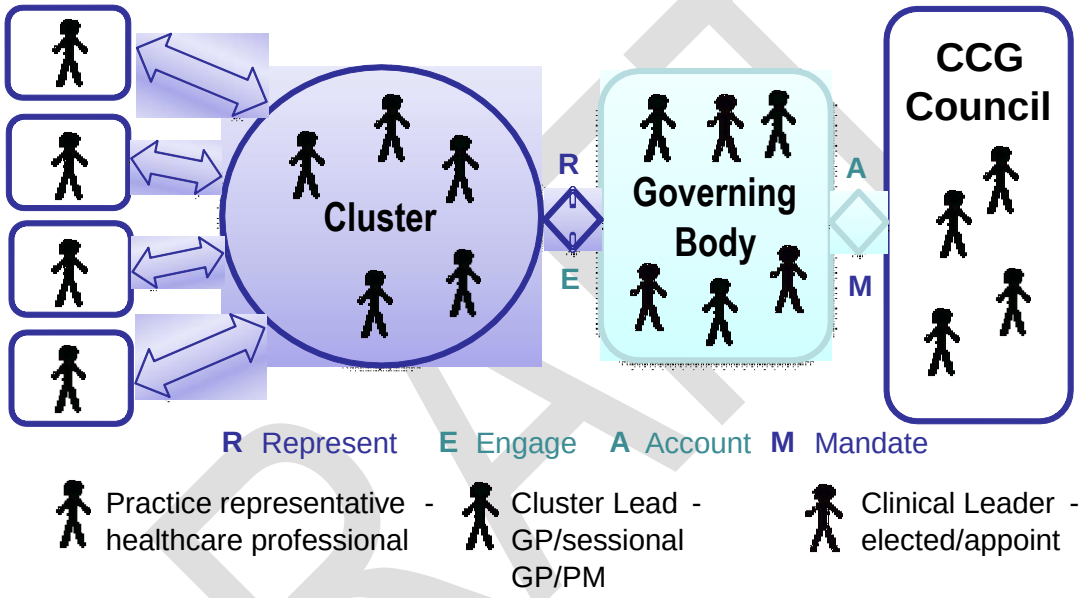
- 'Towards Establishment', February 2012
- CCG Governing Board committees: terms of reference, March 2012
- CCG Governing Body members: role outlines, attributes & skills, April 12

- 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

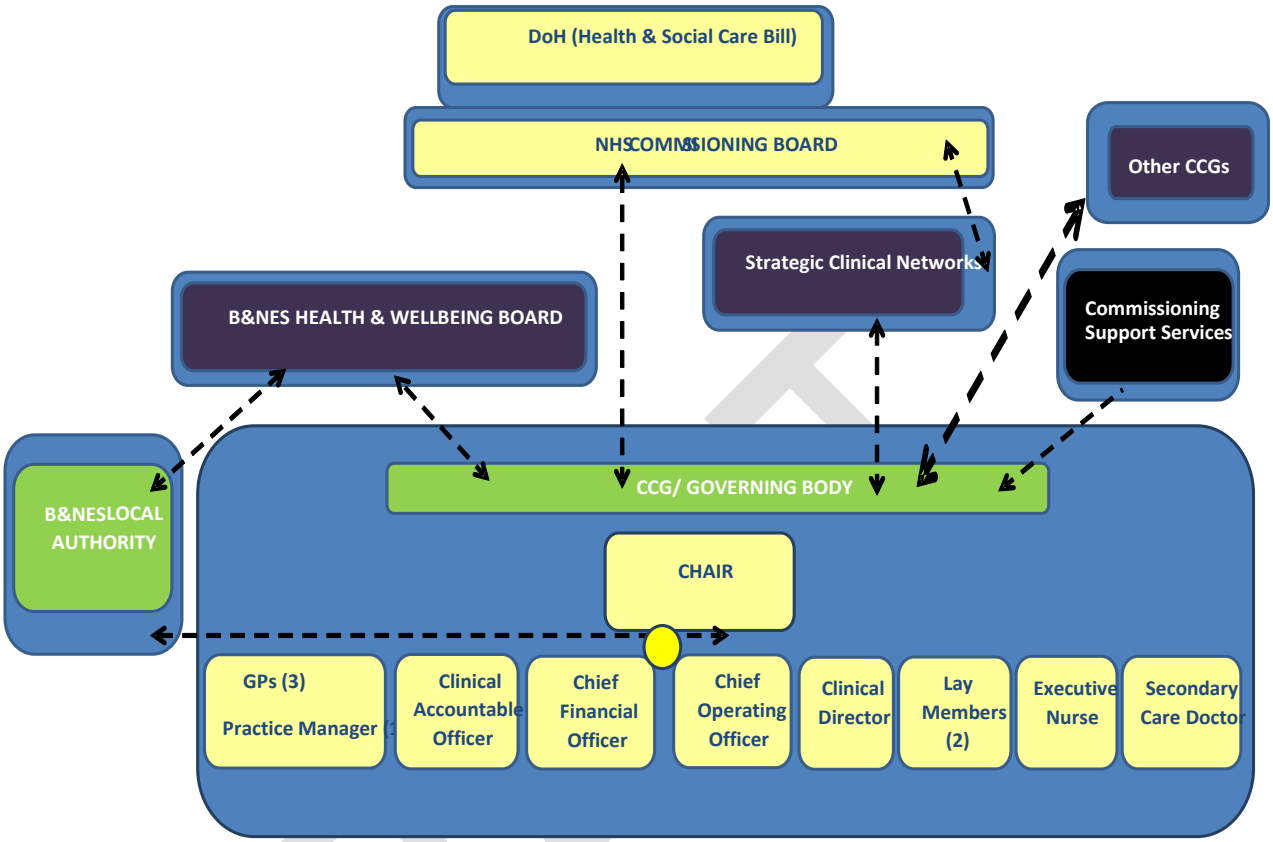
GP Practice



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.

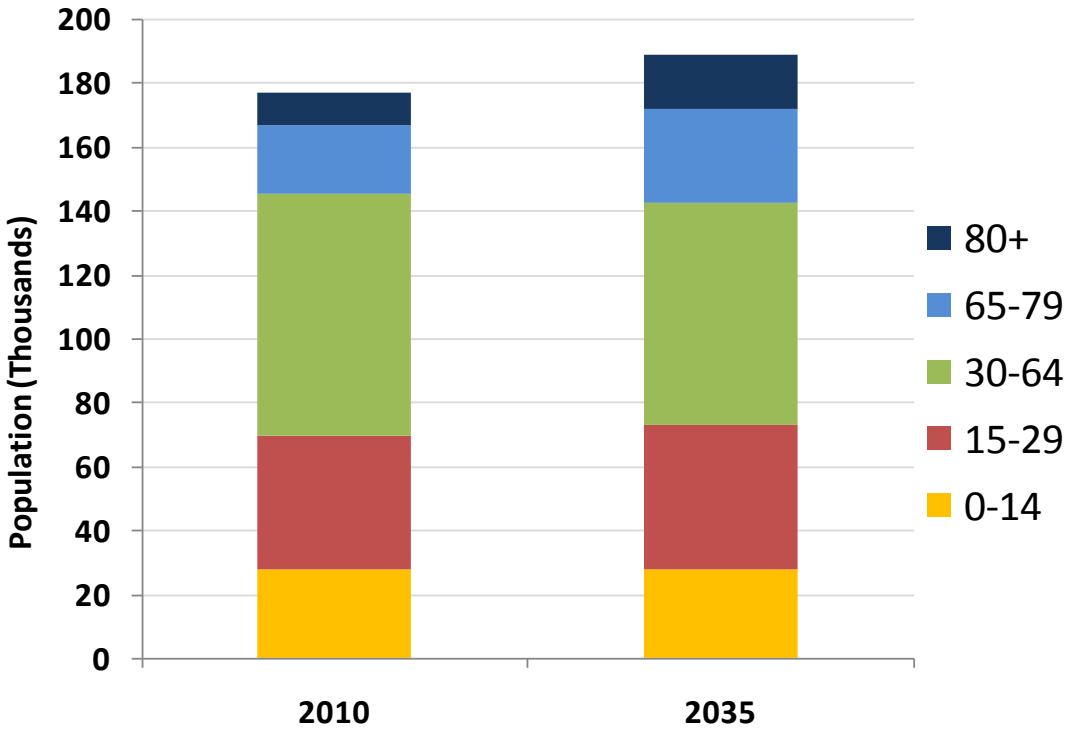
Bath and North East Somerset is less ethnically diverse than the UK as a whole but more so than the South West. 88% of residents are likely to define their ethnicity as White British. 'White other' (3.66%) is the most significant non-white British ethnicity by volume which is likely to include EU Accession 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.

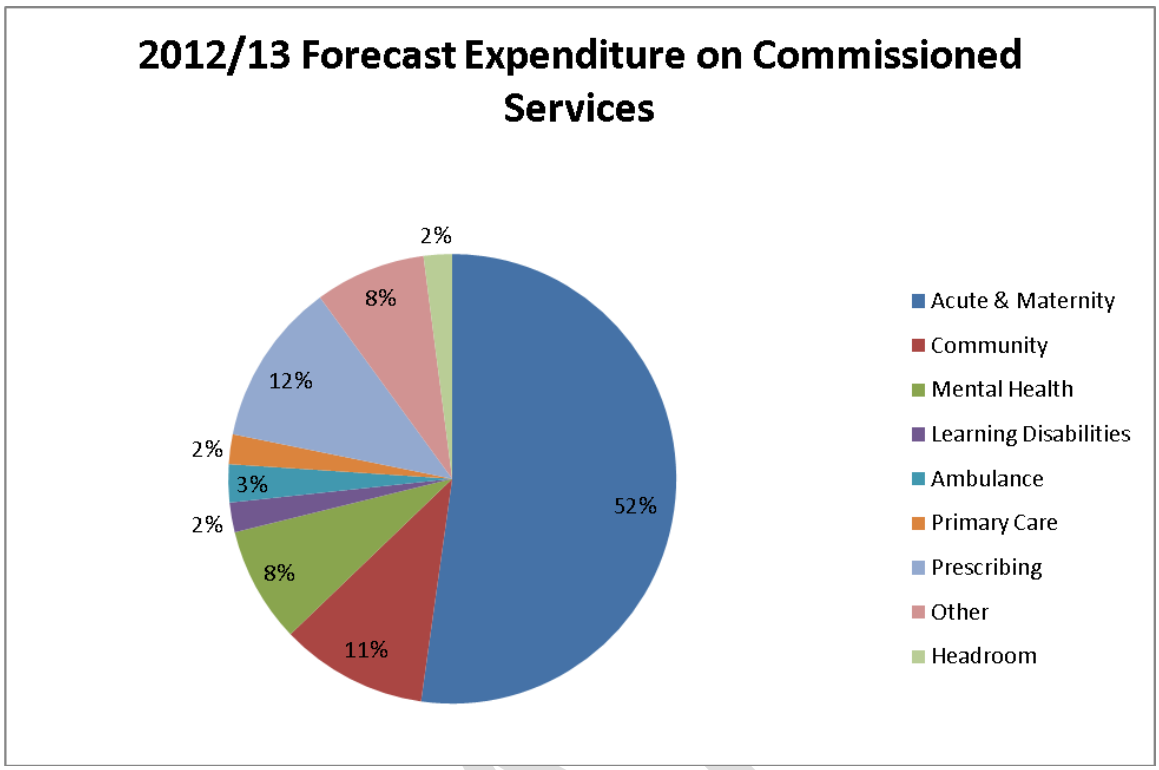
The CCG has developed a three-year financial plan which builds on the established 2012/13 to 2014/15 PCT medium term financial plan. The NHS Operating Framework underpins the priorities and financial assumptions. This is shown at summary level in the following table:

	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	

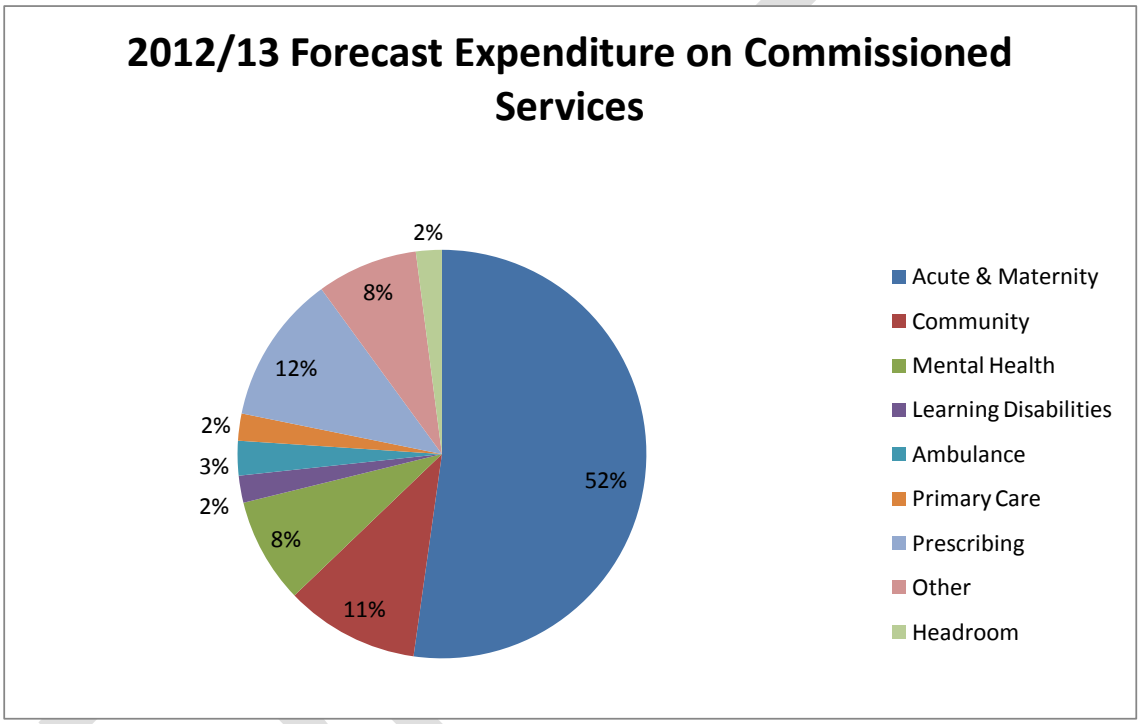
13.3 Impact on Providers

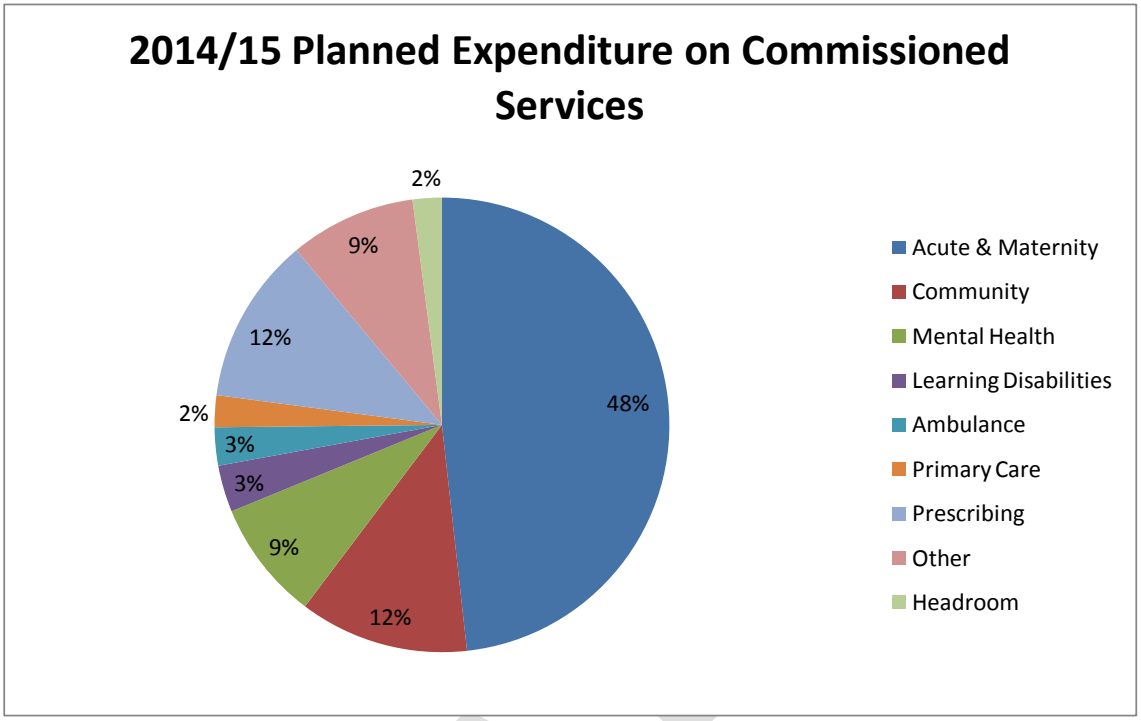
Impact of changes on activity:

- 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%
2%
3%
3%
9%
12%
48%
Acute & Maternity
Community
Mental Health
Learning Disabilities
Ambulance
Primary Care
Prescribing
Other
Headroom

Bath & North East Somerset
Clinical Commissioning Group

PART 2

Operational Plan for 2012/13

Healthier, Stronger, Together

v.7 (12 September 2012)

Xxxxxxxxxxxxxxxxxxxxxxxxx

Bath & North East Somerset
Clinical Commissioning Group

PART 3

Draft Commissioning Intentions 2013/14

Healthier, Stronger, Together

v.7 (12 September 2012)