Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Bath and North East Somerset Health & Wellbeing Board

Democratic Services Riverside, Temple Street, Keynsham, BS31 1LA	Direct Line:	01225 394452
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	Date:	27 May 2014

To: All Members of the Health & Wellbeing Board

Members: Dr. Ian Orpen (Member of the Clinical Commissioning Group), Councillor Katie Hall (Bath & North East Somerset Council), Ashley Ayre (Bath & North East Somerset Council), Councillor Simon Allen (Bath & North East Somerset Council), Bruce Laurence (Bath & North East Somerset Council), Dr Simon Douglass (Member of the Clinical Commissioning Group), Councillor Dine Romero (Bath & North East Somerset Council), Jo Farrar (Bath & North East Somerset Council), Pat Foster (Healthwatch representative), Diana Hall Hall (Healthwatch representative) and John Holden (Clinical Commissioning Group lay member)

Non-voting member Douglas Blair (NHS England - Bath, Gloucestershire, Swindon and Wiltshire Area Team)

Observers:

Other appropriate officers
Press and Public

Dear Member

Health & Wellbeing Board

You are invited to attend a meeting of the Board, to be held on **Wednesday, 4th June, 2014** at **10.00 am** in the **Brunswick Room - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Jack Latkovic

Committee Administrator

This Agenda and all accompanying reports are printed on recycled paper

NOTES:

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

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

3. **Webcasting at Meetings**:-
   This meeting is being filmed for live and archived broadcast via the Council's website: www.bathnes.gov.uk/webcast

   At the start of the meeting, the chair will confirm if all or part of the meeting is to be filmed.

   The Council will broadcast the images and sound live via the internet. An archived recording of the proceedings will also be available for viewing after the meeting. The Council may also use the images/sound recordings on its social media site or share with other organisations, such as broadcasters.

   To comply with the Data Protection Act 1998, we require the consent of parents or guardians before filming children or young people. For more information, please speak to the camera operator.

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

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

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

6. **Declarations of Interest**

   At this point in the meeting declarations of interest are received from Members in any of the agenda items under consideration at the meeting.

   (a) The agenda item number in which they have an interest to declare.
   (b) The nature of their interest.
   (c) Whether their interest is a **disclosable pecuniary interest** or an **other interest**, (as defined in Part 2, A and B of the Code of Conduct and Rules for Registration of Interests)

Any Member who needs to clarify any matters relating to the declaration of interests is recommended to seek advice from the Council's Monitoring Officer or a member of his staff before the meeting to expedite dealing with the item during the meeting.

7. Attendance Register:

Members should sign the Register which will be circulated at the meeting.

8. Emergency Evacuation Procedure

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

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

Health & Wellbeing Board

Wednesday, 4th June, 2014
Brunswick Room - Guildhall, Bath
10.00 - 11.30 am

Agenda

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

3. APOLOGIES FOR ABSENCE

4. DECLARATIONS OF INTEREST

   At this point in the meeting declarations of interest are received from Members in any of the agenda items under consideration at the meeting.

   (a) The agenda item number in which they have an interest to declare.

   (b) The nature of their interest.

   (c) Whether their interest is a **disclosable pecuniary interest** or an **other interest**, (as defined in Part 2, A and B of the Code of Conduct and Rules for Registration of Interests)

   Any Member who needs to clarify any matters relating to the declaration of interests is recommended to seek advice from the Council's Monitoring Officer or a member of his staff before the meeting to expedite dealing with the item during the meeting.

5. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

6. PUBLIC QUESTIONS/COMMENTS

7. HEALTH AND WELLBEING NETWORK FEEDBACK

8. NHS BANES CCG 5 YEAR STRATEGIC PLAN 2014/15-2018/19

9. NHS ENGLAND: BGSW AREA TEAM OPERATIONAL PLAN FOR 2014/15 AND 2015/16

10. TWITTER QUESTIONS

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

MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**04/06/2014**
TYPE	**An open public item**

Report summary table	
Report title	Health and Wellbeing Network Feedback
Report author	Ronnie Wright, Healthwatch B&NES - 0117 958 9333
List of attachments	Appendix One: Health and Wellbeing Network (13.05.14) – meeting notes
Background papers	
Summary	The Healthwatch B&NES Health and Wellbeing Network met on 13th May 2014 to discuss the NHS BaNES CCG Plans and feedback to the CCG ahead of its final submission. This report outlines the key feedback highlighted by the network.
Recommendations	The Board is asked to note the feedback from the Health and Wellbeing Network as part of its discussion on the NHS BaNES CCG 5 Year Plan.
Resource implications	None
Consultation	The Health and Wellbeing Network brings together a range of health and social care providers and other interested parties.
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

THE REPORT

1.1 The Healthwatch B&NES Health and Wellbeing Network session on Tuesday 13th May 2014 was attend by 35 people from a range of different organisations. The session was an opportunity for interested organisations and people to hear an update on the NHS BaNES CCG draft Strategic 5 Year Plan and discuss the priorities and next steps for putting the plan into action.

1.2 As part of the session, two workshops were held with attendees which discussed the CCG's priorities on Prevention and self-care and Care for frail older people.

1.3 A range of points were highlighted by the participants and a summary of the key themes is noted below:

- The critical importance of continuing to improve and build on collaboration and joint working was highlighted as key by many of the working groups. This includes collaboration that goes across ages, workstreams and sectors. It includes more effective communication.

- Looking beyond health and social care to wider determinants including housing and education for examples was highlighted as vital. Addressing inequalities was also highlighted as fundamental to this.

- Overcoming social isolation is of great importance.

- Developing our understanding of motivation, and how to improve or build on people's motivation, was important.

- Community engagement and involvement has a key role to play in delivering the plan.

- A shift towards more early intervention was welcome and necessary and needed to be supported.

- Particularly in relation to frail older people, the idea of making every contact with older people count was a strong theme.

- Transport is also a major consideration.

- Continue to build on the good work that is already taking place.

1.4 The full details from the workshop and subsequent email feedback following the draft notes are available in Appendix One.

Please contact the report author if you need to access this report in an alternative format

Health and Wellbeing Network – Meeting Notes

Tuesday 13 May, Guildhall, Bath

The meeting was attended by 35 people. Apologies were given by 15 people. Details are given at the end of the meeting notes.

B&NES Clinical Commissioning Group (CCG) Five Year Plan

Update on the Commissioning Landscape – Ian Orpen

Ian explained what services the CCGs are responsible for and commented that whilst B&NES CCG has a stable financial history there are challenges coming in 2015/16. Ian stressed that there is still time to contribute to the draft plan outside of the meeting and asked for comments to be sent to Ronnie who will feed them through to the CCG to contribute to the development of the five-year plan. There will be an extraordinary meeting of the Health and Wellbeing Board in early June where the five-year plan will be discussed.

Overview of the CCG's Draft Strategic Plan – Simon Douglass and Tracey Cox

Simon talked through the CCG's vision and five-year plan. He highlighted the 'tough challenges' ahead particularly with a growing number of older people and a student population of 25,000. There are inequalities in B&NES with pockets of significant deprivation and a widening picture of health inequalities. Life expectancy is rising, the 75+ population is set to increase by 20%.

The uncomfortable truth is that if changes in services and delivery are not made there will be a £60.8m gap by 2018/19. Care in hospital is very costly and there needs to be a shift to more community based care situations. The CCG plans to group services into clusters that centre around GP practices with patients and carers at the centre. Simon gave the example that those with type 2 diabetes who have support to manage their condition do much better. How to manage those with a complexity of long term conditions is a difficult question.

Tracey said that the plan is in draft form and is a 130 page document on how to transform and deliver services. The CCG believes that the priorities to concentrate on are: -

- Frail older people
- Prevention and self-care
- Diabetes
- Urgent care
- Musculoskeletal services
- Records

She went on to explain the 'What, Why, So? and 1 Result' for each of the categories and asked people to consider these and respond to six questions in feeding back to the CCG any comments around the five year plan:

1. What's your overall response?
2. Are we being realistic, given the context?
3. Are there any obvious 'quick wins' to help us achieve our goals?
4. What should our first steps be?

5. Are there any further opportunities which we have missed?
6. Have we missed anything obvious in connection to the wider integrated care picture?

Break Out Session 1 - Prevention and self-care: Becky Reynolds

Question 1: - Given the major causes of early death, what do you think about our suggested focus on one or more of the following areas of prevention:

- **Smoking/tobacco control**
- **Physical activity**
- **Healthy eating**
- **Mental health and wellbeing?**

Group 1
Inequalities focus and geographical focus
Higher impact – more capacity and awareness
– mapping existing provision
– provision outside of health and social care?
Workforce focus by local providers

Group 2
Significant challenge! Can't focus on more than 5 areas
***** Smoking is already quite successful
Presentations were really good: 'Bus stops' e.g. should also reflect the amount of time spent experiencing poor quality of health
Focus on self – prevention very good
- must develop link with housing
- have seen fantastic programmes looking at improving people's motivation and accomplishment e.g. expert patient

Bigger picture e.g. around housing, motivation etc good but very big
Education/schools also key: cross fertilisation
Housing – role for more joined up working – front line services and housing professionals: health impacts of cold homes/potential housing loss
Housing adaptations to promote independent living – also has an impact for mental health wellbeing
Joined up – must trust each other as professionals

Group 3
Define mental health and wellbeing – does it include social isolation
Will all 6 aims be thought of together?
e.g. physical activity → Prevention
→ Diabetes
→ Elderly and frail
→ Managing Long Term Conditions
Longevity of impact of services – voluntary sector
Links between commissioned services and voluntary/community services
Specific support voluntary sector open/generic services

Group 4
Although a range of interventions may be offered they need to be delivered collaboratively, not in silos, i.e. whole system approach
Need to look 'upstream' – what causes people to undertake 'risky behaviours' e.g. smoking, alcohol, unprotected sex. Impact on lifestyle etc
Communication between service providers/organisations they are supported by, to prevent a person's care being broken down (Integrated care)
Community engagement approach – deliver services where people are = in the community

Identifying patients/'at risk' groups who could benefit from support before a condition/issue presents → need a presence within the community who understands the 'inner workings'

Group 5
Ensure we focus on collaboration rather than directing public health
Embed the prevention messages throughout all intervention – from GP message to consultant
Work more closely with services that see people before they become patients e.g. housing associations, sexual health clinics. Third sector must be a system player

Question 2: - What can the CCG do to reduce differences in health that exist between different parts of our population (health inequalities)?

Group 1
Maximise opportunities through contacts
Engage through existing local services – develop plan with existing local providers

Group 2
Physical activity – Birmingham Council is working with particular disadvantaged areas to involve communities in determining what they want
- identify key players in the community

Housing approach – key, must be joined up
Everyone plays a part
Isolation is a big issue. Not just older people
- village agents

Work and inequalities. Having a job and being engaged. Also crucial cultural issue: e.g. smoking and manual labour
What's missed – always asked about history of health issues but this isn't followed up
Local identity/ communities: any ways of tapping into local culture? Local identity?
- people must see the results of having been engaged!

Group 3
Inclusive process of service development to lower barriers
Research into different population needs
Understanding that change takes time
Rural isolation – difficulty reaching the population

Group 4
BME communities/traveller communities
Need to understand demographics
Recognise those people that need support to navigate health services e.g. ALDs
E.g. Dorothy House attracts some people who may be in equality groups – understand their needs
→ changing consumer trends – Primark?
Churches/faith community contacts, food bank, BEMSCA
Bus route example – extending participation of community groups to a wider demographic, not just within a small community
Wider determinants of Public Health – housing/education/employment
Carers – recognising who is (helping them to) support, Quality of Life
Resources management – (NCMP/IMD etc. data)
→ use this to identify areas which would/could benefit most

Group 5
Better integration of services
Planned health checks for more groups and better accessibility of information

Question 3: - What can we do to help people to manage their health better?

Group 1
Joint campaigns, marketing and promotion
Smarter working between providers – joint events
Well Aware – link to surgery websites
Financial incentives?
Targeted efforts

Group 2
Self-care really important and empowering
Healthy eating messages aren't helpful – confusing
Culture change vital
Links and Children and Young People – think about how we collaborate
Being clear about where responsibilities sit
Also links with planning
Role of the Health and Wellbeing Board – understanding of health being part of everyone's responsibility
Role of prevention in surgeries. Role of social prescribing e.g. Bromley-by-Bow work

Group 3
What do we mean by individual responsibility?
Education and early intervention
Digital technology for all
HIAs, ensuring health is high on the agenda for all public sector bodies
Public transport access and improvement
Ensure sporting bodies promote healthy activity

Group 4
Need to make legislation and public health messages more positive i.e. 'how could life be better' 'what do you want'
→ elements of motivational interviewing
→ empower people to decide what they want
→ patient as expert
→ peer support
Work places
Sharing patient data to identify/support people who could benefit from services
→ data confidentiality
→ cost of writing out/contacting people
→ consent

Group 5
A sense that people who need the most support don't seek it – so how to find them?
Telehealth/Apps/Befriending – companionships
Better promotion of the successes – the human stories and benefits
Provide the knowledge for people to be able to self manage

Break Out Session Two - Care for Frail Older People: Dawn Clarke

Dawn Clarke particularly highlighted the commissioning guidance on Safe Compassionate Care for Frail Older People produced by the Department of Health.

Question 1: Are there any obvious 'quick wins'?

Group 1
Planning for being frail/old
Independent Living Centre – access around adaptations in B&NES
Wellbeing for older people. Sense of being part of their community – not isolated

Transport – key. Does a lot of good for mental wellbeing, and better use of rural care agencies:
Domestic Care Agencies. Increasing social stimulation. Not just physical care
→ must be commissioned
Making every contact count
Joining up the information – and for signposting
Encouraging people to talk about it more – Death cafe style?
Retirement – dealing with it beforehand
Promoting independence needs also to think about purpose and structure
Example of older people's home being built within a school – very positive links
Focus on earlier old age important for later old age
Needs joining up of work and older people – better collaboration

Group 2
There are 5 GP cluster areas in B&NES – Sirona will go in and support this
Befriending
Make use of contact that is already being made, i.e. social care support/community health services, care/support plans coming out of hospital
Home from hospital scheme (Age UK and British Red Cross)
Contact the elderly
Use Well Aware for information
Town/Parish Councillors (Councils)
e.g. First Contact/Good Neighbours scheme (both South Glos Council)
Linage example in Bristol
Sheltered housing scheme in Wellow
UJA
Use of volunteers – Dorothy House, British Red Cross

↳ recognise capacity here} Community and
Invest in sharing ideas } Voluntary Service

Directory of services (111)/one stop shop

↳ are these aligned and accessible to cluster teams?

Older people serving as carers → reliance on one another despite long term conditions/need
Bereavement support

↳ DRC are doing a joint project with Age UK in Gloucester (DLF)

Group 3
Shared contact details – transport = public and private
Companionship (loneliness → heart conditions, smoking)
↓ ↓ ↓
Healthy homes (reduce clutter and therefore reduce trips and slips and falls
Slipper exchange/doormats/carpet tacks
EOL care planning – shift the social perspective on death!
Ensure a work force is in place to do it!

Group 4
Transport
Better co-ordination of support services
Lifestyle MOT – Active Aging – RUH – all public health staff
Normalizing of a healthy lifestyle
Marrying of 'support services' and 'normal activities'
Investing in building community support

Question 2: What should our first steps be?

Group 1
Revive Older People's Strategy – transport would be key issue within that

Examples of volunteering projects
Lack of time for people e.g. ‘posties’, a lost opportunity
Being ‘old’ a relative concept
Day care: could change the model of how day care works. More flexibility. More creative about what’s provided. Support to overcome e.g. health and safety

Further information

A copy of the CCG’s Draft 5 Year Strategic Plan can be found under the News Section on the CCG’s website at: http://www.bathandnortheastsomersetccg.nhs.uk

The presentations from the meeting can be found at http://www.healthwatchbathnes.co.uk/notes-and-presentations

Evaluation

Content	Average mark (out of 5)
Your understanding of subject at start	3.4
Your understanding of subject at end	4.3
Sessions	
Speakers	4.4
Other elements	4.3
Organisation	
Pre-event information	3.8
Facilitation	4.5
Organisation on day	4.6
Venue	
Access	4.4
Refreshments	4.1
Standard of room	4.4

What was the most significant outcome of the event for you?

- Prevention and self-care discussion - inclusion of minority groups
- Enlightenment on plan and reasons behind priorities
- Understanding more about CCG and Healthwatch and the importance of prioritising how they deliver services.
- Networking and knowledge of area priorities.
- Meeting colleagues in the health sector that I have not been able to interact with before.
- Diverse range of thoughts and ideas - not just 'single issue' thinking. Refreshing! But general agreement that integration is the only solution.
- Networking with others. Hearing overview of CCG priorities.
- Understanding of ongoing discussion at B&NES CCG.
- Getting an insight into CCG aims.
- The depth of the problem.
- Seeing a bigger picture of NHS care.
- To be able to meet the decision makers.
- Feeling that I could contribute. Realisation of a clear sense of direction and purpose from CCG.
- Understanding the plan, which is big, joint working will make it deliverable.
- Great to meet with so many like-minded people.

Do you have any suggestions regarding topics/speakers for future meetings?

- Needed more time to delve into discussions.

- Discussion of opportunities.
- Joining up former/current supporting people services with health.
- Linking further with housing associations.
- Submission of written evidence of what works.
- Dying matters and end of life care.

Are there any other comments you would like to make?

- Learnt a lot and enjoyed it.
- Thank you!
- A good opportunity to contribute to what is a significant challenge.

Present

Ian Orpen	Bath and North East Somerset CCG
Simon Douglass	Bath and North East Somerset CCG
Tracey Cox	Bath and North East Somerset CCG
Dawn Clarke	Bath and North East Somerset CCG
Adam Bladwell	British Red Cross
Katy Berwick	Alzheimer's Society
Steve Bryce	Consensus Support
Jos Clarke	WE Care and Repair
Mark Coates	Developing Health and Independence
Julia Cook	Riverside
Beverley Craney	Swallow
Simone Fullagar	University of Bath
Karen John	Age UK
Simon Knighton	Sirona Care and Health
Peter Miles	Developing Health and Independence
Claire Graham	Bath and North East Somerset Council
Chris Mordaunt	Bath and North East Somerset Council
Martin Pellow	Bath and North East Somerset Council
Viv Pritchard	Bath and North East Somerset Council
Becky Reynolds	Bath and North East Somerset Council
Helen Edelstyn	Bath and North East Somerset Council
Jane Pye	Regional Rheumatology Group
Richard Smith	Way Ahead Care
Jill Souter	Dorothy House Hospice
Justin Wride	Sirona Care and Health
Fiona Cook	Sirona Care and Health
Clare Emery	Julian House
Sarah Maclennan	Central Southern CSU (NHS)
Tom Baxter	RV Care
Sabrina Kahn	GMC
Laura Marsh	CCG (NHS)
Oliver Jones	Creativity Works
Ronnie Wright	The Care Forum
Alex Francis	The Care Forum
June Aland	The Care Forum

Apologies

Jessica Brodrick	Bath and North East Somerset Council
Lynda Deane	Bath and North East Somerset Council
Sandra Elmer	Bath and District Cruse
Tom Fox-Proverbs	Bath and North East Somerset Carers Centre
Elizabeth Griffin	Minerva

Angie Jakubowska	Avon and Wiltshire Mental Health Partnership Trust
Sheena Jones	Sirona Care and Health
Adrian Marchment	Priory Group
Rachel McKenty	Sirona Care and Health
Kate Moreton	Bath Mind
Rosie Phillips	Developing Health and Independence
Janet Rice	Sirona Care and Health
Karen Webb	Four Seasons Health Care
Tracey Wilmot	Support Empower Advocate Promote
Melanie Woolgar	Avon and Wiltshire Mental Health Partnership Trust
Audrey Spearing	

MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**14/05/2014**
TYPE	**An open public item**

Report summary table	
Report title	NHS BaNES CCG 5 Year Strategic Plan 2014/15-2018/19
Report author	Simon Douglass, Clinical Accountable Officer, BaNES Clinical Commissioning Group
List of attachments	• Appendix 1: Draft 5 Year Strategic Plan 2014/15 to 2018/19 & its associated Appendices • *(Appendices to Strategy not included in main strategy document: Appendix 1 - 2 year Operational Plan, Appendix 2 - National metrics, Appendix 3 - Equality Impact Assessment)*
Background papers	• *A Call to Action* NHS England (July 2013) • *Everyone Counts: Planning for Patients* 2014/15 to 2018/19 NHS England (December 2013).
Summary	*Everyone Counts: Planning for Patients 2014/15 to 2018/19* (December 2013) NHS England set out the requirement for Clinical Commissioning Groups to develop a 5 Year Strategy, a 2 Year Operational Plan and a plan for implementing the Better Care Fund. This is on the basis of an identified Unit of Planning, which for us is the coterminous area for which both the Council and CCG have responsibility. Provider organisations and NHS England were also asked to develop their plans for hospital, specialist and primary care services at the same time, to enable whole system triangulation of plans. The Clinical Commissioning Group (CCG) was required to develop a 5 Year Plan to demonstrate how the NHS England Vision for **'high quality care for all, now and for future generations'** will be delivered. There is a focus on outcomes through the NHS Outcomes Framework. The Health and Wellbeing Board reviewed the 2 Year Operational Plan and the Better Care Plan on 26th March 2014. Final versions of these plans were submitted to NHS England on 4th April 2014.
Recommendations	The Health and Wellbeing Board reviewed an earlier version of the 5 Year Strategy on 26th March. The Board is now asked to support

	the direction of the 5 Year Strategy and confirm it is consistent with the Joint Health and Wellbeing Strategy, noting that the document details the CCG's priorities for transformational change and does not cover the full range of commissioning responsibilities. The plan is still in draft but has been updated to include:- • The CCG's 2 Year Operational Plan as an annex to evidence the proposed commissioning work programme across all areas (see Appendix 1 of 5 year Strategy) • An Equality Impact Assessment (see Appendix 3 to 5 Year Strategy) • Patient Stories to describe the desired impact of the 6 priority areas (page 88) • Sensitivity Modelling (Page 100) • A strengthening of the "Case for Change" including the CCG's review of "Any Town" modelling. This is a national tool that looks at the potential benefits of high impact changes. (Page 46) • A high level implementation plan (Page 125) The 5 Year plan still requires further refinement and will be submitted on the 20th June 2014. The final version will: • Articulate more clearly our plans for implementation • Articulate the impact of the changes on providers and the whole health care system.
Rationale for recommendations	The CCG and Council are working to a national timetable which requires submission of the final 5 Year Strategy to NHS England by 20th June 2104. The 5 Year Strategy provides the rationale for the key strands of our plans.
Resource implications	The resource implications are fully detailed in the Strategy.
Statutory considerations and basis for proposal	This report responds to the national guidance received by the Clinical Commissioning Group from NHS England - *A Call to Action* (July 2013) and *Everyone Counts: Planning for Patients* 2014/15 to 2018/19 (December 2013). Fundamental elements of the plan include reducing health inequalities and developing health and social care system sustainability.
Consultation	The plan has been developed and endorsed by a broad range of partners, including representatives from: provider organisations; primary care; the third sector; Healthwatch BaNES; the HWB; the Local Authority, including Public Health; NHS England; and Wiltshire CCG. The Council's Section 151 Officer has been consulted on proposed

	use of the Better Care Fund.
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Clinical Commissioning Group's decision making risk management guidance. The 5 Year Strategic Plan, Better Care Fund and Operational Plan each include an analysis of the risks.

THE REPORT

1.1 The purpose of the plan is to identify our strategic vision for the next 5 years and describes our role as a high performing CCG to lead our health and care system collaboratively through the commissioning of high quality, affordable, person centred care which harnesses the strength of clinician led commissioning and will empower and encourage individuals to improve their health and wellbeing.

Please contact the report author if you need to access this report in an alternative format

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NHS
Bath and North East Somerset
Clinical Commissioning Group

DRAFT 230514 - v0.116

Seizing Opportunities – A Five Year Strategy

23rd of May 2014

VERSION CONTROL SHEET

Date	Change required	Amended by	Version Number
24/03/14	Master reformatted	RG	V 0.61
25/03/14	Master restructured using existing content from version 0.61	RL	V 0.62
30/03/14	Master restructured using content from version 0.64	RL	V0.64
31/03/14	Multiple edits	RL	(Version 0.64) – Restructure v0.40
01/04/14	Chapter changes following initial QA – Vision section moved and comments added.	RG	(Version 0.64) – Restructure v0.41
02/04/14	Edited to reflect TC's comments and suggestions	RL	(Version 0.64) – Restructure v0.46
04/04/14	Edited and schemes added	RL	(Version 0.64) – Restructure v0.109
11/05/14	Changes to Title on pg 55	RG	V111
15/05/14	Risk section update Chapter 2 – narrative reword	RG	V112
19/05/14	Graphs update	RG	V113
21/05/14	Chapter 4 & 5 updates (JAW) Quality changes (DC) Diabetes update (LM)	RG	V114
22/05/14	Engagement section updates	RG	V115
23/05/14	Prevention/self-care update (RR) TC updates Internal review for H&W Board within the CCG	RG	V116

STRATEGY SIGN OFF HISTORY

Date	Forum	Version Number	Comments
26/03/14	Health & Wellbeing Board		
27/03/14	BaNES CCG Board		

Foreword

The NHS constitution makes our task as leaders of the NHS clear as stated in its opening lines.

The NHS belongs to the people.

It is there to improve our health and wellbeing, supporting us to keep mentally and physically well.

This document describes the vision of how the health services for the people of Bath and North East Somerset need to change over the five years from 2014 to 2019, but also how this will be achieved. This represents a step change in the way the NHS has operated as for the first time we are setting a detailed plan for five years as opposed to one or two years. While it comes at a time of unprecedented prolonged financial challenge to the health and social care sector, twinned with rapidly rising demand, it also represents a huge opportunity to create a system that operates in a way better suited to the 21st century.

As NHS Bath and North East Somerset CCG we need to show this with clarity of direction in our role as local system leaders, while working closely with both our partners in the commissioning of related services and providers of health and social care. Indeed, as our strap line *"Healthier, Stronger, Together"* indicates, we do not see this as a CCG responsibility alone. At all times we will keep in focus our patients and public.

So in the fashioning of this plan, we have built on our very close working links with the council as demonstrated by the long established partnership and joint commissioning arrangements, the Joint Health and Wellbeing Strategy, as produced by the Health and Wellbeing Board. This 5 year plan is based on a much wider base than purely health issues, underpining our belief (supported by evidence) that there is much beyond the traditional health model that impacts directly on the health of the population.

We also recognise the importance of a breadth of ownership of the plan, both in its creation and implementation. We have, therefore, worked to co-create these plans by involving the people and organisations who have an important stake in the delivery and performance of local health and social care. This has included hospital, community, mental health, primary care, voluntary sector and housing services, amongst others. We have already held meetings with the public through our ‘Call to Action’ and ‘5 Year Plan’ events.

It is critical to the success of the plans and vision we have, for the public and patients to be central to their conception, development and implementation. So we will shape the services around patients in design and delivery, with as much of this provided locally in their communities as is feasible and appropriate.

Plans are only documents and will make no difference if they do not become reality. So we will continue to spent significant effort in developing robust mechanisms to oversee the implementation of the plans. It is essential that they do deliver the ambitions articulated in these plans for us to meet the responsibility we have for our population as set out in the NHS constitution.

For us to meet the challenges outlined above, it will require two distinct elements for success, Ambition and imagination. I hope that as you read this, you will feel reassured that we are describing a vision that meets both those descriptions.

Dr Ian Orpen – Chair

Contents

Executive Summary

Our Vision

When we embarked on our journey to become a Clinical Commissioning Group (CCG), we encapsulated our strategic vision in the statement 'Healthier, Stronger, Together'. Bath and North East Somerset CCG (BaNES CCG) has been established for a year, and this vision is all the more relevant.

We believe that our role as a high performing CCG is to lead our health and care system collaboratively through the commissioning of high quality affordable person centred care which harnesses the strength of clinician led commissioning and will empower and encourage individuals to improve their health and wellbeing status.

Seizing Opportunities

There can be no doubt that all health and social care systems in England, whatever their starting point, face unprecedented challenges in the years ahead. We believe that the five year strategic plan is a key milestone in the development of the CCG and the evolution of clinical commissioning in our health system. We will use this platform to extend our ambitions.

We start the strategic planning process with a strong foundation on which to build future success. We have a track record of working in synergy with our local authority colleagues and have been jointly commissioning integrated health and social care services for many years. This is most evident in the range of integrated community services, which in the future will be increasingly focused around our practice clusters based in Bath City, Keynsham and the Chew Valley area, and Norton.

We have clear evidence of effective clinical engagement and leadership in partnership and collaboration with providers, delivering accelerated change and improved outcomes: for example; enhanced nursing home care; a highly effective hip and knee pathway; a more robust urgent care system. We have engaged local providers in the development of this strategy and believe that the strength of existing relationships and broad consensus for our plans sets the foundation for successful implementation of our strategy.

Our Joint Strategic Needs Assessment (JSNA), the Commissioning for Value Pack and other benchmarking data tells us that we perform well on the majority of outcome measures applied to CCGs and are in the top 25% for many. We serve a generally healthy and relatively wealthy population that has some of the happiest people in the country. However, we have pockets of deprivation and poor outcomes which are equivalent to some of the worst performing areas in England. Despite overall good clinical outcomes like many CCGs we continue to face the challenges of an ageing population. By 2021 we will see a 27% increase in the number of patients aged 75-79 and a 39% increase in those aged over 90. This does not mean that our older population should be seen as a burden, but that we need to ensure that we can support older people to have happy and healthy lives in BaNES, supported by the right kinds of services that are responsive to their needs. The increasing prevalence of long terms conditions and the number of patients with multiple conditions will create increasing cost pressures and demands on local services.

We face challenges in our provider landscape, with over-provision of elective care and a geographical position where our acute main provider delivers care across several CCG areas, requiring alignment of commissioner plans. We still have areas of significant clinical variation in both primary and secondary care services demonstrated through variability in referrals and admission rates.

The financial context is also set to become more challenging, as demographic and national and local economic pressures continue to impact on the scale and nature of demand for services and the level of resource available to meet it. Although we are fortunate to have inherited a stable financial legacy from the outgoing Primary Care Trust, we anticipate that the financial challenge faced by the whole health economy over the next five years will be in the region of £50m, taking into account both provider and commissioner resource utilisation gains needed to offset rising costs. We will meet this challenge by deploying a range of financial, contractual and cultural approaches to ensure our use of resource is maximised to deliver the safest and most effective care for patients at the best obtainable value.

To address the challenges we face, our five year vision has at its centre patients who are supported to manage their long term conditions more effectively with care delivered closer to home where it is appropriate to do so.

We will achieve this by continuing to focus on the urgent care system, further developing community services built around practice clusters in order to deliver joined up long term condition management and personalised care planning and efficient use of elective care pathways with strong referral support.

Over the next five years, we will aim to deliver a programme of change that will mean:

- Enhanced primary, community and mental health services will be provided 7 days a week, where required and focused on our practice clusters of populations
- Specialist and hospital based services will be supporting community based services with their expertise and provide care for those with complex needs
- Innovative pathways of care with self-care and personalised care planning at their core
- Patients and their carers will feel supported to be able to navigate their way around the health and social care system supported by their local community, navigators and volunteers.
- The challenges of a significantly tougher financial environment will be met by alternative and more efficient models of care and a greater reliance on self-care and personal responsibility

Our Priorities

Our commitment to quality is central to the CCG's values and over the next five years we will focus on continually improving the quality of services and be alert to the needs of all our population, particularly those who are most vulnerable.

Our five year plan builds on existing programmes of work, including those set out in our two year Operational Plan and responds to the areas identified where our commissioning activities will have a beneficial impact to the quality of patient care and where efficiencies in the system can be improved.
Through our stakeholder engagement events, we have prioritised 6 key transformational projects:

- Increasing the focus on prevention, self-care and personal responsibility
- Improving the coordination of holistic, multi-disciplinary Long Term Condition management (focusing initially on Diabetes)
- Creating a stable, sustainable and responsive Urgent Care system
- Commissioning integrated safe, compassionate pathways for frail older people
- Redesigning Musculo-Skeletal pathways to achieve clinically effective services
- Ensuring the interoperability of IT systems across the health and care system

Our strategic plan therefore does not cover all the areas of commissioning responsibility that the CCG has, but focuses on core areas where service transformation is required to create a sustainable system. This does not mean that other areas of our commission responsibilities will overlooked, the CCG will continue where possible to ensure other services evolve and develop in line with patients' needs working closely with providers and patients.

Delivering Change

As clinical commissioners, we are committed to introducing a more agile and dynamic model of commissioner-led change to underpin the achievement of this plan. We do not believe that we can rely on confrontational models of contracting to deliver the scale of change required at the pace that is required. This may include the use of different models for commissioning services with a greater focus on an outcomes based approach.

We will use the full range of commissioning levers available to us, these are set out in figure1:

Service Performance Management:

We will use service performance management to drive greater benefit from the healthcare services we have already commissioned. We will adopt and evidence-based approach to evaluation and performance management. This will require us to use information in new ways to provide greater insight about the impact of our services on patients and the scope for improvement.

System Performance Management:

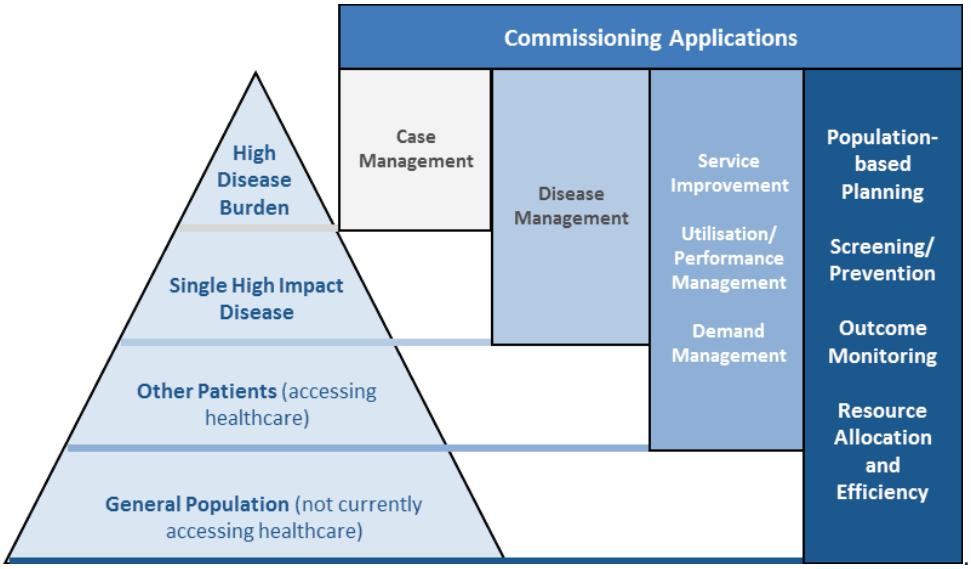
We will develop a locally agreed and clinically-derived set of Key Performance Indicators (KPIs) and outcomes that enable us to have a comprehensive perspective of the 'health' of our health system. We will want to measure success not by absolute benchmarks of these KPIs but by continuous improvement. We will aim to select

indicators that can only be achieved through co-operative working, collaboration and integration.

Investment and dis-investment:

We will seek to invest in new pathways and services where they deliver improved outcomes and experiences at lower unit cost. We will work with providers and patients to establish new models of care that carry the confidence of both and test the case for change through evidence, analysis and engagement. We will expect providers to work together to introduce new models of care and realise the expected benefits. As we introduce new models of care, we will manage the cessation of the historic pathways that are being replaced. As a health system, we must commit to minimise the duration and cost of any double running costs identified in the case for change.

Figure 1: Commissioning Levers



Making It Happen

We acknowledge the very positive response of our stakeholders to the development of our five year plan and this has demonstrated a broad level of enthusiasm for our vision and commitment to its delivery.

We have designed a governance structure that will underpin the implementation of our key priorities and is based on sound change management principles and the philosophy of Managing Successful Programmes (MSP).

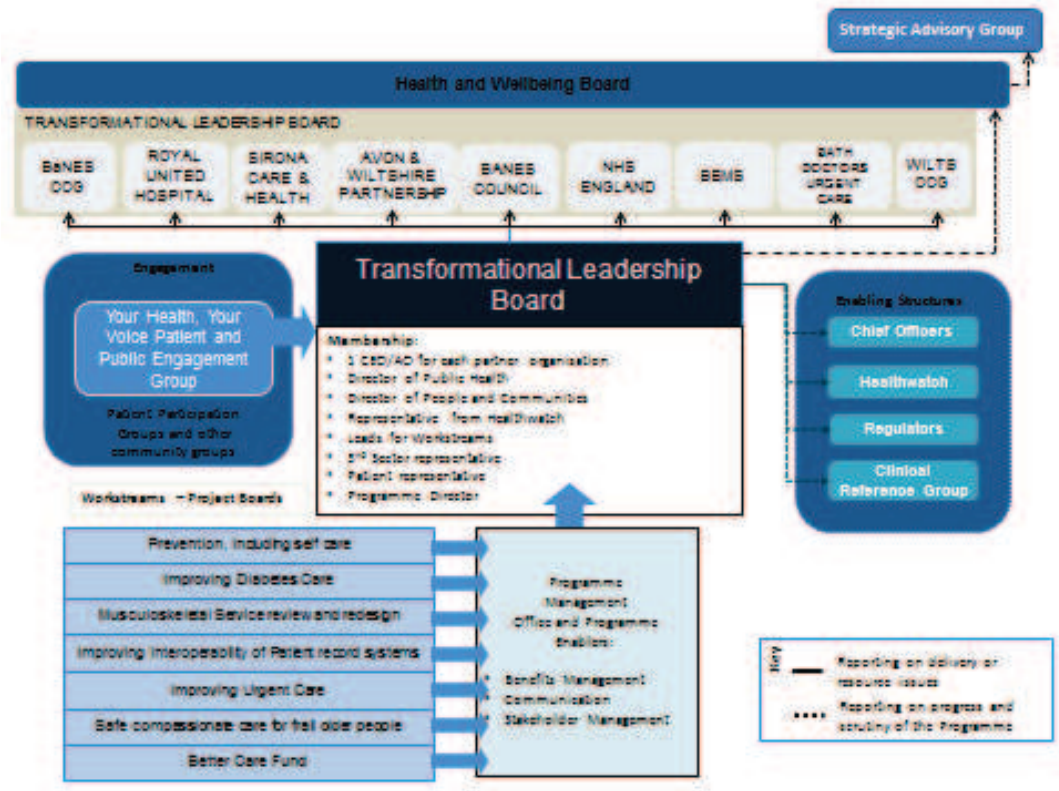


Figure 2: Governance Structure

Our five year Transformational Leadership Board (TLB) will oversee the different work streams within the scope of the five year plan and will be led by the CCG. It will comprise a multidisciplinary group of Directors and Clinical Leaders from our constituent organisations. The TLB will be supported by a Programme Management Office [PMO] led by a programme director. The PMO will ensure that progress and benefits of the work streams are tracked and variances, risks, dependencies and issues are identified, managed and addressed.

The adequate resourcing of this governance structure will be vital to ensure the successful delivery of our key priorities and other work streams that will evolve and develop in the future. Stakeholders acknowledge that support for this will need to be a community responsibility, shared across the health and care economy. The adoption of this principle of widespread “buy-in” echoes the approach we have had with our Urgent Care Working Group and will ensure a greater level of commitment from the community.

Conclusion

Our five year plan reflects an ambition to take full advantage of our good starting position, our well-developed relationship with the Local Authority, strong and effective clinical leadership supported by excellent senior management and administrative support. We are committed to achieving top decile performance in our outcomes and ensure that we will be relentless in our focus on improving patient experience, quality and safety of care and a thriving health and social care community that is financially stable.

Dr Simon Douglass
Clinical Accountable Officer

PART A
The Health and Care Economy in Banes

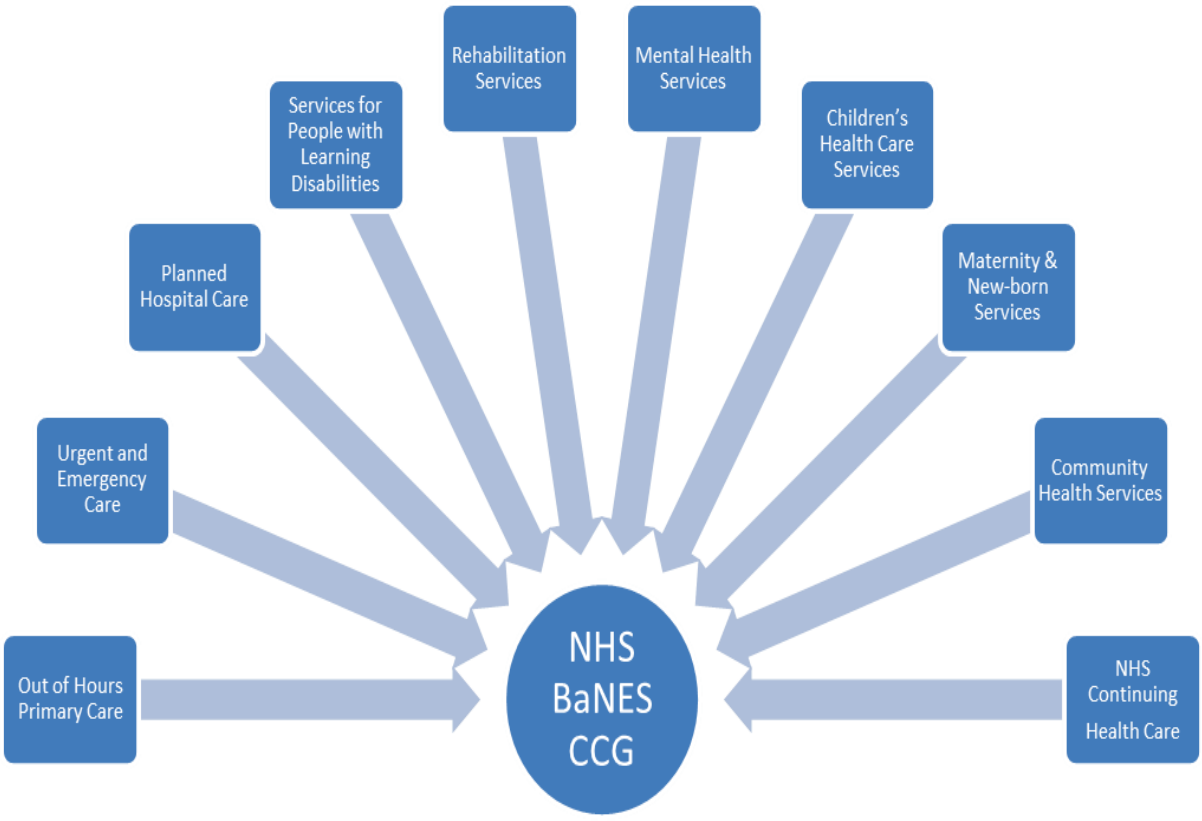
Chapter 1 – An Introduction to Our CCG and the local economy

Our Role

The CCG serves a resident population of 177,643 and a registered population of 197,040 with a budget of £220m. Our boundary is co-terminus with B&NES Local Authority and for the purposes of the development of our five year Strategic Plan our unit of planning (UOP) is defined as BaNES. We believe that our role as a high performing CCG is to lead our health and care system collaboratively through the commissioning of high quality, affordable, person centred care which harnesses the strength of clinician led commissioning and will empower and encourage individuals to improve their health and wellbeing status

The CCG is responsible for commissioning a range of health care services as set out below.

Figure 3: What is the CCG Responsible



Our Values

We believe that it is important to be transparent about the way in which we make decisions, and to have an on-going dialogue between commissioners and providers to ensure that we have a balanced system that can be tuned to respond to the future needs of our population. We will continue to work with providers to ensure that each understands the role they can play in achieving our collective vision for services by 2018/19 and we will create an environment in which providers can continue to thrive and become more efficient.

Patients, their families and their carers will be at the core of everything we do and we will strive to engage patients in the design and commissioning of services, as well as in their own care planning and management.

Our Values

1. Focus on continually improving the quality of services
2. Be credible, creative and ambitious on behalf of our local population
3. Work collaboratively and be respectful of others
4. Be focused, committed and hard working
5. Operate with integrity and trust
6. Be alert to the needs of all of our population, particularly those who are most vulnerable

Our Commitment to Quality

We recognise the centrality of quality in the guidance that has prompted the development of this strategy, in both A *Call to Action* and *Everyone Counts*, and are committed to ensuring that quality is integral to our local plans.

Improving quality is a wide-ranging agenda and in order for it to be implemented efficiently and effectively, it is essential to maintain awareness with regards the diversity of health and care in BaNES. It requires the development of a co-operative approach within both primary and secondary care and in partnership with other agencies and organisations and with the public. There is a need to foster trust and a willingness to share good practice, lessons learnt from adverse experience, knowledge and skills. It is essential that arrangements are simple, practical, non-threatening, inclusive and negotiated.

The NICE quality standards and other national guidance provide a robust evidence base to support the definition of high quality care across developing care pathways. We use these national evidenced based quality standards to improve the services we commission in terms of clinical effectiveness, safety and patient experience. Over the forthcoming year this process will be strengthened still further and will continue to evolve to ensure our key strategic initiatives are properly understood and the impact of any changes made are not detrimental to the care provided. The monitoring and evaluation of quality, equality and diversity and privacy impact assessments, not only for individual providers but across the whole pathway development will be an essential remit of the Transformational Board and the supporting sub-groups. This work will be overseen by the Quality Committee and Board.

Leadership and Culture

We have strong clinical leadership that demonstrates zero tolerance of poor care. The CCG Quality Committee, working in conjunction with the appropriate CCG Clinical Leads and Senior Commissioning Managers, is aiming to achieve a coordinated approach to achieving quality across the organisation and in partnership. It will align its work with the 'Your Health, Your Voice', our Public and Patient Engagement Group and is aligned with the other board-level committees. We will continue to work in partnership with HealthWatch, the Council and our Health and Wellbeing Board, NHS England, neighbouring CCGs, the public and other key stakeholders to continually improve the quality of services for residents in BaNES.

Clinically Led Commissioning

Fundamental to our role as a CCG and the delivery of our five year strategy is effective clinical engagement at all levels. Clinical relationships between commissioners and providers at both strategic and operational levels underpin this and we have worked hard at establishing this as the new norm over the last few years. Our Clinical Director and other clinicians on the Board have taken the lead in interacting directly with clinicians in acute, community and primary care providers to shape the redesign of services to ensure that changes are in line with clinical needs that alter over time.

Examples of this include heart failure management which has moved from a silo based approach with over reliance on episodic care to a passport model where the patient holds a record of their care plan and takes it with them whenever they interact with health services. This will allow clarity over their individuals plans, better communication and clinical management, as well as reduced unnecessary admissions and investigations and/or treatment. This approach has been developed only by close working between clinicians across the various sectors and the involvement of patients to ensure we meet their needs in its design.

This has led to it being used as a pilot of an extension of the friends and family test where direct feedback about the service is obtained at a range of different places in the patient's experience.

The benefit of having clinical buy in means it is easier to adopt the principle of this practice elsewhere and use of this model as a basis for a CQUIN both our CCG and neighbouring CCGs.

Through the delivery of our five year plan we will aim to build and maximize the influence of clinician- led commissioning with a greater focus on patient engagement and participation to bring about change in clinical practice.

The Provider Landscape

We have a complex provider landscape in and surrounding BaNES. Several of our local providers are still aspirant Foundations Trusts, including the Royal United Hospital, Bath, North Bristol NHS Trust and Avon and Wiltshire Mental Health Partnership Trust. We also have a well-developed market for elective care with a high number of independent sector providers including BMI Bath and Circle Bath and ITSC provision provided by Care UK at

Emerson's Green and Shepton Mallet. This means that there is some over provision of elective capacity.

There is a long-standing history of collaboration and joint commissioning between health and social care commissioners in BaNES. Commissioning of adult and children's health and social care has been integrated since 2009 with aligned budgets and common commissioning goals. Our commitment to this model covers the whole of our shared agenda but is most fully realised around adult services, including mental health, learning disabilities, physical and sensory disability, carers and our elderly frail population. These arrangements are supported by pooled budgets for Learning Disabilities and Children's Services and a series of 256 arrangements. This joint working has been mirrored since 2009 by the provision of community health and social care services for adults through a single management structure. Since October 2011, the community services formerly provided by the PCT and Council have operated as an independent Community Interest Company (Sirona Care & Health CIC).

Integrated health and social care services to people with mental health problems are provided by multi-disciplinary teams that are co-located through partnership arrangements between the Council, CCG and with Avon & Wiltshire Mental Health Partnership NHS Trust (AWP).

We work with each of our providers and other local CCGs on continually improving the quality and safety of patient care. The quality and safety of provided services is assured through quality schedules, commissioning for quality and innovation indicators (CQUIN), monitoring of the quality impact of cost improvement schemes and site visits of major providers. This includes performance against quality schedules which comprises of a range of indicators including safeguarding, healthcare associated infections and patient and staff satisfaction outcomes for instance.

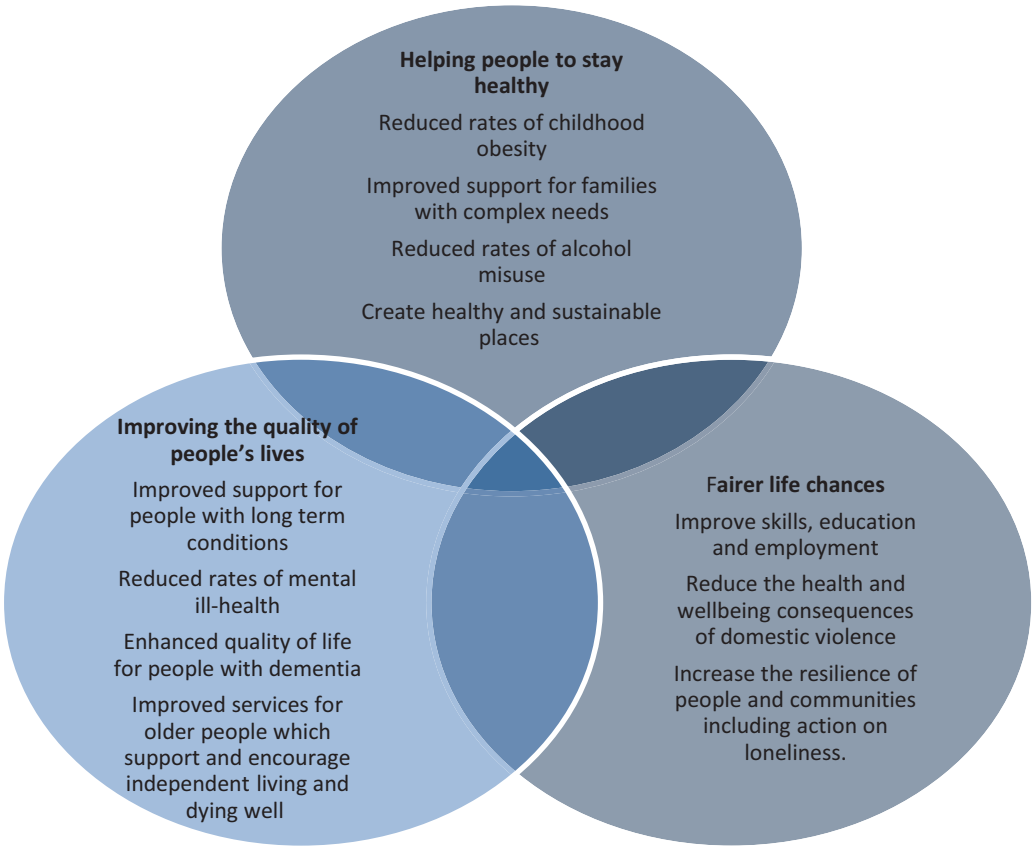
Regular assurance reports are made to the Quality Committee. This ensures that the Committee has oversight of areas of patient safety, patient experience and clinical effectiveness on behalf of the CCG Board. Information, both qualitative and quantitative, is triangulated: to achieve a more rounded picture of the services we commission. Benchmarking data is also considered where available.

Chapter 2 - Our Vision

The Overarching Vision for Healthcare in Bath and North East Somerset (BaNES) in 2018/19

Our Vision for health care has a strong foundation built with effective links to the three core objectives contained within the strategy of the BaNES Health and Well-Being Board (H&WBB). The H&WBB provide strong local leadership and hold the whole system to account for improving health and well-being outcomes, with a particular focus on prevention and early intervention. The successful work undertaken so far in BaNES has defined our integrated services for both adults and children

The local H&WBB objectives and priorities are: -



We are developing services to deliver care and support to the people of BaNES in their homes and communities by: -

- Empowering individuals, carers and communities and ensuring they feel supported and confident to:
    - take responsibility for their own health and wellbeing
    - manage their long-term conditions
    - be part of designing health and social care services that work for them

- Developing responses to health and wellbeing needs close to home with enhanced and integrated primary, community and mental health services, working 24/7 with

clusters of our population with hospital admissions being based in the need for specialist and emergency treatments.

- Further developing the care needed for long term conditions and deliver integrated pathways including self-management, transition, urgent and contingency planning elements as routine
- Focusing on supporting and safeguarding the most vulnerable, at risk, frail or excluded citizens as a matter of priority regardless of age
- Involving local people of all ages to work with clinicians to develop, design and access information enabling them to be confident in the quality and safety of our services in BANES and, where they are not confident, to raise concerns easily.
- A Care Record system that facilitates and supports the delivery of integrated health and care services
- Services that represent excellent value for money, measured by quality and effectiveness (outcomes) of services as experienced by the people who use them

Delivering Our Vision

Our six priority work programmes (Chapter 6) to enable us to deliver our Vision are;

1. Increasing the focus on prevention, self-care and responsibility
2. Improving the co-ordination of holistic, multi-disciplinary Long Term Condition Management (focusing initially on Diabetes)
3. Creating a sustainable and responsive Urgent Care System
4. Commissioning safe , compassionate pathways for frail older people
5. Re-designing musculoskeletal pathways to achieve clinically effective services
6. Ensuring the inter-operability of IT systems across the health and care system

Our 5 Year Strategic Plan is a **'Plan for Change'** and to achieve success within the current financial climate we will focus within this document on a small number of areas to show our expectations in exceling at achieving transformational goals. We will not lose sight of delivery in areas such as Cancer or Children's services as these and others are detailed within the 2 Year Operational Plan (Annex A).

One of our biggest challenges will be the management of patients with long term or multiple conditions as national benchmarking shows this area is increasingly becoming the norm. These patients have the greatest healthcare needs of the population, accounting for 50% of all GP appointments and 70% of all bed days, with treatment and care absorbing 70% of acute and primary care budgets in England. We are expecting there to be a significant opportunity to improve outcomes and contain costs in this area to the benefit of our patients.

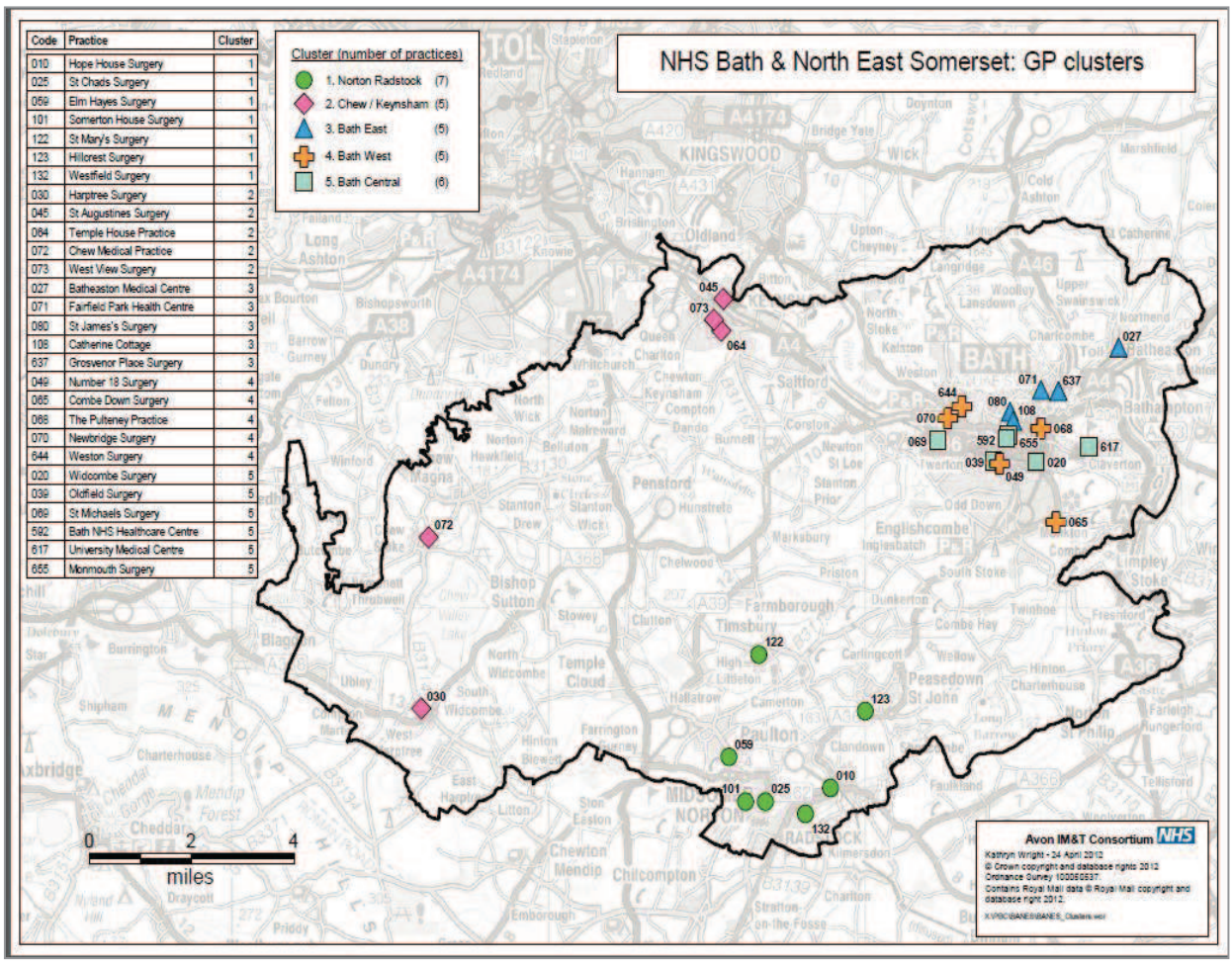
The overall impact of our 6 priority work programmes will vary within each individual priority strand as they are linked and support a common requirement to enhance integrated care in BaNES, with clinicians' part of the multidisciplinary teams with the needs of the patient at its heart.

We already have an emerging model of five practice clusters, each with populations of 30, 000 to 50,000. These clusters forming the basis of the Community Cluster Team model in BaNEs, and we intend to build on these clusters to develop future community based services, unless there is a strong argument for providing services at an even greater scale.

It is possible the developing strategy for primary care in BaNES may propose a different number and configuration of clusters, but at this stage in the development in our planning the current working assumption is five clusters.

The diagram below shows the current configuration of our GP clusters.

Figure 4: Configuration of GP Clusters



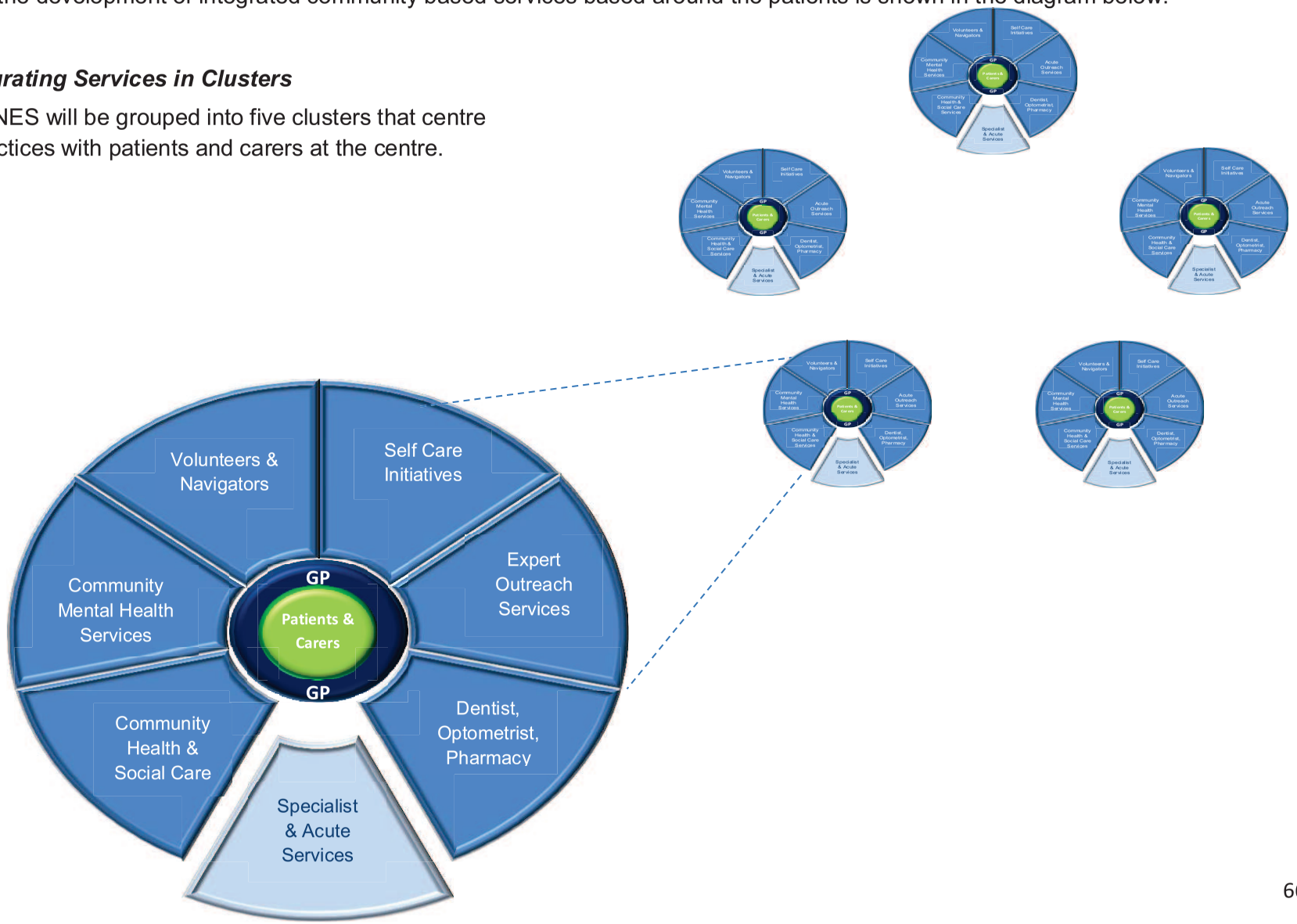
NHS

Bath and North East Somerset Clinical Commissioning Group

Our Vision for the development of integrated community based services based around the patients is shown in the diagram below.

Figure 5: Integrating Services in Clusters

Services in BaNES will be grouped into five clusters that centre around GP practices with patients and carers at the centre.



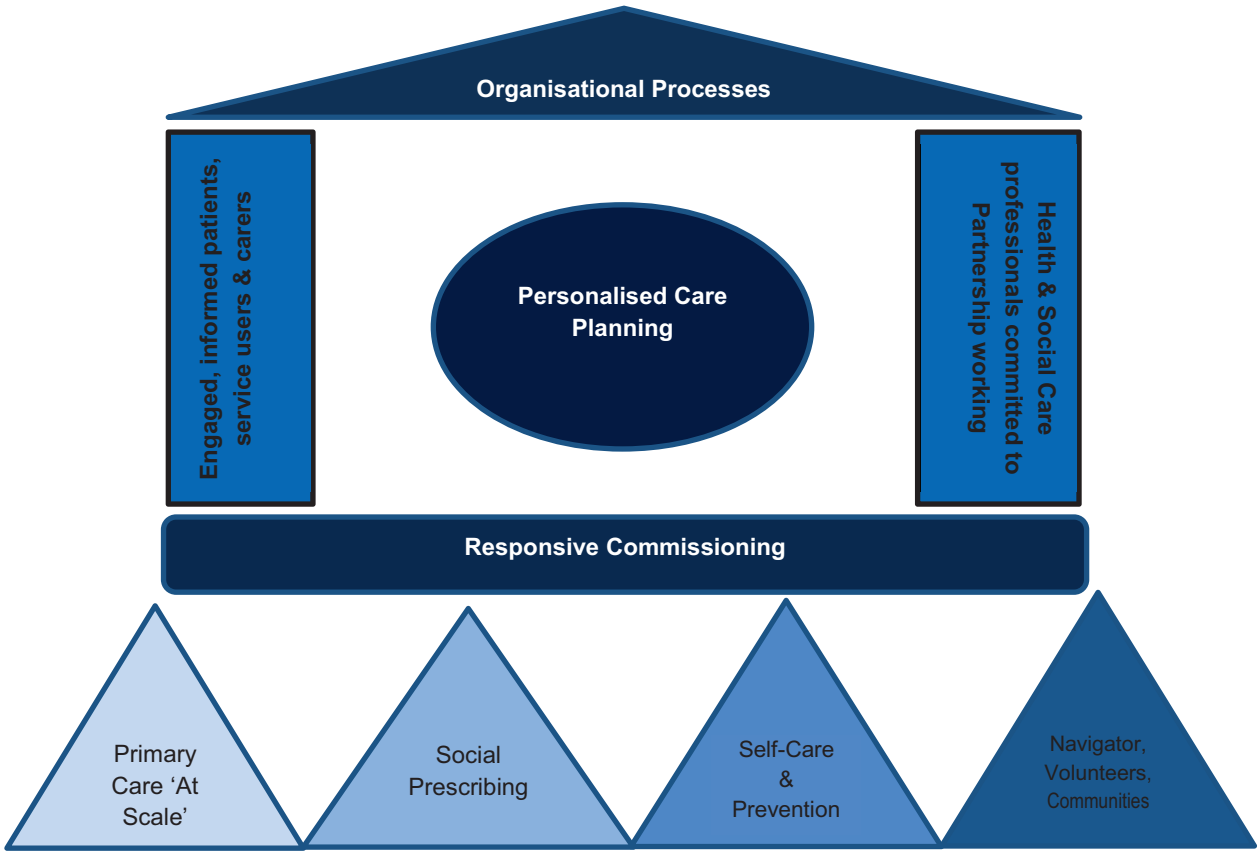
Building Integrated Care in BaNES

We are developing and framing our thinking about whole system integration in the context of an emerging "Your *House of Care"* Model in BaNES. This is based on the Kings Fund Report "Delivering Better Services for people with Long- term conditions – Building the House of Care" [1].

This approach sets out four interdependent components and if delivered together will achieve patient centred, co-ordinated care for people living with long term conditions and their carers.

Whilst this work is at its formative stages, we will utilise the Better Care Fund as a key enabler to develop and enhance integrated services. This is described further in Chapter 10.

Figure 6: The House of Care Model in BaNES



[1] (http://www.kingsfund.org.uk/publications/delivering-better-services-people-long-term-conditions

Acute and Specialist Services

As part of these changes we expect specialist hospital based services to increasingly support community based services, through outreach arrangements, providing care and expertise for patients with the most complex needs. There are opportunities for strengthening integrated working between providers through better data sharing, shared care agreements, end to end pathway development and agreement on how the skills of both primary and secondary care clinicians can be best deployed.

Our Vision also carries an expectation of all pathways having a self-care component including pathways of care provided in a secondary care setting.

We anticipate that the impact of these changes will be the shifting of investment from acute and specialist services to community and primary care. More detail of this is set out in Chapters 4 and 9.

Developing Primary Care at Scale

Our vision has significant implications for the role of primary care in BaNES and is integral to the delivery of our five year strategy.

The role of primary care will form the bedrock of our approach in enhancing and integrating the care and support of patients and their carers in our community. Our strategy sets out the demographic and financial challenges ahead.

A clear emerging challenge for the CCG is the impact of managing multimorbidity. The current paradigm of single long term condition focus on which guidelines are built is no longer fit for purpose. We know that certain combinations of long term conditions will have a variable impact and demand on services, both in the community and in the acute sector. For example, a patient with both type 2 diabetes and asthma will potentially have much greater need of both primary and secondary care services than a patient with just one of these conditions, whereas a patient with dementia will require far more help from mental health and social care services. The costs of an individual's needs both in health and social care are driven more by the profile of their morbidity than by their age.

We will support primary care to develop in such a way that it is able to meet these challenges, by putting personalised care planning at the centre of long term condition management. A multidisciplinary team approach focused on practice clusters will draw on the experience of primary care physicians, practice nurses, pharmacists, social workers, community matrons, district nursing and community therapy staff as well as secondary care advice in order to establish care plans that help to address the needs and complexity of patients who experience multimorbidity.

Built around this will be a more efficient use of information technology and administrative support; improved education and support for patients to ensure they gain a greater sense of control over their lives; a different focus for the primary care practitioner in consultation with their patients fostering a more collaborative style of interaction; with the commissioning of services in respond to the outcomes of these approaches. Primary care will need to be able to

responsive to this ambition. We will collaborate with NHSE, the LMC and practices to support this process of transformation.

The key enabler will be the ability for primary care in BaNES to speak with one voice, to ensure:

- There will be a far more rapid negotiation with practices around implementation of the House of Care Model
- Primary care is able to take its place as a system player in the health and social care community, for example in urgent care and the implementation of the Health and Wellbeing Strategy

The case for change will continue to be articulated very clearly to our practices and we are beginning to see good progress towards the development of an organisation that can take primary care to the next level in order to make it fit for purpose and deliver on our vision for enhanced long term condition management in the community.

Participation and Empowering Patients

Our approach to Citizen Participation and Empowerment over the next 5 years has been developed following the feedback we've received from our engagement activities. We expect to deliver a substantial shift in how we engage with individuals and communities.

Our ambition is to hold regular events with our stakeholders and members of the public, providing them with the opportunity to hear and see our plans through traditional events, meetings and focus groups. However, we need to ensure that a wide range of perspectives are heard and we have plans to ensure local activity is flourishing, co-ordinated, accessible and appealing across our entire demographic - and most importantly flows both ways. We will also develop the role of the CCG's newly established Patient and Public Involvement Group, "Your Health, Your Voice".

In the delivery of our 6 core transformational workstreams we will ensure the patient voice and patient engagement processes are core to the development of new service models.

We are also ensuring our mechanisms help patients feeling more empowered and in control of their care by:-

- Supporting patient choice and decision making
- Increased and enhanced care planning
- Rolling out personal health budgets
- Increasing our focus on self-care and the emphasis on personal responsibility

Our Strategy on a Page

We have condensed the most salient elements of our strategy so that it can be presented on one page that sets out:

Our Vision – How we understand our role in the health and care economy

Our Focus – How we will channel our efforts to achieve our vision

Our Approach – The way in which we commit to commissioning services and 'doing business'

Our Priorities – The areas of care that we have chosen to prioritise to achieve the greatest impact for our population

Enablers – the systems, processes and infrastructure that we believe we need to develop to achieve our goals

For Patients – An explanation of what we believe will feel different for patients in five years' time.

Our Mission	**Healthier, Stronger, Together** *"to lead our health and care system collaboratively through the commissioning of high quality, affordable, person centred care which harnesses the strength of clinician led commissioning and empowers and encourages individuals to improve their health and well being status".*				
Our Focus – high quality health and care system	▸ Improving quality, safety and individuals experience ▸ Improving consistency of care and reduce variability of outcomes and experiences	▸ Providing proactive care to help people to age well and proactively help people with complex care needs	▸ **Sustainable health system** within a wider health and social care partnership with resources directed to support commissioning priorities	▸ Enpowering & encouraging people to take personal responsibility for their mental and physical health and wellbeing	▸ Reducing inequalities and social exclusion and supporting our most vulnerable groups
Our Approach	▸ We want to lead a reconfigured system that meets the current and future needs of our population, targeting deprived areas, is **financially sustainable** with care offered in the optimum setting	▸ We will **improve outcomes.** ▸ We will drive **improvements in the performance, productivity and individuals experience.**	▸ We will encourage Providers to collaborate, innovate and work in effective partnerships to deliver seamless and integrated care	▸ We will invest resources in areas and activities that support better prevention and early intervention	▸ We will focus on both the mental health and physical health needs of individuals.
Our Priorities	▸ Increasing the focus on prevention, self-care and personal responsibility ▸ Improving the co-ordination of holistic, multi-disciplinary Long Term Condition Management (focusing initially on diabetes)	▸ Creating a **sustainable Urgent Care system** that can respond to changes in demand ▸ Commissioning safe, compassionate care for frail older people	▸ Redesigning musculo-skeletal services to improve their efficiency **(productive elective care)** ▸ Ensuring the interoperability of IT systems across the health and care system	▸ Delivering the plans for the Better Care Fund to support our model of **integrated care** with a focus on: • 7 Day Working • Protection of Adult Social Care Services • Integrated reablement and hospital discharge • Admission avoidance • Early intervention and prevention	
Our Enablers	▸ Develop contractual levers ▸ Develop Incentives for innovation, improvement and **integration** ▸ Enhanced primary, community and mental health services provided 7 days per week ▸ **Sustainable model of primary care**	▸ Develop Referral Management Support ▸ Develop interoperability to improve integration of information systems ▸ Develop commissioning support services	▸ Develop 'Our House of Care' model to improve integration of services for patients. ▸ Develop organisational capacity and competence.	▸ Develop our approach to **Citizen Participation and Empowerment** ▸ Improve quality and **outcomes** for patients ▸ System wide governance arrangements: ▸ Delivery overseen by Transformational Leadership Board ▸ Agreed high level measures of success	
Our Vision for Patients	▸ Patients and carers will feel supported, confident and able to navigate their way around the health and care system, supported by local communities, navigators and volunteers ▸ Patients will work with clinicians to help design services and will be confident in the quality and safety of services	▸ Enhanced, seamless primary, community and mental health services will be provided 24/7 where required around clusters of populations: 'care closer to home' ▸ Specialist and hospital based services will be supporting community based services with their expertise and providing care for those of us with complex needs	▸ We will have evidenced based, efficient and innovative pathways of care that will evolve and develop as population needs change with self care and personalised care planning at their core ▸ Services will have an equal focus on the physical and mental health well-being of the people that use them	▸ There will be reduced inequalities & social exclusion of our most vulnerable groups and areas in Bath and North East Somerset ▸ We will be using integrated care records to share information where it counts with different organisations: 'tell our story only once' ▸ Patients will have the ability to and understand how to voice and raise concerns easily ▸ Patients will be cared for by staff who are caring, motivated, trained and supported to deliver effective clinical practice	

Chapter 3 - Understanding the Case for Change

1. The National Drivers For Change

We are driven by a challenging environment for commissioning health and social care.

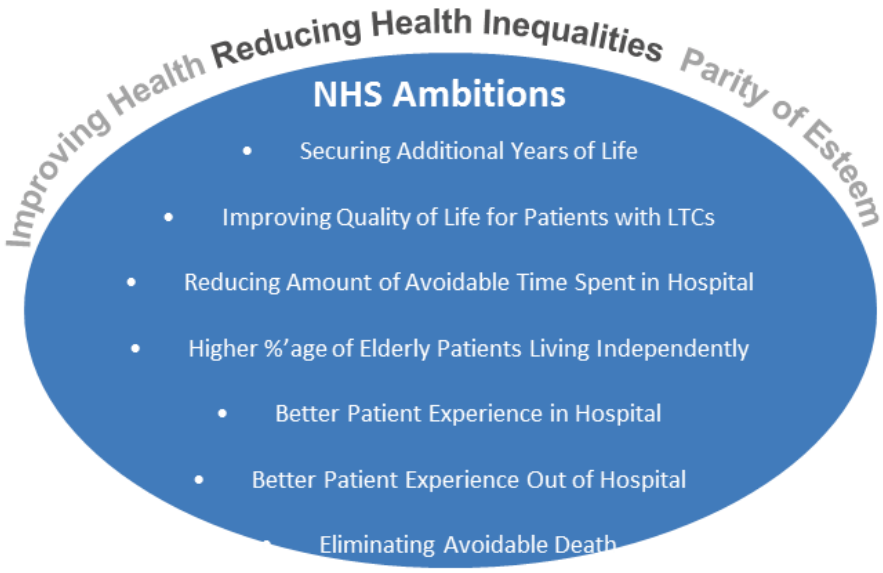
Nationally, the demands on health and care services are increasing as people live longer with more complex long term conditions. Patient expectations continue to rise, despite confidence in the NHS brand suffering as a result of high profile system failures such as Mid Staffordshire Trust NHS Foundation Trust Public Inquiry and Transforming Care: A National Response to Winterbourne. The Berwick Review into Patient Safety has helped to place the focus on quality at the fore of NHS policy, and providers and commissioners alike face intense scrutiny in this area. There is also a universal drive to increase productivity and efficiency that necessitates radical changes in the way we structure our workforce, such as the move to 7 day services; all at a time of limited or no growth and significant financial challenge.

In response to these challenges NHS England published Everyone Counts in December 2013, following a Call to Action. The guidance marks a watershed in the planning of health and care services by mandating that CCGs engage with Local Authority commissioning colleagues, as well as providers, to work as a Unit of Planning and ensure that there is a system wide approach. The guidance also marks the shift away from short term annual planning cycles.

Everyone Counts is a commitment from NHS England to improving outcomes in five key domains:

The domains have been translated into a set of specific measurable outcome ambitions that will be the critical indicators of success, against which progress can be tracked. Additionally, there are three further areas in which NHS England expects to see significant focus and rapid improvement. We have developed our strategy to achieve these ambitions, the themes of which are reflected throughout this document.

Figure 7: Everyone Counts



2. The Local Case for Change

In the following section we set out our understanding of the local case for change which we believe lies in:

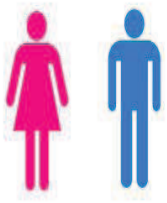
- Meeting the needs of a changing population
- Maintaining strong performance and quality
- Ensuring financial stability
- The financial position of the health and care economy
- How we perform comparatively
- Responding to the views of the public and local stakeholders

Meeting the Needs of a Changing Population

Our Population

In the latest (2011) population estimates there were **177,643 residents** in Bath and North East Somerset and **197,040 patients** registered with Bath and North East Somerset General Practices. According to the census there were an estimated **176,016 residents** in Bath and North East Somerset in 2011. **Between 2011 and 2021** the population of BaNES is expected **to increase by 5.5% to 185,663 residents.** The number of patients registered with Bath and North East Somerset General Practices is slightly higher than the resident population, at 199,284 patients (Jan 2014)[2].

The resident population sex profile remains largely consistent compared with previous years, with a 49% / 51% male/female split.



51% **49%**

The age profile is largely consistent with the UK as a whole, except for the 20-24 age bracket which accounts for 10% of the population as opposed to 7% seen nationally. A larger proportion of people are in this age bracket range, as a result of the student population at two universities in BaNES.

There are expected changes across the age profile **by 2021** with for example **a 30% increase in the population over 70**, 16% reduction between 40 and 49 and a 10% increase in under 10's.

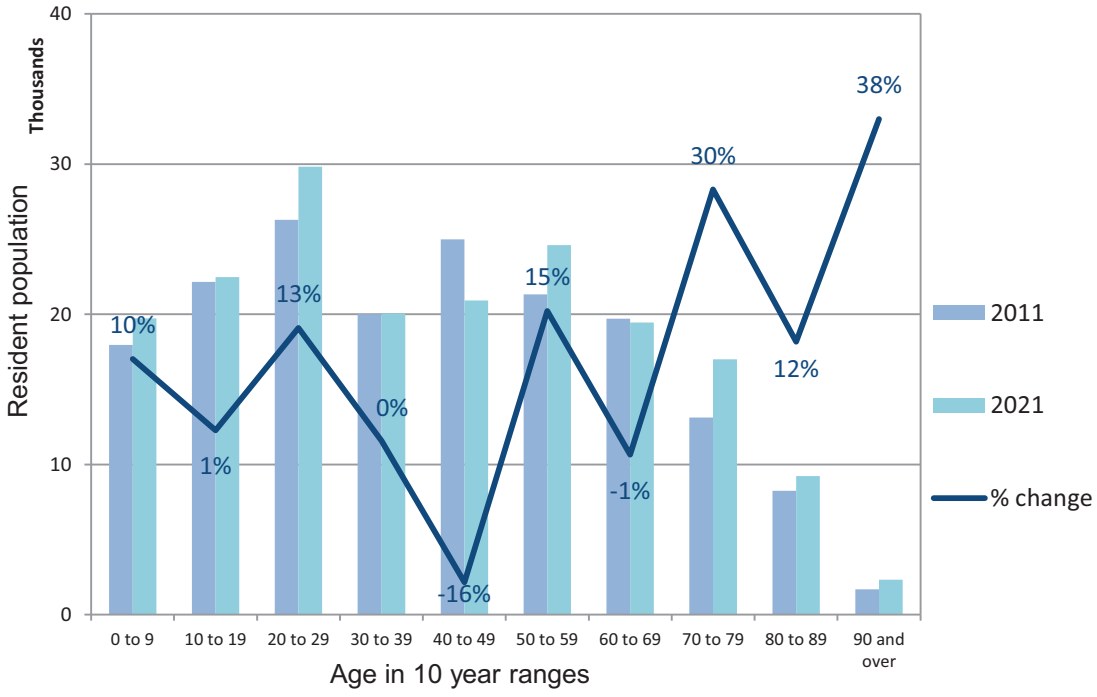


Figure: 8 – Sub national population projections, 2011-2021 comparison by 10 year age range: Bath and North East Somerset

[2] BaNES JSNA http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki and http://www.hscic.gov.uk/catalogue/PUB13365

The 2011 census showed our population to be **90% White British**, with the next two largest groups being **3.8% (approx. 6,600) Other White**, and **2.6% (approx. 4,500) Asian or Asian British descent.** Bath and North East Somerset is less ethnically diverse than the UK as a whole but more so than the South West[3].

Overall, **BaNES is one of the least deprived authorities** in the country, ranking 247th of 326 English authorities and 49th out of 56 Unitary Authorities. Although the level of deprivation is lower than average, **approximately 3,800 children live in poverty**.

Lower Super Output Areas (LSOAs) are small geographical areas with populations of between 1000 and 3000 people which do not change over time. BaNES is divided into 115 LSOAs. At an LSOA level in BaNES there are significant differences in levels of deprivation.

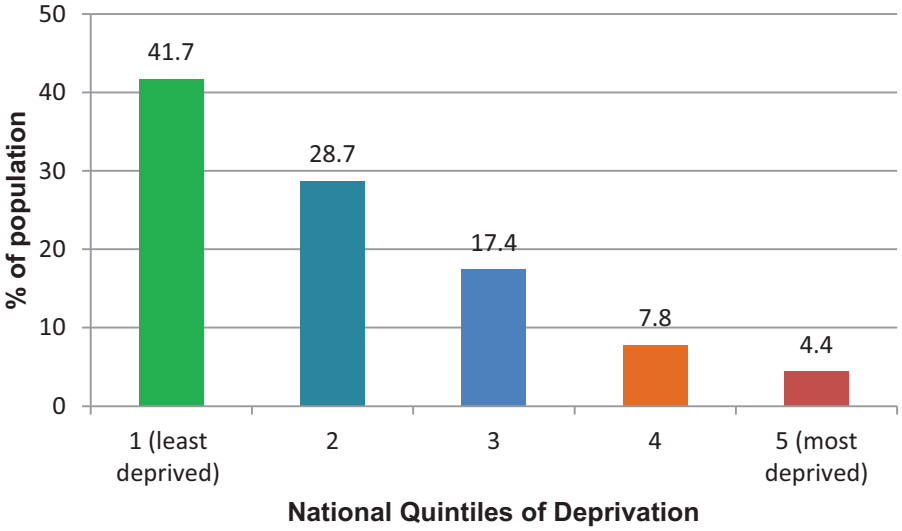
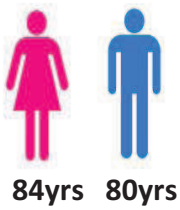


Figure: 9 – Deprivation levels in BaNES by LSOA showing percentage population.

Five areas within BaNES are in the most deprived 20% of the country across a range of metrics: Twerton West, Whiteway, Twerton, Fox Hill North and Whiteway West[4].

Our Health



Life expectancy in BaNES is higher for both men (80 years) and women (84 years) **than the regional and national averages**. Generally BaNES performs better than or similar to England on the majority of the indicators that address healthy lifestyles, health improvement, and healthcare and premature mortality, although there are a number of indicators where outcomes need to be improved. Given the relative good health that our population experiences as a whole, an increasing focus for our work will be to develop programmes aimed at reducing avoidable differences in health outcomes between different sections of our population and to develop a strategy with underpinning strands of work that promote self-care and personal responsibility for health.

[3] BaNES JSNA http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki and http://www.hscic.gov.uk/catalogue/PUB13365
[4] BaNES JSNA http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki and http://www.hscic.gov.uk/catalogue/PUB13365

Infant, children and young people's health

Overweight 4-5 year olds	BaNES	South West	National
	23.2%	22.9%	22.2%

Table 1: – Rates of children aged 4 – 5 being overweight / obese in 2012/13

The proportion of 4-5 year olds classified as being overweight or obese in 2012/13 was 23.2% (approx. 440 children). Although this figure fluctuates slightly year on year, it remains similar to the figure for 2006/07. Local rates are slightly above South West (22.9%) and national (22.2%) figures[5].

Hospital admissions for alcohol in the under 18s has risen in recent years. Rates of alcohol-specific hospital stays for under 18s show an increasing trend rising from 78.9/100,000 in 2007/08-2009/10 (pooled) to 85.7/100,000 (27 admissions) in 2008/9-2010/11 (pooled). This is against a falling trend nationally from 61.8/100,000 to 55.8/100,000 in the same time period[6].

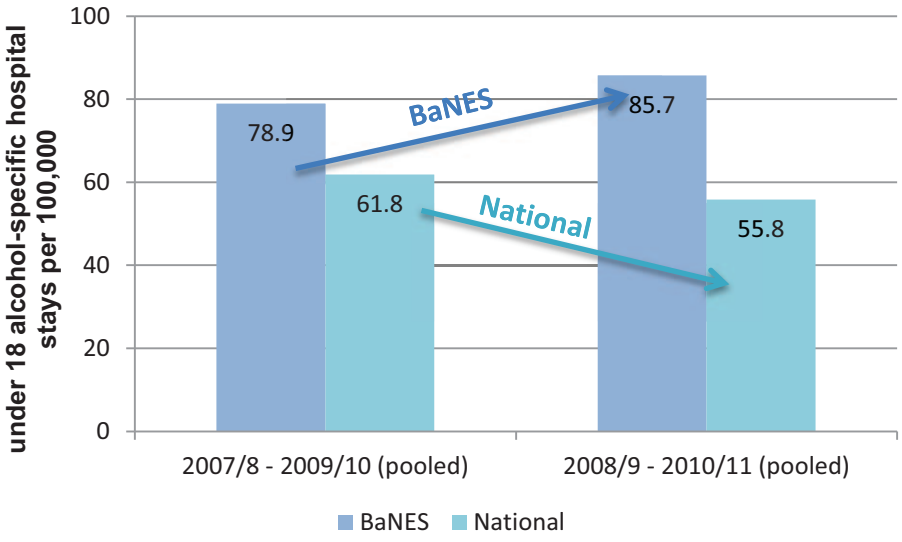


Figure 10: Rates of alcohol-specific hospital stays for under 18s per 100,000

Adult Health and Wellbeing

2012 Smoking Prevalence	BaNES	National
Everyone aged 18+	16.2%	19.5%
Routine and manual groups	25.6%	29.7%
Women at time of delivery	9.4%	12.7%

[5] Public Health Outcomes Framework Data Tool http://www.phoutcomes.info/

[6] Local Alcohol Profiles for England http://www.lape.org.uk/data.html

Table.2 Smoking prevalence in adults (18+)in 2012

There has been a significant fall in teenage pregnancy rates from 29/1000 females aged 15-17 in 1998 to 18/1000 (53 conceptions) in 2012. The rate for England in 2012 was 27.7/1000.

Smoking prevalence in BaNES is 16.2% (23,269 smokers aged 18+) which is lower than the England rate of 19.5% (2012 data). Smoking prevalence amongst routine and manual groups is 25.6% locally compared with a national rate of 29.7%[7]. The proportion of women who are smokers at time of delivery is also lower than national rates, at 9.4% (183 women) compared with 12.7%. Locally we are below target on smoking quitters. This is in line with a national and regional drop in people accessing NHS stop smoking services. Although local smoking prevalence rates are lower than regional and local averages, smoking is a major risk factor for a number of causes of death and disability and so remains a priority.

NHS Health Checks

Uptake of the NHS Health Check programme varies between practices and is lower than the national average (43.9% compared with 48.1%). Uptake locally has reduced, mirroring national trends[8].

The results of an Office for National Statistics survey show that in 2012/13, 84% of respondents in BaNES reported high levels of satisfaction with their lives. The level of satisfaction in BaNES was higher than in the South West overall where 79% reported high levels of satisfaction, and England as a whole, with 77%.

Domestic Abuse

Approximately 40% of women and 20% of men in the UK have been victims of domestic abuse since the age of 16. It is estimated that 5,936 women aged between 16-59 years in BaNES would have been a victim of domestic abuse in the past year[9].

Disease, Poor Health and Death

Hospital admissions resulting from Self Harm (per 100,000)	BaNES 2009/10	BaNES 2011/12	National 2009/10	National 2011/12
	229 ▲	281	198 ▲	208

Table 3: Trends in Hospital Admissions resulting from Self Harm per 100,000.

In BaNES hospital admission as a result of self-harm has risen from 229/100,000 (408 stays) in 2009/10 to 280.8/100,000 (495 stays) in 2011/12. Local analysis of hospital data identified 588 emergency admissions for BaNES residents in 2012/13. There has been a significant

[7] Public Health Outcomes Framework Data Tool http://www.phoutcomes.info/

[8] NHS Health Checks http://www.healthcheck.nhs.uk/interactive_map/

[9] BaNES JSNA http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki and http://www.hscic.gov.uk/catalogue/PUB13365

increase in the rate of male hospital admissions for self-harm between 2011/12 and 2012/13. Hospital admission rates for England have risen only slightly in the same time period from 198.3/100,000 in 2009/10 to 207.9/100,000 in 2011/12. Admission rates for self-harm need to be considered within a wider context as they are not an indicator of the prevalence of level of self-harm.

The prevalence of diabetes has been steadily increasing locally, regionally and nationally. Locally recorded prevalence **for 2012/13 is 4.59%; 7,460 people** aged 17 and over are registered as having diabetes mellitus on GP registers[10].

The BaNES emergency admission rate for alcohol-related liver disease has fallen significantly from an outlier position of 31.3/100,000 (50 admissions) in 2010/11 to 15.9/100,000 (25 admissions) in 2012/13. The current local rate **is now below the current national rate** of 25.2/100,000[11].

Suicide Rates (per 100,000)	BaNES 2001/3	BaNES 2010/12	National 2001/3	National 2010/12
	7.4	8.7	10.5	8.5

Table 4: Trends in Suicide Rates per 100,000, local data source.

Local data on **suicide rates** suggests an **increasing trend** from 7.4/100,000 in 2001-03 to 8.7/100,000 (46 people) in 2010-12. This is against a slight drop nationally from 10.5/100,000 to 8.5/100,000 over the same time period. Males account for approximately two-thirds of all suicides[12].

Life expectancy and health inequalities

Over the last ten years, the all-cause mortality rate for men has fallen. The all-cause mortality rate for women in the same period shows no clear trend[13]. Life expectancy in BaNES is higher for men (80 years) and women (84 years) than regional and national averages[14].

There are significant variations in life expectancy related to socio-economic inequality. Life expectancy is 7.1 years lower for men and 4.4 years lower for women living in the most deprived areas of BaNES than in the least deprived areas. In Twerton, life expectancy for men is significantly lower than the BaNES average.. As this is the only ward where life expectancy for men is statistically significantly lower, much of the inequalities in

[10] Public Health Outcomes Framework Data Tool http://www.phoutcomes.info/
[11] Health and Social Care Information Centre https://indicators.ic.nhs.uk/webview/

[12] Public Health Outcomes Framework Data Tool http://www.phoutcomes.info/

[13] BaNES JSNA http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki and http://www.hscic.gov.uk/catalogue/PUB13365

[14] PHE Health Profiles http://www.apho.org.uk/default.aspx?QN=HP_FINDSEARCH2012

life expectancy for men across BANES are linked to this area. Life expectancy for women is significantly lower than the BANES average in High Littleton, Mendip and Paulton[15].

Collectively, a small number of causes of death contribute to the overall life expectancy gap between the most and least deprived quintiles in BaNES (Table 2).

Amongst men, the difference in life expectancy can be largely attributed to cancer (24% of additional deaths), particularly lung cancer; circulatory diseases (20%); digestive diseases (19%), particularly chronic liver disease including cirrhosis; and respiratory diseases (16%), particularly COPD; and external causes (13%), particularly suicide.

Amongst women the difference in life expectancy can be largely attributed to cancer (23%), but not lung cancer; circulatory (15%), digestive diseases (12%), but not particularly chronic liver disease; and COPD (11%)[16].

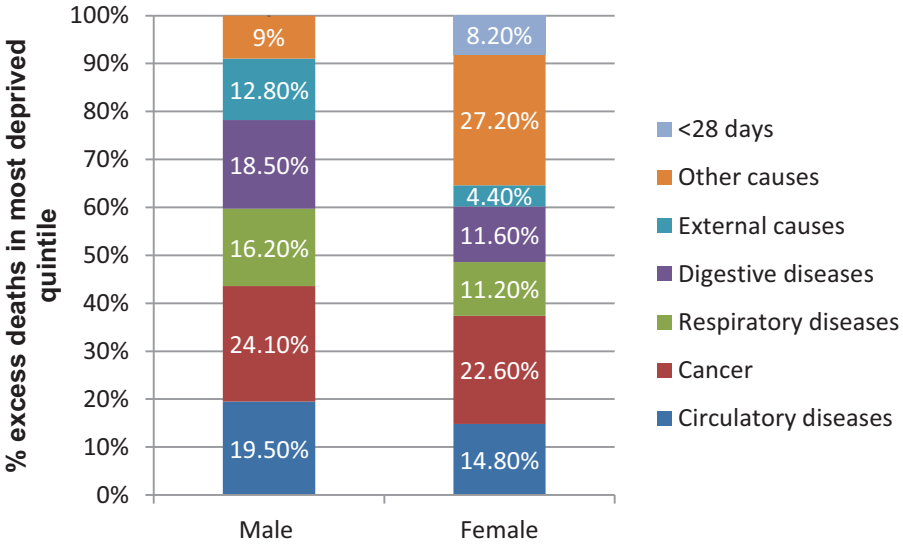


Figure 11: Breakdown of the life expectancy gap by cause of death between the most deprived and least deprived quintiles in BaNES, 2009-2011

BaNES has a premature death rate of 290.5 / 100,000. Comparing the under than 75 mortality rates of BaNES with National rates for the main causes of premature death gives an indication of the burden of premature mortality in BaNES. The results show that **BaNES performs well, with under 75 mortality rates for CVD, respiratory disease, cancer and lower disease that are well below the national average[17].**

	BANES	National
CVD	44.2	65.5

[15] BaNES JSNA http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki and http://www.hscic.gov.uk/catalogue/PUB13365

[16] PHE Segmentation Tool http://www.lho.org.uk/LHO_Topics/Analytic_Tools/Segment/TheSegmentTool.aspx

[17] Health and Social Care Information Centre https://indicators.ic.nhs.uk/webview/

Respiratory disease	**15.5**	**27.4**
Cancer	**100.6**	**123.3**
Liver disease	**10.8**	**15.4**

Table.4 – Rates of Mortality under 75 / 100,000 by cause of death (DSR), 2012[7]

The Public Health England Campaign; Longer Lives, highlights the burden of premature mortality in England by comparing rates of pre 75 mortality in different local authorities across the country. The results give two contrasting pictures for BaNES. When compared to the whole country BANES performs well, falling either into the best or second best quartile for all indicators. However, **when compared to local authorities with similar levels of deprivation, performance is poor,** coming out second worst for liver disease and worse than average for cancer and overall premature mortality[18].

[18] PHE Longer Lives http://longerlives.phe.org.uk/#are//par/E92000001

Maintaining Strong Performance and Excellent Quality

Current Performance

The illustrative figures that follow are from our performance report as at Month 9 (December 2013) 2013/14. We have used the data contained in this report, to provide an overview of the current performance of our healthcare system against key indicators, focussing on the National Constitution Indicators. All of the indicators in these tables are included in monthly reporting to the CCG's Board along with other national and local indicators reporting on quality and joint social care services

Detailed performance data has been provided in the submitted Unify templates as part of the strategy development process.

NHS Constitution Access Metrics
Overall the CCG performs well against the NHS Constitution metrics. Most of the areas where improvements are required relate to pressures on the Urgent Care System:

A&E Department - % of A&E attendances under 4 hours (RUH): The BaNES health and social care economy has delivered new levels of operational resilience, capacity planning and operational performance management of the whole Urgent Care System (UCS) throughout the winter of 2013/14. This has resulted in much improved performance. For 2014 /15 and onwards we plan to build on this work to move to delivery of year-round system resilience through continued strategic and operational UCS management, supported by the UCS transformation, led through a mature and effective Urgent Care Working Group (UCWG).

Ambulance clinical quality – Category A (Red 1) 8 minute response time (SWAST), Ambulance clinical quality – Category A (Red 2) 8 minute response time (SWAST), Ambulance clinical quality - Category A 19 minute transportation time (SWAST): South West Ambulance Service Foundation Trust has had performance challenges during 2013/14 following the acquisition of Great Western Ambulance Service ; we aim to ensure the continued recovery in response times through the application of contractual levers, targeted investment, robust engagement and monitoring to deliver the response standards and service transformation to provide higher quality outcomes for our patients in 2014/15 and beyond.

Mixed Sex Accommodation (MSA) Breaches (RUH): The mixed sex accommodation breaches have all been in Medical Assessment Unit (MAU) during periods of escalation in the Emergency Department. The continued focus on improvements to the Urgent Care System should resolve this issue.

Cancelled Operations - not rebooked within 28 days (RUH): Poor performance for rebooking cancelled operations was seen in quarter 1 of 2013/14, when the winter pressure period extended in to April 2013. Since quarter 1 performance has been on target and is expected to continue so.

Tables 5 and 6 on the following pages shows the NHS Constitution Access to Services Metrics.

National Quality and Safety Standards

Overall the CCG performs well against National Quality and Safety metrics. The monthly reporting monitors the metrics that are updated regularly.

Health Care Associated Infections (HCAI) MRSA and C.Difficile: are both above target for the CCG. Incidents of MRSA are investigates and reviewed for lessons learned. With the initiation of the HCAI collaborative, the CCG is working with local providers to reduce incidents. The group has been focussed on antimicrobial prescribing

Appendix 3 shows the National Quality and Safety Metrics.

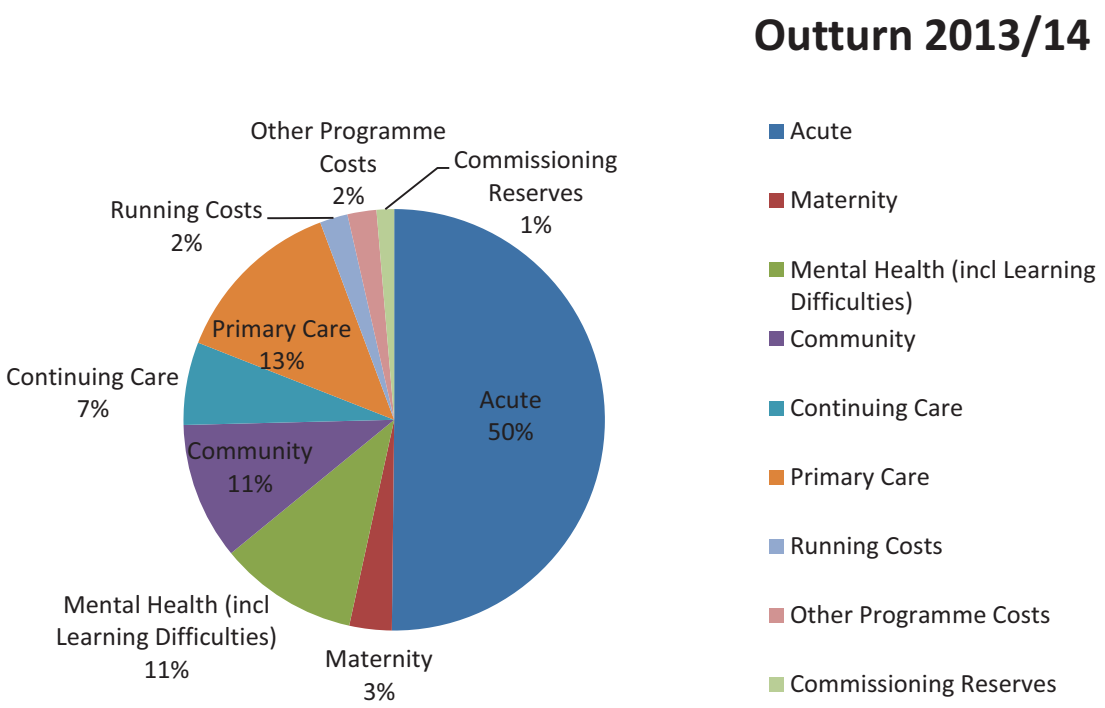
Ensuring Financial Sustainability

How We Use Our Resources

A key component of the CCG's financial strategy is to maximise the use of resources by ensuring costs incurred are those which deliver the safest and most effective care for patients at the best obtainable value. We expect the financial challenge for the health community to be in the region of £50m for the 5 years of our plan, so achieving this is essential to enable us to continue commissioning the care our population need. In Chapter 8 of this document we provide a detailed synopsis of our financial plan. Here we provide an overview of how we currently use our resources for our population.

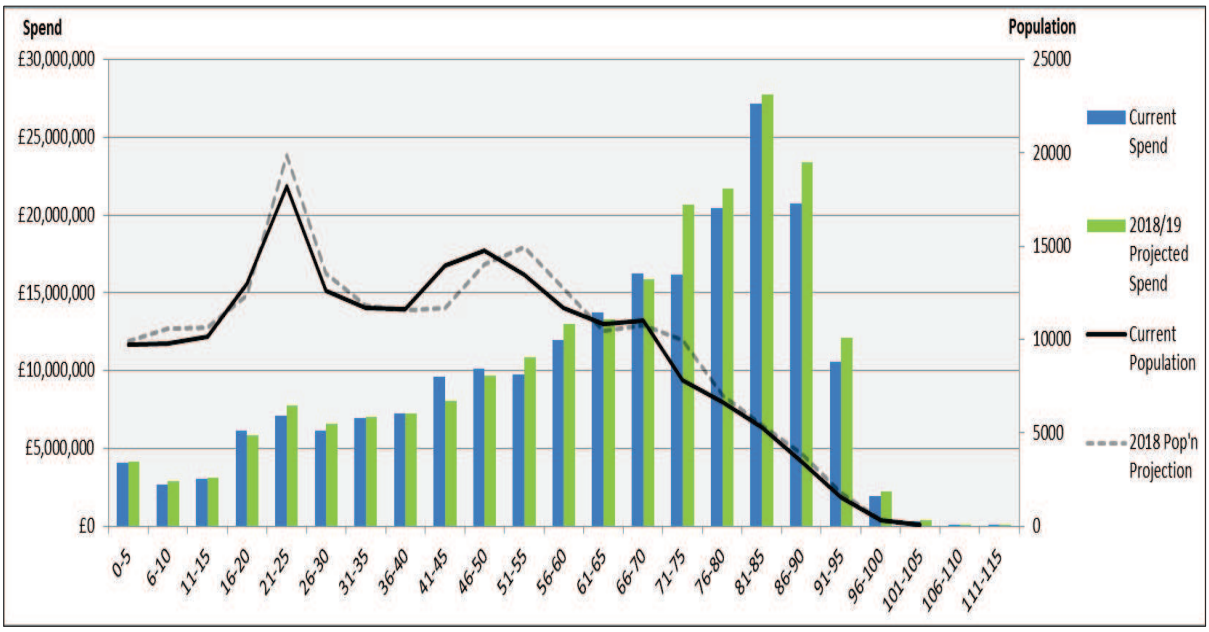
The pie chart below shows our forecast outturn expenditure by type of care for 2013/14, our starting point for understanding how our resources are used and identifying how we can use them differently to meet the challenges ahead. Over half of our commissioned service spend is allocated to acute services which have traditionally been provided in hospitals, with further hospital based spend included in the maternity and mental health sectors.

Figure 12: Outturn 2013/14



We have analysed our spend by age group to further understand our current use of resources and to provide a baseline for identifying areas where changes in commissioned services are likely to have the greatest impact on activity and expenditure. The chart below shows the breakdown of our total 2013/14 forecast outturn commissioned expenditure into estimated age bands, and models the anticipated impact of population change on spend for the period of our plan.

Figure 13: Spend against population by five year age band



Despite constituting just 18% of the population, people over 65 account for over 53% of CCG commissioning spend. Over the next five years, the over 65 population will increase by approximately 8.7% compared to a 1.6% increase in the population aged 65 and under. We expect the impact of population growth overall on spend to be 5.3% and to contribute to our anticipated financial gap by 2018/19.

Given the proportion of our expenditure which currently relates to the provision of hospital based services for members of our population who are over 65, we have undertaken more detailed analysis of our spend in this area. The chart below shows the breakdown by type of care activity of resources allocated to acute services for the entire population and for those who are aged over 65. It is clear that the majority of expenditure is directed towards non-elective care and particularly towards unplanned admissions, accounting for 42% of all age spend and 49% of spend on people aged over 65.

Figure 14: BaNES CCG All Age and 65+ by Spend and Type of Care

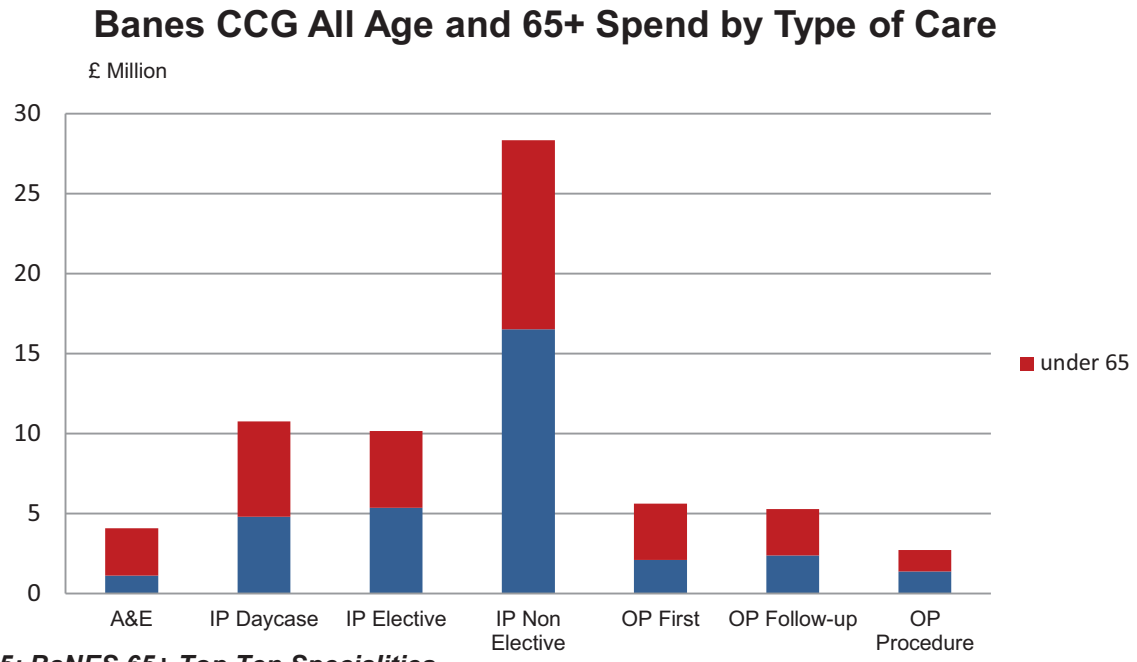


Figure 15: BaNES 65+ Top Ten Specialities for Non Elective Admissions

Source: April 13 - Jan 14 SUS PBR Data

Within non-elective care, we have reviewed the cost of admissions in further detail to identify which specialties account for the greatest proportion of spend, both for the entire population and for those who are over 65. This analysis of the top ten specialities for each age range shows that General Medicine attracts significantly more financial resource than any other specialty, as illustrated in the diagram below;arts below.

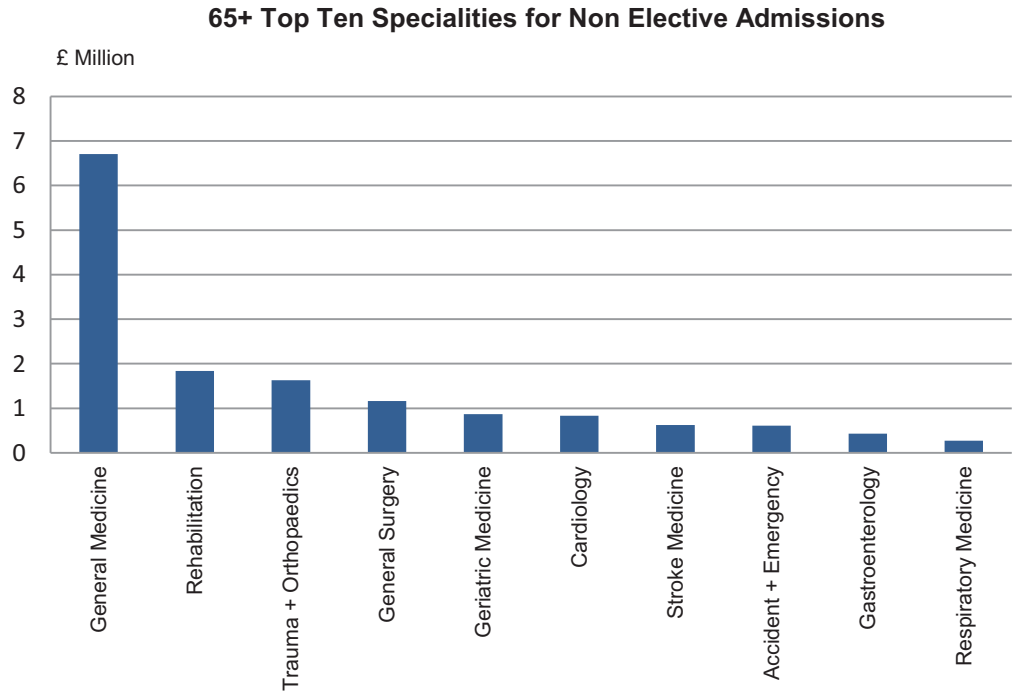


Figure 16: BaNES All Age Top Ten Specialities for Non Elective Admissions

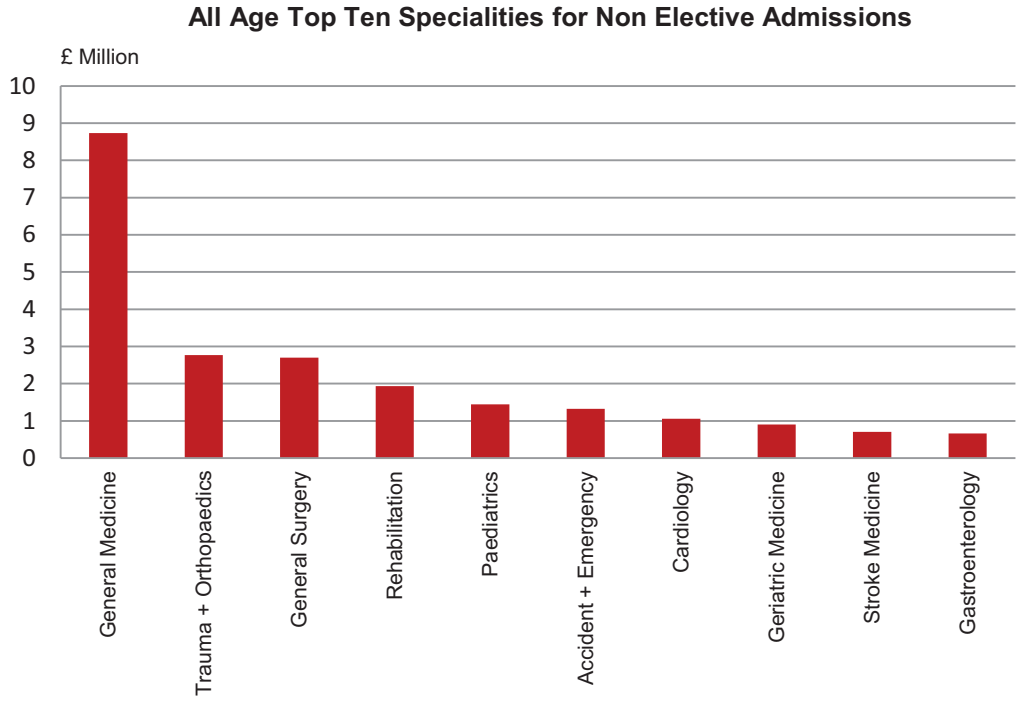
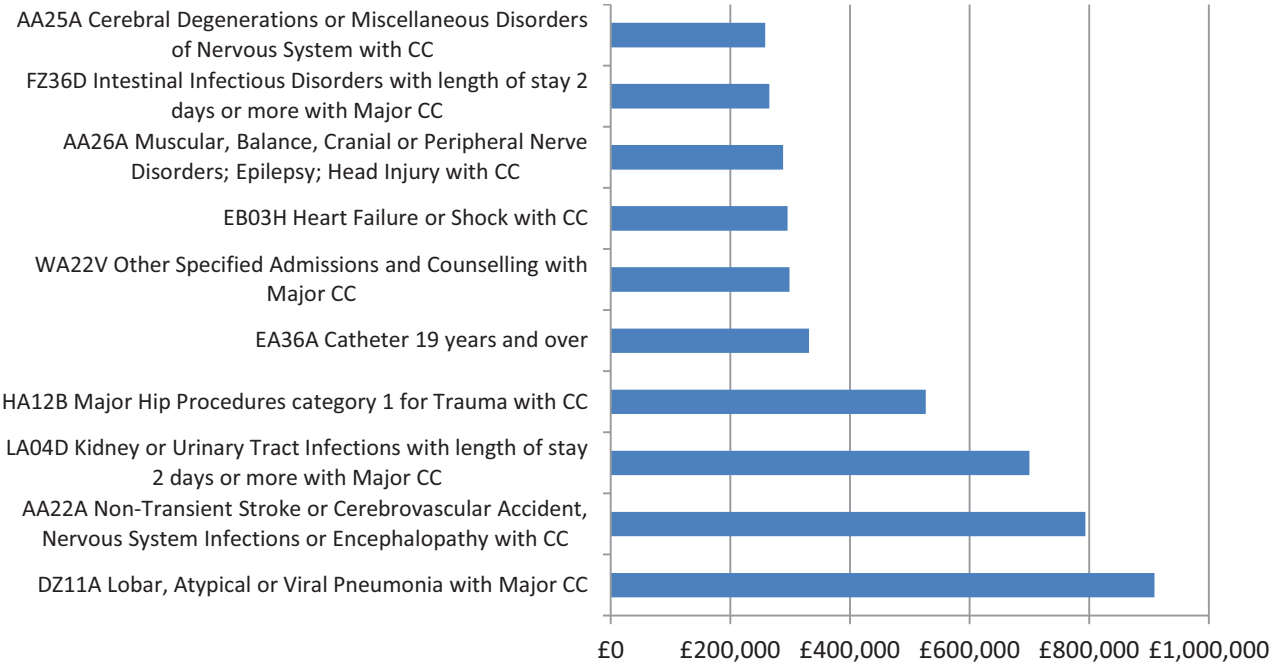


Figure 17: NHS Banes CCG Top 10 Non Elective HRGs by PbR Spend 65+



The Financial Position of the Health and Care Economy

Our local health economy has a generally stable financial position, having emerged from a period of financial challenge for a number of organisations including acute and mental health providers and influential neighbouring commissioners. Although a relatively high proportion of local providers have yet to gain Foundation Trust status, our main acute and mental health providers are actively progressing through the process to achieve this.

The existing level and configuration of commissioned service is currently affordable within our allocated resources and largely meets the current demand, with some challenges in non-elective care capacity at the busiest periods. However, as our population increases and ages, provider capacity in all sectors of the health and social care economy will become insufficient to deal with the volume of non-elective care demand within the affordability envelope unless the pattern of use of services changes significantly. Many of our providers will have challenging Cost Releasing Efficiency Savings to deliver over the next 5 year period, A further factor affecting the future affordability of our services is the nationally determined view that our allocated income is above the target value required to purchase services for our population on an equitable basis with other CCGs. Commissioners whose income is above target will be awarded the lowest available level of growth monies in future years with the intention of reducing their income to the nationally calculated equitable value. Due to the complexity of transfers between commissioners during 2013/14, it is difficult to determine accurately the scale of our distance from target, but we estimate it to be between £4m and £7m.

Our Local Authority partners are also facing significant financial challenges with a savings target of £27m over the next three year period.

The creation of the Better Care Fund will impact on the health economy with its requirement to release resources largely from acute health care services for reinvestment in integrated initiatives. We have operated shared and aligned financial arrangements in support of joint commissioning for some years, making use of the flexibilities offered by Section 75, Section 10 and Section 256, and our integrated approach has already released resources in a managed way from acute care for this purpose. We anticipate that the additional requirement can be delivered without destabilising otherwise viable providers.

We also face existing challenges in four areas:

The RNHRD has been determined to be financially unviable in its current organisational form, with the income available for its services insufficient to cover its costs. We therefore need a solution which ensures the population of BaNES have access to good quality, affordable Rheumatology and related services from a sustainable provider for the future.

Primary care providers deliver a range of services in addition to those reimbursed through their standard contracts with NHS England, some of which have evolved historically or emerged as an unforeseen consequence of other initiatives. We need to review these existing arrangements and to develop an approach with primary care providers which allows new work to be identified, evaluated and reimbursed at a fair price.

We have a local overprovision of elective acute capacity, with several geographically close providers competing for shares of a demand which we do not expect to expand significantly, based on clinical need. We are at risk of incurring the costs of avoidable procedures if this overprovision drives up demand in a way which is inconsistent with our commissioning objectives.
We do not have an established mechanism for identifying where and how differential targeting of investment might aid us in addressing differential access to and outcomes from services, for example in our most deprived areas.

How We Perform Comparatively

A range of resources are available which allow us to compare our performance against that of other CCGs with similar populations and resources.

We have analysed the data from these sources including: the Commissioning for Value packs, CCG and Local Authority Outcomes Benchmarking Support packs, the Levels of Ambition Atlas, Atlas of Variation, 'Any Town' Health System Modelling, together with local analysis of activity and spend to identify areas which present the opportunity for both quality improvements and financial or productivity benefits. Each of these sources of data and analysis provides benchmarking type information to enable us to see whether we are directing resource comparable with other commissioners towards activities, conditions, specialties or broader areas of care, and whether we are achieving comparable outcomes as a result of our resource allocation choices. They thus provide a basis for assessing both the quality and value for money of our commissioned services.

Our review of these sources provide the following intelligence:

Commissioning for Value – this data provides a review of indicative data from similar CCGs to highlight the best opportunities for transformation and improvement. It triangulates quality, spend and outcomes.

The data suggests that making improvements to services for musculoskeletal system problems and circulation problems offer the greatest financial and quality gains. Musculoskeletal services offer the highest potential for savings on elective conditions and musculoskeletal, trauma and injuries offer the highest potential savings on non-elective admissions.

This database confirms the CCG has lower mortality rates in cancer, neurological conditions, respiratory, gastro-intestinal and trauma and injuries than the average of the 5 best performing similar CCGs.

Outcomes Benchmarking Support – this sets out key data to inform the local position on outcomes at CCG and Local Authority (LA) level. The LA pack includes comparative information on the NHS, Adult Social Care and the Public Health Frameworks. BaNES CCG is in the Prospering UK and ONS Clusters. The table identifies from the QOF disease register where the CCG has higher prevalence rates than the England average; where outcome indicators have significantly better performance than the England average and those with poorer performance than the England average.

In response to this data, the CCG set targets for local improvement to reduce the number of Alcohol specific hospital admissions to the RUH and patient reported outcome measures for elective knee replacement as part of the quality premium in 2013/14.

Levels of Ambitions Atlas - The Levels of Ambition Atlas is an interactive tool which allows commissioners to view their outcomes baseline and trend data for each ambition indicator and compare to other local commissioners. The Atlas confirms that BaNES CCG is one of the best performing CCGs in terms of Potential Years of Life Lost (PYLL).

Any Town - 'Any town' uses detailed data including population size and disease prevalence, to predict what a typical health system's quality and financial baseline may look like in 2018/19. It uses extensive research to highlight both interventions that are already proven to have a significant impact (High Impact Interventions) as well interventions that could have benefit but have not yet been widely adopted or fully impact assessed (Early Adopter Interventions) both with a view to helping health economies to deliver better quality care within the available financial resources. We have used the Anytown Lite model to test our ideas for transformation and the model confirms there is significant scope for improvement through High Impact Interventions (HII) such as Case Management/Co-ordinated care, reductions in variability within primary care and self-management programmes for those suffering with a long-term condition. Plans to reduce urgent care demand, acute visiting services and integrated health and social care for older people also demonstrate positive effects, which supports our decision making. The suggested interventions modelled are congruent with our plans to develop primary care at scale and work within the Better Care Fund framework to improve the scale and intensity of home based services. This would be particularly focused on the over 65s, which is the age group that drives significantly the

requirement for additional resources. The detailed outputs from the Anytown Lite model are below;

Intervention	Description	Population subgroup affected potential % reduction	Point of Delivery Impact and potential % reduction
HII02 	**Reducing variability within primary care by optimising medicines use and referring**	All population sub groups	Primary care prescribing -4.38%
HII03 	**Self-management: patient-carer communities**	Long term conditions – Adults	Community Care, self-care and LTC -10.9%
HII05 	**Case management and coordinated care .**	LTC and Frail Elderly. Across all areas apart from maternity	No effect on Primary and Community Care
EAI05 	**Acute visiting service**	Long term conditions – Adults & Children, Frail elderly.	Inpatients – Emergency with a reduction of -16.4% No effect on Primary and Community Care
EAI06 	**Reducing urgent care demand**	Good Health Older People, children and Adults, Early Years 0-4.	No effect on Primary and Community Care. -5.94% reduction - Emergency's
EAI11 	**Integration of health and social care for older people**	Frail Elderly	Across all areas apart from maternity with reductions between -7% and -17%. No effect on Primary and Community Care

Responding to the Views of Local Stakeholders and the Public

Engaging Providers and other Commissioners

In developing our strategy we have engaged with local providers, the Local Authority, the Health and Well-Being Board and other key stakeholders including Healthwatch through a series of workshops intended to share and test our understanding of the case for change and gather support from across the health and care community.

The first session on the 12th February provided us with an opportunity to set out our vision and emerging priorities for Bath and North East Somerset over this time frame. We set our intent to build on existing integrated service arrangements in BaNES, developing our focus on urgent care and long term condition management and to tailor our commissioning plans based on evidence based approaches.

During the second session on 27th February we considered these issues further and six potential priority work streams for a focused health and system wide approach over the next three to five years. These areas were:-

- Increasing the focus on prevention, self-care and personal responsibility
- Improving the coordination of holistic, multi-disciplinary Long Term Condition management (focusing initially on Diabetes)
- Creating a stable and sustainable Urgent Care system that can respond to changes in demand
- Commissioning safe, compassionate and integrated care for frail older people
- Re-designing Musculo-skeletal services to improve their efficiency
- Ensuring the interoperability of IT systems across the health and care system

There was a high level of consensus amongst providers around the need to develop a greater level of personal responsibility, self-care and improved lifestyle choices and maximising opportunities for all our roles in influencing this across the system.

We believe that there was also a high level of consensus amongst our providers that we need to develop integrated working and systems of care and more effective clinical pathways. Discussion and feedback supported our proposed priorities and that, if delivered effectively these should secure good services for local people. This echoes the themes raised at the 'Call to Action' engagement events with the public in the autumn of 2013.

There was also a request from some providers for the establishment of a Strategic Forum where providers can jointly work with Commissioners on agreed change programmes. However, we also received feedback on the need to carefully sequence change programmes and how we deliver change will determine the success we have as a health and care economy. There was a strong request from many providers for collaborative rather than competitive approaches to procurement and commissioning wherever possible.

Providers told us that their primary concerns for the current system are:

Working in silos is unsustainable. Providers recognise that there is a need to work in a more integrated way but highlight the necessity of effective enabling infrastructure

Increasing demand is accompanied by increasing complexity of case mix as a result of an ageing population and the prevalence of multiple comorbidities

Patients' expectations continue to rise at a time of financial constraint

The third and final session on 13th March brought together the leadership teams from stakeholder organisations to agree the governance structure for the delivery of the strategy and reaffirm the commitment to jointly support Programme Management Office arrangements.

This approach will build community buy in and ensure that we are talking about what matters to individuals who may only want to discuss one particular issue which is important to them or specific to their location. This approach will allow for a continuous dialogue which flows both ways – either on an individual level, or direct to community interest groups.

Listening to the Public - A Call to Action

A 'Call to Action', published in 2013 in anticipation of 'Everyone Counts' encouraged CCGs to engage with stakeholders and representatives of the public in the early stages of strategy development and sought people's views to help shape the future of NHS health services in the Bath and North East Somerset area.

Eight engagement sessions were held in different locations across Bath and North East Somerset:

16th October 2013	**9am-1pm**	**British Royal Literary & Scientific Institution**
24th October 2013	6pm-9pm	Centurion Hotel, Midsomer Norton
30th October 2013	1pm-4pm	Fry's Centre, Keynsham
27 February 2014	10am – 12pm	Hilton Hotel, Bath
13 March 2014	12pm – 2pm	British Royal Literary & Scientific Institution

13 March 2014	4pm – 6pm	British Royal Literary & Scientific Institution
13 May 2014	10am – 12pm	Guildhall, Bath
13 May 2014	6pm – 8pm	Centurion Hotel, Midsomer Norton

The events were well attended generally, with attendance approximately 200 people attending from a variety of organisations.

The meetings provided an opportunity for us to update the public regarding achievements in the first 6 months since the CCG was established, a high level description of future plans and priorities and describe the background to the national 'Call for Action'.

Those present were also asked to participate in discussions with the theme of 'Looking after Yourself'.

One strong, consistent theme emerged across all of the engagement and consultative events we have held so far, which was that the audience want to retain the NHS and that it must, for the most part, be kept free at the point of delivery.

However, there was also resistance to privatisation or at least a wish to limit the amount of private sector involvement in the NHS. Knowing that they could depend on a high quality, reliable service that was not driven by commercial motives was important to most of those who responded.

More specific themes also emerged across events which were:-

- That the vital contribution the voluntary sector makes must be more highly valued and better used
- That preventative care should be improved and should incorporate more self-care and education for patients and carers
- That improved levels of integration across health and social care providers were needed, incorporating more team working and better co-ordination of care so that services and pathways are seamless. In fact, that this is essential for change because it is a basic expectation, but which currently does not exist
- That the right staff/services need to be used in the right way. There is a feeling of insufficient self-care, under-use of pharmacists, over-reliance on GPs and over-use of emergency services; with the need to "break the people expect prescriptions cycle"
- That there should be more focus on community services, particularly for those with long term conditions and for the frail older person. The idea of 'hospital at home' is welcomed, if with caution, and there is a perception that a lost 'community spirit' needs to flourish once again
- That hand in hand with the focus on community services and better co-ordination of care is the fact that many people working in community services are in contact with

people before they become in need of healthcare, and more can therefore be done to prevent them becoming patients

- That there is a need for complete transparency over the extent of the financial challenge ahead, a requirement for the public to be educated as the real cost of the service being provided and for attitudes of entitlement to be changed. That this can only be achieved through public and patient involvement and collaboration with commissioners
- That there needs to a greater focus on the needs of carers and mental health service users, especially young people with mental health needs
- Local people want more public engagement processes and joint decision making, particularly in the commissioning processes and procurements

People who took part in our events want to see a more joined up health and social care service that uses the skills and expertise of the voluntary sector to full effect. They also want to see more of a focus on keeping people well and preventing ill-health than the NHS provides at the moment.

They want to see all of this in the context of keeping the NHS free, for the most part, at the point of use and not ceding state control of the health service to the commercial sector.

We will continue to engage with the public and service users regularly to ensure people can contribute to our developing strategy and to allow them to be involved in our progress.

Chapter 4 - Summarising the Local Case for Change

Meeting the Needs of A Changing Population

The future impact of demographic changes and comorbidity are significant in BaNES:

We intend to work with our Public health colleagues to further assess the prevalence of multi-morbidity and future trends in BaNES. From a national perspective we know:-

- Of those aged over 65, half have at least three chronic conditions and 1 in 5 have five or more chronic conditions
- In deprived areas, multi-morbidity is more common and happens 10-15 years earlier and there are more people with mental as well as physical long term health problems

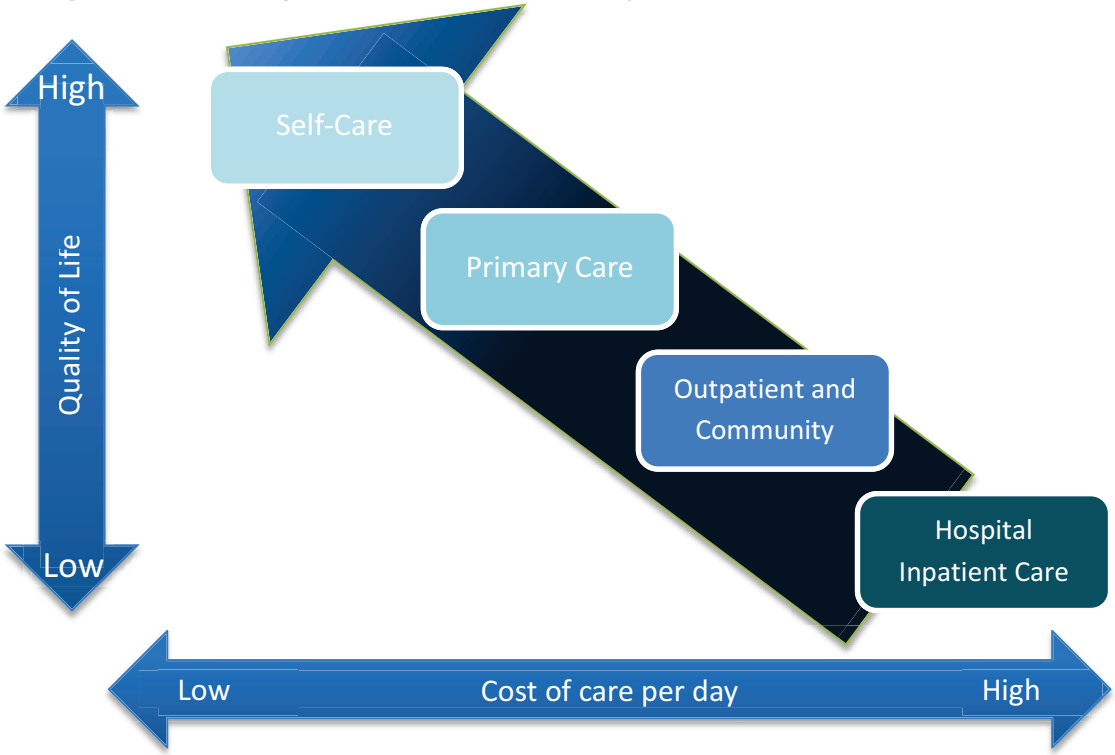
The current paradigm for delivering care, both in secondary and primary care results in the creation of silos of care, and guide lines encourage us to view patients from a single disease perspective.

If we are to address all these factors, it is clear that we must focus on the influences that lead to an increased risk of developing long term conditions: socio-economic factors, deprivation, poor lifestyle choices resulting in obesity, smoking and alcohol related diseases as well as effective support of those of us with a long term condition.

To this end, we need to focus on personalised care planning and intensive support to make sustained lifestyle changes- good evidence exists for this in relation to type 2 diabetes and COPD. The effective collaboration between the third sector, primary, community and secondary care will give us the greatest possible chance of successfully supporting people with multi-morbidity.

The graph below shows the shift of resources from acute and secondary care to community and primary care will therefore need to be supported by all our stakeholders if we are to successfully address the challenges of demographic change, multi-morbidity and tighter resourcing of both health and social care.

Figure 17: Shifting Resources within the System



Maintaining Strong Performance and Excellent Quality

Though the performance of the system is generally strong, and outcomes for patients are good when compared with our statistical peers, we acknowledge that there are challenges to both local system performance and quality.

These challenges are broadly related to the pressures in the urgent care system, and include:

- Meeting the 4hr A&E transition target
- Achieving ambulance response time targets
- Eliminating Mixed Sex Accommodation
- Supporting admission avoidance and more effective management of patients with long term conditions.

We understand that we must act now to address these challenges.

Ensuring Financial Sustainability

Whilst the CCG currently has inherited a strong financial position, we recognise that existing service models and patterns of spend are not sustainable in the context of future demographic and financial pressures. We have estimated that £50m of resource releasing savings need to be achieved from a health perspective by commissioners and from providers' internal efficiency savings plans by 2018/19. This is as a result of the following factors:

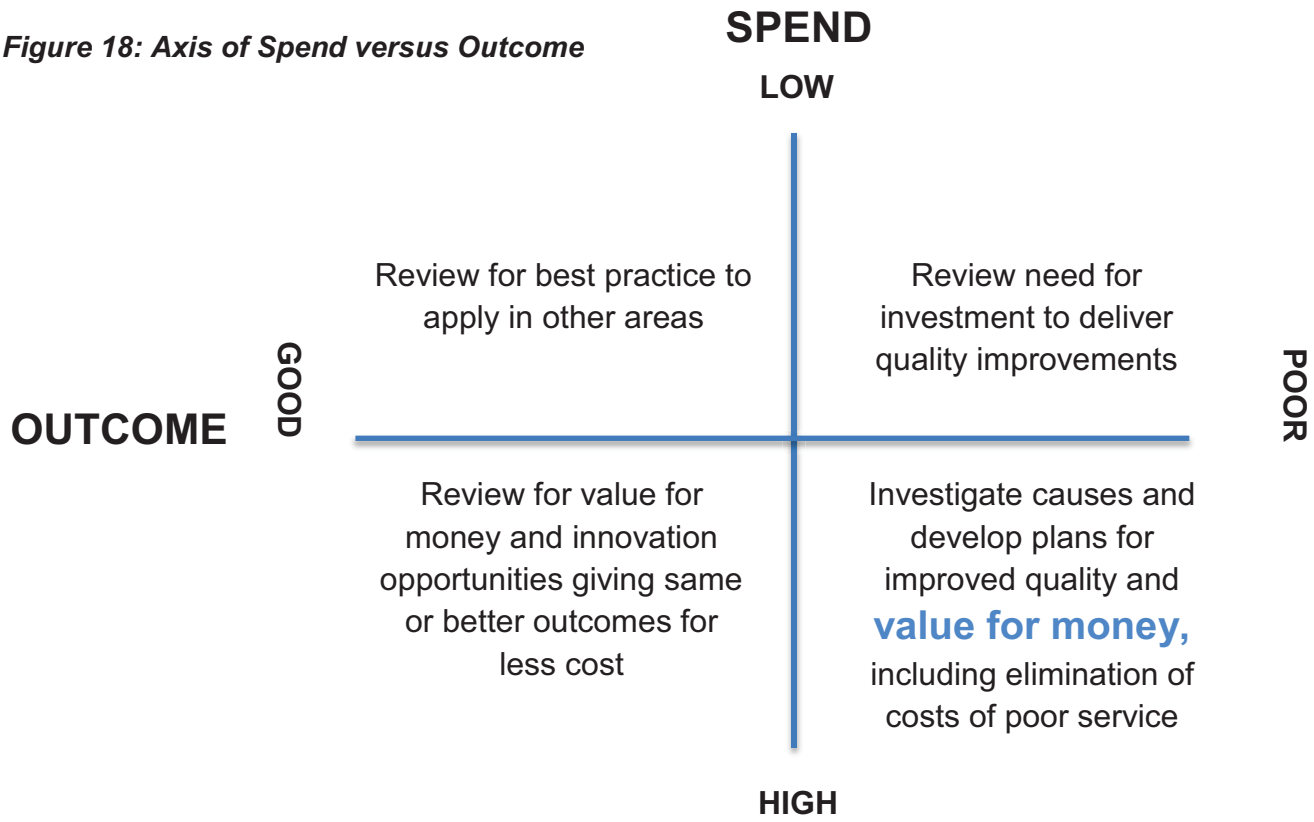
- Limited increases in allocation as a result of national economic constraints and a national commitment to move all CCG's allocations closer to the target level for their population
- Demographic growth which is below the national average overall, but shows a disproportionate increase in the oldest members of our population, who are likely to be more frequent and more intensive users of health services
- An increase in the numbers and life expectancy of people with complex or multiple disabilities or conditions, who are also likely to have a higher level of need for health services

BaNES Local Authority, a key partner with whom we have strong joint commissioning arrangements, face similar financial challenges with savings requirements of £27m over the next 3 years, and we also expect welfare reform to result in a reduction of £40m from the local economy.

If demand and activity are to increase at a greater rate than the available financial resource, we will need to treat people at a lower mean unit cost than is currently incurred in order for the right level of care to remain affordable overall. As we expect the most poorly members of our population to incur an increasingly high cost of care in acute settings, we will need to provide good quality, effective treatment for more people in lower cost community and primary care settings to maintain balance. This links directly with our drive for quality, as we will avoid the costs associated with poor quality services and poor outcomes if we ensure that all patients receive the most appropriate care in the best value setting for delivery of that care. This is illustrated in the diagram above that shows the shift in resources.

We have developed an approach to reviewing the value for money of our commissioned services to determine where our commissioning activities can best be focused. The chart below shows our approach to acting on the results of benchmarking information and partner and stakeholder feedback, which can be combined with intelligence about areas of growing demand and escalating spend to determine our priorities from a value for money and affordability perspective.

Figure 18: Axis of Spend versus Outcome



Responding to the Views of Local Stakeholders and the Public

The public that we serve have told us that they want to retain an NHS that is free at the point of delivery. If we are to protect the NHS we must act now to ensure financial sustainability. The public also tell us that they would like to see:

- A focus on prevention, self-care and education
- More integration between health and social care services
- Services provided in the right place, at the right time, by the most appropriately skilled

We believe that this gives us a mandate to proceed with our transformational programmes.

The Case for Change

We have synthesised all the sources of useful data and intelligence, including:

- Our local population needs
- National requirements
- Benchmarking intelligence
- Our current performance – NHS Constitution and Outcomes
- Our current use of resources

Future financial pressures

Views of patients, stakeholders and members of the public

We have identified that the CCG has good performance across a range of indicators but synthesis of the data also leads us to identify the areas of focus for transformation;

Older People – Life expectancy is higher for both men (80) and women (84) than the regional and national averages. By 2021 there will be a 30% increase in population over 70. Of those aged over 65, half have at least 3 chronic conditions. Despite constituting just 18% of the population, people over 65 account for over 53% of CCG commissioning spend. The impact of population growth will contribute to our anticipated financial gap. We wish to ensure that older people in our local society are valued and respected and are supported to stay well as long as possible and enabled to lead fulfilling and happy lives. Therefore, we wish to commission integrated safe, compassionate pathways for frail older people through integrated health and social care community cluster teams. This work will be supported by national initiatives which also focus on the care of frail elderly people.

Long Term Conditions – As detailed above, the life expectancy of our population is generally very good and the risk of developing multiple chronic conditions appears to increase with age. In deprived areas, multi-morbidity is more common and happens 10-15 years earlier and there are more people with mental as well as physical long term health problems. The prevalence of diabetes has been steadily increasing locally, regionally and nationally and in 2012/13, 7,460 people aged 17 and over were registered as having diabetes mellitus on GP registers. Therefore we need to focus on prevention and providing personalised care planning and intensive support to help people who have long term conditions to make sustained lifestyle changes which enable them to manage their conditions more effectively.

Urgent Care System – Most of our challenging performance issues relate to the urgent care system and include 4 hour A&E response times, ambulance response times, and eliminating mixed sex accommodation. Failure to address these performance issues has the potential to impact on the quality of care provided for patients in other parts of the health system, planned care being the most obvious area with resulting increases in cancelled operations and extended waiting times. Therefore, we need to create a sustainable urgent care system with sufficient capacity to respond to increasing demands from an ageing population and the number of people living with long term conditions.

Musculoskeletal Services – The Commissioning for Value benchmarking data identified musculoskeletal services as providing opportunities to improve quality and outcomes and to reduce spend. This service, along with improvements to circulation problems was one of the few opportunities identified for transformation and improvement within BaNES. Therefore, we plan to undertake a whole system review of musculoskeletal services to ensure we deliver high quality, co-ordinated and integrated care across the entire MSK pathway.

Prevention and Self-Care – Whilst life expectancy in BaNES is higher than the regional and national averages, there are significant variations in life expectancy related to socio-economic inequality in BaNES. As detailed above, in deprived areas, multi- morbidity is more common and happens earlier and we wish to support people to take responsibility for their own health and care. The evidence suggests that prevention programmes can prevent disease, improve wellbeing, slow disease progression and reduce demand for specialist services. Therefore, we wish to develop and implement a 'Prevention, Self-Care' Work Programme to guide the way in which the CCG tackles prevention focusing on areas of higher deprivation, and enabling residents and patients to take greater responsibility for their health.

PART B

Seizing Opportunities – Developing a Better Health

Chapter 5 – Our Priority Areas of Focus

We have set out our understanding of the challenges facing the local health and care economy in BaNES. Whilst we have strong and better than national average performance in many areas we believe that against the national outcomes measures performance in the top decile is achievable over a five year period. Our local vision is:-

- Empowered individuals, carers and communities who are supported, confident and able to:
    - Take increasing responsibility for their own health and wellbeing
    - Manage their long-term conditions
    - Be part of designing health and social care services that work for the people that use them

- Enhanced and integrated primary, community and mental health services, support and expertise will work 24/7 with clusters of populations in order to respond to health and wellbeing needs close to home and ensure that hospital admissions are driven by the need for specialist and emergency treatments
- Innovative and widely integrated and utilised pathways of care understood for each long term condition and will include self-management, transition, urgent and contingency planning elements as routine
- A focus on supporting and safeguarding the most vulnerable, at risk, frail or excluded citizens as a matter of priority regardless of age
- Local people of all ages will have worked with clinicians to design, inform and then have access to information that enables them to be confident in the quality and safety of services in BANES and, where they are not confident, to voice and raise concerns easily
- Integrated information and care record systems that facilitate the delivery of integrated health and care services
- Services that represent excellent value for money, measured by quality and effectiveness (outcomes) of services as experienced by the people who use them

To achieve this we believe we need to:

- Continue to focus on improving the urgent care system to ensure patients are treated in the right place and to achieve sustainable performance on measures such as the 4-hour target and length of stay
- Continue to focus on long-term conditions and find ways to manage future demand pressures that will be experienced in these areas
- Find new ways to manage the demands associated with an ageing population and treat and care for patients in non-acute settings
- Develop our approaches to self-care and prevention to further improve outcomes on conditions that are amenable to health care
- Develop our approaches to commissioning to consider how we continue to reduce inequalities within BaNES

- Find new ways to engage patients in the decisions that impact their health care, help patients and carers to take greater responsibility and involving patients from the outset in our commissioning processes is essential

This means that we will:

- We will disinvest in acute services over time
- Increase our investment in primary and community provision
- Encourage further integration of primary, community and mental health services
- Promote self-care, personal responsibility
- Encourage the role of volunteers, navigators

We believe that to achieve success we should focus on a small number of areas and excel at achieving our goals in these areas, rather than trying to spread limited capacity for implementing change too thinly.

We have chosen to focus our energy on improving quality, outcomes and efficiency in the following six areas:

1. Increasing the focus on prevention, self-care and personal responsibility
2. Improving the coordination of holistic, multi-disciplinary Long Term Condition management (focusing initially on Diabetes)
3. Creating a stable, sustainable and responsive Urgent Care System
4. Commissioning integrated safe, compassionate pathways for frail older people
5. Redesigning Musculo-Skeletal pathways to achieve clinically effective services
6. Ensuring the interoperability of IT systems across the health and care system

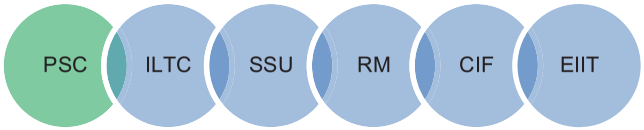
We have chosen a transformative approach, taking a system wide view on specialty and programme areas to ensure redesign improves the whole spectrum of service provision for specific areas of care.
The following is a summary of key messages from benchmarking and other information which have helped in shaping our direction of travel for the next five years as described in subsequent chapters. Sources of data consulted include but are not limited to:

The following table highlights key information which supports the development of five of our six priority areas. Interoperability is excluded as it is more of an enabler than a transformative work stream.

Table 8: CATEGORY/SOURCE/INDICATORS		**PRIORITY 1 PREVENTION, SELF-CARE & PERSONAL RESPONSIBILITY**	**PRIORITY 2 LONG TERM CONDITION MANAGEMENT**	**PRIORITY 3 URGENT CARE SYSTEM REDESIGN**	**PRIORITY 4 MUSCULO-SKELETAL PATHWAY REDESIGN**	**PRIORITY 5 INTEGRATED PATHWAYS FOR FRAIL OLDER PEOPLE**
Population projections, JSNA & Health profiles	• Ageing population • Increasing prevalence of LTC & co-morbidity	✓	✓	✓	✓	✓
	For deprived part of pop: • Lower life expectancy, higher prevalence of LTCs, alcohol misuse, increased risk of premature births, increased hospital admissions for self-harm and poor dental health	✓	✓			
Commissioning for Value pack	Musculoskeletal System & Cardio Vascular Circulation Problems offer greatest opportunity in terms of both quality and spending	✓	✓		✓	
	Areas offering greatest opportunity for quality improvements are: Cardio Vascular Circulation Problems, Musculoskeletal System, Endocrine, Nutritional and Metabolic Problems, Mental Health Problems and Cancer & Tumours.	✓	✓		✓	
NHS Constitution – Everyone counts scorecard	Underperforming on - A & E 4 hour wait - Mixed sex accommodation - Cancelled operations		✓	✓	✓	
JSNA	- Self-harm & depression prevalence is high - Potential under-reporting of dementia. Number of cases expected to rise by 23% for females and 43% for males between 2010 and 2025	✓	✓	✓		✓

Table 8: CATEGORY/SOURCE/INDICATORS		PRIORITY 1 PREVENTION, SELF-CARE & PERSONAL RESPONSIBILITY	PRIORITY 2 LONG TERM CONDITION MANAGEMENT	PRIORITY 3 URGENT CARE SYSTEM REDESIGN	PRIORITY 4 MUSCULO-SKELETAL PATHWAY REDESIGN	PRIORITY 5 INTEGRATED PATHWAYS FOR FRAIL OLDER PEOPLE
Outpatient attendance data, Better care better value, Q2 13/14	- BANES overall rank 59 - Overall performance better than national average BUT - Potential opportunity for that quarter of circa 8000 appointments equivalent to £1,4million cf upper quartile performance	✓	✓		✓	
NHS Atlas of Variation in Healthcare for People with Diabetes (2012)	Sub-optimal blood pressure control for both types 1 & 2 DM - Performance in lower 4th & 5th quintiles Admissions for stroke among patients with DM are higher than national average	✓	✓	✓		

Increasing the focus on prevention, self-care and personal responsibility



High level description of the priority area:

The development and implementation of a 'Prevention, including Self Care' (PSC) work programme will guide the way in which the CCG tackles prevention focusing on areas of higher deprivation, and enables residents and patients to take greater responsibility for their health. Evidence suggests prevention programmes can prevent disease, and improve wellbeing, slow disease progression and reduce demand for specialist services.

Rationale for Inclusion:

- The UK performs poorly on several important health problems compared to peers e.g. IHD, low back pain, COPD, stroke, lung cancer
- The NHS spends only about 4% of total budget on prevention
- Preventing early deaths – deaths from heart disease in France are 25% of that of the UK; male deaths from cancers in the US is 90% of UK rate
- We could reduce prevalence of chronic disability and reduce its impact on wellbeing
- We can do more to tackle underlying risk factors – smoking, alcohol, physical activity, healthy weight
- Targeted prevention activities will impact on reducing health inequalities

The Local Case for Change:

- Although the health of people in BaNES is generally better than England average and life expectancy for men and women is higher than England average, inequalities exist
- Life expectancy is 7.1 years lower for men and 4.4 years lower for women living in the most deprived areas of BaNES than in the least deprived areas
- The proportion of children aged 4/5 years overweight/obese, and alcohol-specific hospital stays for <18s is higher than expected
- Smoking prevalence in R&M groups is 25.6%
- By 2021 the number of over 75's in the population is projected to increase by 20% with an expected increase in prevalence of LTCs
- Prevalence of LTCs 2012/13. (Taken from QOF so generally lower than true prevalence): COPD = 1.3%; Diabetes 4.6%; AF = 1.7%; CHD = 2.9% ; Stroke and TIA = 1.8%

Our Approach:

The CCG will take forward this work in collaboration with the Health and Wellbeing Board and other stakeholders.

In the first year the CCG will convene a PSC task force to produce a PSC action plan to be implemented over the subsequent four years .

The plan (underpinned by evidence of need, cost-effectiveness information, budget restraints, review of current work, and stakeholder engagement) will aim to:

- tackle risk factors that have the greatest impact on the differences in life expectancy seen across BaNES
- increase primary prevention activity amongst the population
- ensure equality of access to healthcare, targeting resources to areas and populations with the greatest need
- Support self-management for people diagnosed with long-term conditions.

Within the plan the CCG will consider how it could deliver elements of the PSC action plan through opportunities including:

- contracts to include prevention initiatives (employees and patients)
- incentivising prevention initiatives
- adding value to existing PSC and health inequalities programmes being implemented by partners in the wider health and social care family
- systematically developing PSC workforce skills
- using targeted communications based on social marketing principles

The PSC action plan will be implemented from the second year onwards..

Expected Impact	Measures of Success
• Reduction in gap in premature mortality rate from selected causes between least and most deprived areas of BaNES	• *TBA by PSC task force*
• Increase in levels of primary prevention amongst BaNES residents, with greatest focus on areas of greater deprivation	• *TBA by PSC task force (potentially measured through data collected by public health on lifestyle behaviours)*
• Improved self-management support for patients with selected long term conditions	• *TBA by PSC task force (potentially could be measured using the LTC6 six item patient questionnaire)*
• Reduced unwarranted variation in management of people on selected LTC primary care disease registers	• *TBA by PSC task force*
• Increased workforce capacity to support PSC	• *TBA by PSC task force (could include increase in the proportion of health-related job descriptions that include PSC related competencies; proportion of staff attending PSC training; impact of training etc)*
• Reduced unwarranted variation in referrals to hospital and community services	• *TBA by PSC task force*

Timeline

2014/2015

- Establish PSC task force
- Create health inequalities framework
- Identify resources
- Conduct PSC needs assessment (analyse key health problems, review existing self-care initiatives)
- Engage with stakeholders to develop prevention and self-care action plan
- Identify outcome and process metrics
- Commission /deliver agreed programmes/action

2015/2016

- Commission/deliver agreed programmes/ actions
- Deliver agreed support to existing programmes
- Deliver agreed actions

2016/2017

- Evaluate and review

2017/2018

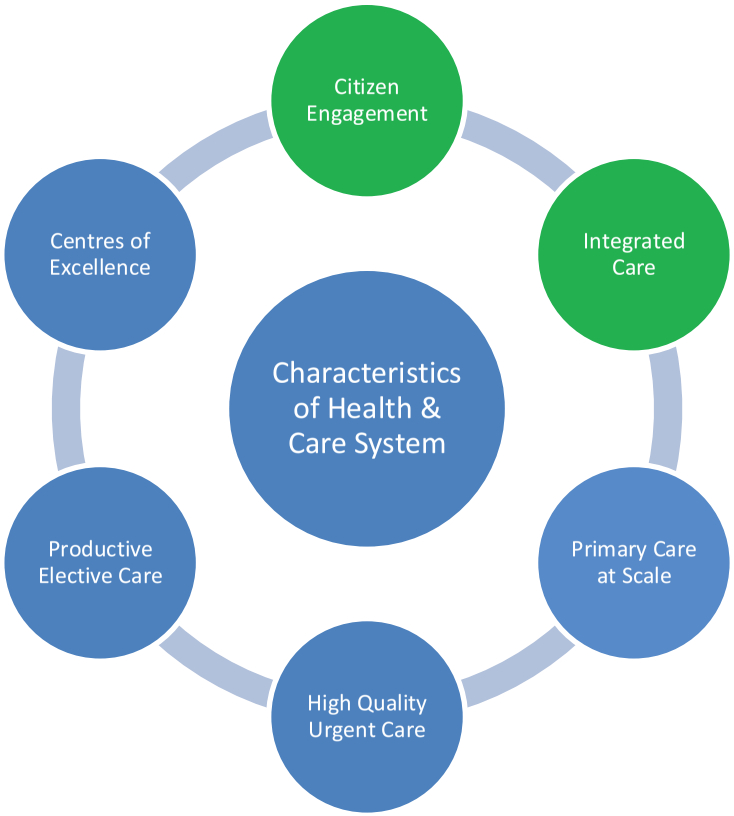
- Evaluate and review

2018/2019

- Evaluate and review

Anticipated Impact On The Six Characteristics of A Future Health and Care System:

Prevention including Self-Care



Denotes characteristics impacted

Citizen Empowerment and Engagement

Residents and patients contributing to the creation of the PSC strategy; and better able to take action for themselves, their children and families to stay fit and keep good physical and mental health, meet social and psychological needs, and care for minor ailments and long term conditions

Integrated Care

The systematic and structured inclusion of self-management approaches into strategic plans to improve integrated care ensures that people diagnosed with long term conditions requiring integrated care receive the full range of support available

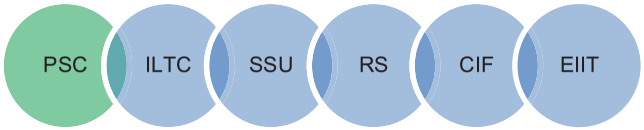
Primary Care Delivered at Scale

High Quality Urgent Care

Productive Elective Care

Reduced variation in referrals to hospital and community services, focussing on practices whose referrals rates appear to be lower than might be expected as well as those that are higher, and agreeing remedial action with the practices where necessary.

Specialist Services Concentrated in Centres of Excellence



Improving the coordination of holistic, multi-disciplinary Long Term Condition management (Diabetes)

High level description of the priority area:

Redesign of the Diabetes Care Pathway so that services are delivered by the most appropriately skilled person in the most appropriate setting and can respond to increasing demand. We will do this by taking a whole system approach, stressing the prevention and self care agenda by up-skilling primary and community care providers working in partnership with specialists in diabetes care. Patient engagement throughout will be crucial to ensure person centred and innovative services.

Rationale for Inclusion:

- The increasing numbers of people, particularly younger adults, with this progressive condition will have a considerable impact on primary, community, secondary and social care services in the future and consequently the CCG is looking to redesign the diabetes care pathway in order to prevent people developing the disease and to meet this rising demand.

The Local Case for Change:

- The local prevalence of diabetes is growing by 5% a year with increasing numbers of people aged 45 and under being diagnosed with type 2 diabetes
- Referrals to secondary care diabetes services are increasing by 7% year on year and up to 20% of all inpatients in the RUH now have diabetes
- Approximately 1400 diabetic medicine outpatient appointments were provided by the RUH in 2013/14, costing over £186,000 (BaNES patients only)
- BaNES has a significantly higher rate of major amputations than the England average

Our Approach:

Years 1-2

Initially, further benchmarking activity will be undertaken to more accurately determine future activity and spend. A Steering group with a sub group including patients and Diabetes UK representatives (if possible) will be established. Joint working arrangements with neighbouring CCGs will also be reviewed. Taking into account the review of current service provision and NICE guidance, the next stage will be to establish evidence based model and appraise the different funding mechanisms. All aspects of the diabetes care pathway will be taken into consideration when developing the new model and in particular, the CCG will review how the nine care checks are delivered and review the pilot of the community based Diabetes Specialist Nurse commissioned specifically to support primary care. It may be necessary to pilot the proposed model and consideration will also be given to piloting a current proposal from secondary care for a cluster based virtual ward in primary care with consultant input - a model which has proved successful elsewhere in the country.

Years 3-5

The redesigned services will be implemented, evaluated and reviewed during years 3-5.

It is also anticipated that education for both patients and health care professionals will need to be reviewed during this period in order to encourage patients to self-care and reduce variation in diabetic care between practices.

Expected Impact	Measures of Success
• Improved patient experience by ensuring patients receive high quality and timely care close to home	• *An increase in the percentage of patients receiving all nine care processes each year* • *Patient reported experience improves by the end of year 5. (Baseline not yet measured).*
• Start to halt the rise in type 2 diabetes and slow the progression of the disease in people who are already diagnosed by promoting self-management	• *Reduce the growth in referrals to Diabetic Medicine (outpatients) by year 5* • *The amputation rate per 1000 people with diabetes does not increase over the next 5 years* • *Start reducing the increase in type 2 diabetes by the end of year 5*
• Mitigation of some of the inevitable growth in spending on diabetes over the 5 year period	• *Reduce the growth in outpatient spend by year 5. However, spending on other areas like podiatry, specialist nursing and primary care may need to increase*
• Sufficient capacity within diabetes services to meet the needs of rising numbers of people with diabetes across different care settings	• *All patients with a foot care emergency will be referred to a multi-disciplinary team within 24 hours*
• Patients and clinicians are better able to manage diabetes	• *Safer use of medicines*

Timeline

2014/2015

- Establish diabetes steering group which has subcommittee which includes patients and, if possible, Diabetes UK representatives
- Review joint working arrangements with neighbouring CCGs
- Benchmarking, prediction of future activity and spend – note the review of current service provision
- Establish high quality evidence based model and appraise funding mechanisms
- Consider pilot of virtual wards in primary care with consultant input
- Consder impact of re-tendering community services on provision of diabetes services.
- Consider impact of CCG Strategy for Future of Primary Care and the potential need for investment in primary care in order to deliver the new model of diabetes care.

2015/2016

- Establish strategy to prevent diabetes with Public Health and the Local Authority
- Explore a 'one stop shop' for 9 care checks to promote self care
- Review community Diabetes Specialist Nurse pilot and consider future commissioning options
- Review and evaluate pilot

2016/2017

- Review education for both patients and health care professionals

2017/2018

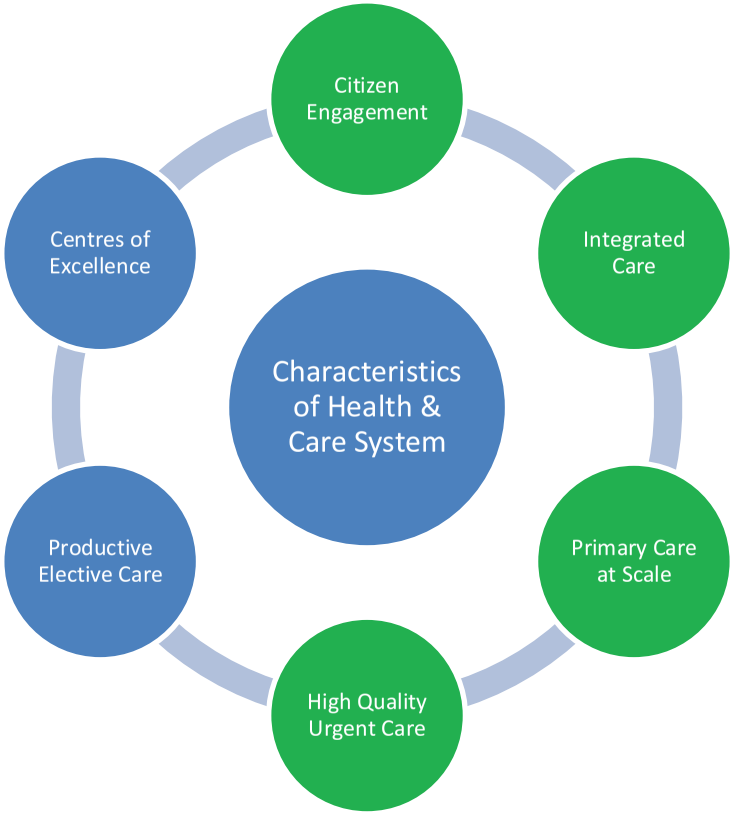
- Implementation of remodelled services.
- Evaluation and Review

2018/2019

- Implementation of remodelled services.
- Evaluation and Review

Anticipated Impact On The Six Characteristics of A Future Health and Care System:

Improving the coordination of Long Term Condition management



Denotes characteristics impacted

Citizen Empowerment and Engagement

The steering group will have a subcommittee which includes patients and, if possible, representatives from Diabetes UK..

Integrated Care

It is anticipated that the new model will provide integrated care delivered by a multi-disciplinary team.

Primary Care Delivered at Scale – This will depend upon the implementation of the CCG strategy for the future of primary care.

Primary care will deliver diabetic care to increased numbers of patients with support from consultants and specialist nurses.

Variation in diabetic care between practices will be reduced.

High Quality Urgent Care

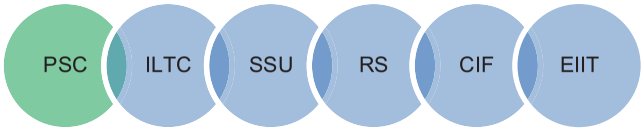
People with diabetic foot complications will receive rapid access (within 24 hours) to multi-disciplinary foot clinics

Productive Elective Care

N/A

Specialist Services Concentrated in Centres of Excellence

N/A



Creating a stable and sustainable Urgent Care system that can respond to changes in demand

High level description of the priority area:

The creation of a streamlined urgent care system to ensure patients are assessed and treated by the right professional with access to the right diagnostic equipment and interventions first time. The system will have sufficient capacity to respond to increasing demands from an ageing population and the number of people living with long term conditions and will self correct when patients present in anything other than the most appropriate setting.

Rationale for Inclusion:

- *An ageing population with increasingly complex needs is leading to ever rising numbers of people needing urgent or emergency care and placing significant pressure on accident and emergency services.*
- *Its recognised nationally that many people are struggling to navigate and access a confusing and inconsistent array of urgent care services provided outside of hospital, so they default to accident and emergency services peaks.*

The Local Case for Change:

- A new UCC, co-located with A&E opens on 1st April 2014. We need to review the impact of this, and 111, on MIU,
- Extend the role of ambulatory care pathways
- Need to move away from short term investment to support winter pressures and commission services that can respond to variation in demand, including

Our Approach:

- *We will create a system that provides better support for people to self- care allow patients to take control of their own health. To achieve this, we will provide better and more easily accessible information about self-treatment options so that people who prefer to can avoid the need to see a healthcare professional.*
- *We will work to ensure people with an urgent care need can get the right advice in the right place, first time, so patients with urgent but non-life threatening needs are provided highly responsive, effective and personalised services outside of hospital. To do this we will greatly enhance the NHS 111 service so that it becomes the smart call to make, creating a 24 hour, personalised priority contact service.*
- *We will develop highly responsive urgent care services outside of hospital by providing faster and consistent same-day, every-day access to general practitioners, primary care and community services such as local mental health teams and community nurses for patients with urgent care needs*
- *We will develop local networks to ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery supported by the presence of senior clinicians seven days a week to ensure the best decisions are taken.*
- *We will work to connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts. We will develop broader emergency care networks. These networks will dissolve traditional boundaries between hospital and community based services and support the free flow of information and specialist expertise needed to achieve the delivery of patient care in the most appropriate and convenient setting.*

Expected Impact	Measures of Success
• Reduced patient hand offs minimising clinical risk and incidents of avoidable harm	• *Reduction in incidents associated with avoidable harm due to clinical handover*
• Reduced ED attendances to be quantified	• *Year on year reduction of attendances to the ED*
• Reduced NEL admissions to be quantified	• *Year on year reduction of NEL admissions*
• Sustained delivery of the four-hour standard	• *Sustained delivery of national performance measures*
• Reduced dependency on bed based services with increased investment in community based services to support care at home	• *A reduction in long term placements of care*
• Improved patient experience through the reduction of repeating the same information to different professionals	• *Better access to patient information across multiple providers to support better clinical decision making*

Timeline

2014/2015

- Embed & assess the impact of the Urgent Care Centre on the urgent care system
- Monitor impact of Southmead Hospital move on system and urgent care flows
- Review role of the MIU at Paulton
- Review & agree Special Patient Notes usage across local health system
- Identify priority ambulatory care pathways for development
- Evaluate the 2013/14 winter pressure schemes
- Pilot Admission avoidance Scheme e.g. Raising the Threshold Project
- Fully embed Demand & Escalation planning
- Embed new DVT pathway & service

2015/2016

- Re-specify the role of the MIU as part of community services re-procurement
- Implement revised ambulatory care pathways
- Assess further scope for admission avoidance e.g. support for residential homes
- Review frequent attenders
- Commission winter pressure schemes on a substantive basis
- Evaluate effectiveness of admission avoidance initiatives

2016/2017

- Embed new MIU arrangements

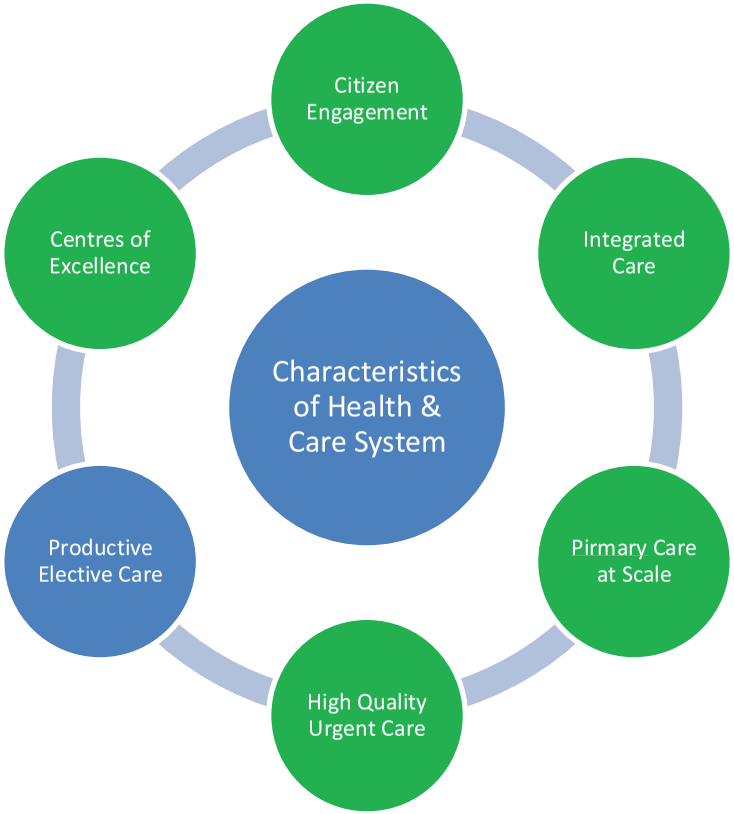
2017/2018

- Review potential to make further changes to urgent care pathways
- Prepare for re-commissioning of 111 services

2018/2019

Anticipated Impact On The Six Characteristics of A Future Health and Care System:

Stable and Sustainable Urgent Care



Denotes characteristics impacted

Citizen Empowerment and Engagement

Engaged patients will help ensure they are able to understand and navigate the urgent care system, choosing well and taking personal responsibility.

Integrated Care

The use of special patient notes will support integrated care, particularly during the out-of-hours period.

Primary Care Delivered at Scale

Primary care will be able to respond to the needs of their patients with urgent non-life threatening problems potentially seven days a week reducing ED attendances and emergency hospital admissions.

High Quality Urgent Care

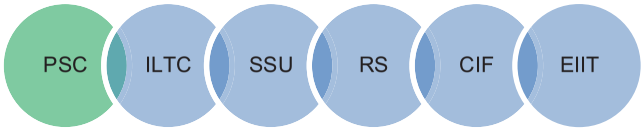
A streamlined urgent care system will reduce patient hand offs minimising clinical risk and deliver efficiencies to reinvest in other services.

Productive Elective Care

N/A

Specialist Services Concentrated in Centres of Excellence

Reducing unnecessary emergency hospital admissions and ED attendances will enable the secondary/tertiary care sector to focus on patients with more complex and specialist conditions.



Redesigning Musculo-skeletal pathways to achieve clinically effective services

High level description of the priority area:

A whole system review and redesign of Musculo-Skeletal services to achieve co-ordinated and integrated care across the entire MSK pathway. The review will potentially include the following services/specialties over the five year period:- Orthopaedics, Rheumatology, MSK Pain Management, Physiotherapy, Osteoporosis and associated Podiatry services.

MSK programme spend c. £20million/annum[1].

Rationale for Inclusion:

- MSK offers greatest scope for improving quality and reducing spend for BaNES CCG (CfV)
- Rheumatology services benchmark high for first outpatient attendances
- Highest non-elective opportunity - hip trauma diagnosis (latest data)
- LTC survey: 47% of respondents not very or not at all confident about managing their condition
- With ageing population, demand for MSK related services is set to increase significantly

The Local Case for Change:

- Commissioning for Value Insight Pack describes potential elective savings of £913k for BaNES if the CCG performed at the average of the best *similar* 10 CCGs
- This represents a reduction in 394 inpatient and day case admissions according to CfV data
- Average health gain expressed as QALYS would be 81 days for hip replacements and 164 days for knee replacements

Our Approach:

We will engage with providers, clinicians, patients, carers and voluntary organisations to develop an integrated model for MSK services and take a phased approach to review of each pathway with the model.

Our intention is to have a single point of access to the MSK service which will ensure:

- patients proceed along the most appropriate pathway
- prevent unnecessary referral to secondary care pathways
- seamless working across the various MSK specialities

In the first two years, we will review a number of pathways:

- pain management
- hip& knee replacement
- other orthopaedic including shoulder and spinal procedures
- rheumatology

We will also review physiotherapy provision and will begin to develop our approach to self care and management.

During years 3-5 of the plan, we will continue to review orthopaedic pathways and to evaluate those already implemented during years 1 and 2. We expect to have the integrated MSK service fully operational by Year 3, so we will increase our focus on how we can further support patients with self care and management, working in partnership with local providers and the voluntary sector, to ensure we provide a wide range of services to meet the needs of patients and to help improve their outcomes.

Expected Impact	Measures of Success
• Improved clinical & patient-reported outcomes	• *Improved patient experience and satisfaction, measured through specific surveys of MSK services, Friends & Family Test etc* • *Improved clinical outcomes measured through national benchmarking information*
• Earlier diagnosis and appropriate treatment; reducing surgery rates and disability	• *Shorter waiting times from diagnosis to treatment* • *Reduced inpatient and day case admissions to best practice levels*
• Better skill mix and increased system capacity	• *Additional capacity and capability developed in primary & community settings*
• More care delivered in community setting and reduction in acute	• *Reduced GP referrals to secondary care and fewer OP attendances (first and follow up).*
• Efficiency savings & financial sustainability from integrated service	• *Reduced spend on OP, day case and IP admissions*
• Increasing patient choice and improving partnership working, patient experience and engagement	• *Improved patient satisfaction, measured through surveys, Friends & Family Test etc* • *Proportion of people feeling supported to manage their condition*

Timeline

2014/2015

- Establish Project Group to oversee MSK workstreams
- Review current service specifications, activity and baselines assumptions by provider
- Stabilise current Rheumatology service arrangements working with Monitor
- Review of hip & knee pathway
- Review & agree changes to Pain management &Fibromyalgia Rheumatology pathway working with existing providers
- Scope potential for wider MSK pathway reviews

2015/2016

- Review physiotherapy provision in BaNES as part of preparation for community services tender
- Review of other Rheumatology pathways working with existing providers
- Pilot alternative pathways
- Start procurement of relevant community services as part of tender for community service re-provision

2016/2017

- Review a range Orthopaedic pathways in line with best practice
- Evaluate & review new Rheumatology pathways
- Evaluate & review Pain management pathways
- Develop further approaches to self care and management

2017/2018

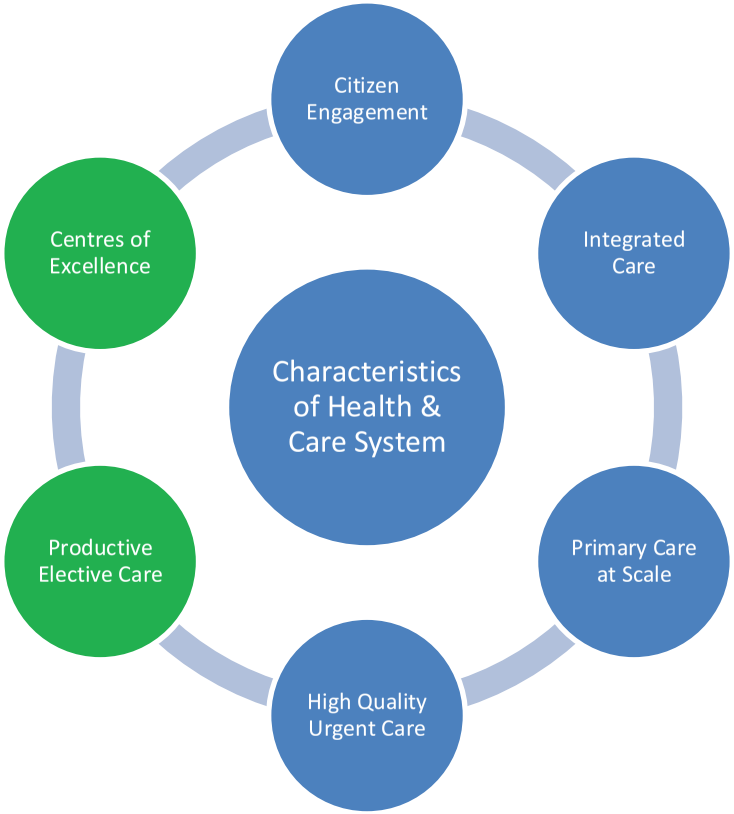
- Review a range of Orthopaedics pathways in line with best practice.

2018/2019

- Review a range of Orthopaedics pathways in line with best practice.

Anticipated Impact On The Six Characteristics of A Future Health and Care System:

Redesigning Musculo-skeletal pathways to achieve clinically effective services



Denotes characteristics impacted

Citizen Empowerment and Engagement

Integrated Care

Primary Care Delivered at Scale

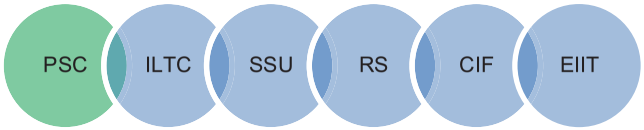
High Quality Urgent Care

Productive Elective Care

Implementing an integrated community model for MSK services will enable significant productivity gains. Enhanced primary and community services will support a reduction in elective hospital admissions with more patients treated at the same or lower cost and with better outcomes.

Specialist Services Concentrated in Centres of Excellence

- Increasing the delivery of MSK services in primary and community care settings will lead to a reduction in demand on acute services. This will enable the secondary/tertiary care sector to focus on patients with more complex and specialist conditions.



Commissioning integrated safe, compassionate pathways for frail older people

High level description of the priority area:

Delivering safe, compassionate care for frail older people through integrated health and social care community cluster teams

Rationale for Inclusion:

- The population is ageing and it is anticipated that there will be over 2.5 times as many people aged 80+ by 2026 compared with 1981.
- 73,000 people in BaNES have at least one long-term health condition and by 2025 the prevalence of dementia will have increased by 23% for women and 43% for men.
- Levels of avoidable harm are considerably higher than in younger age group, particularly associated with polypharmcy, falls, and pressure ulcers.
- The model builds on an established integrated approach to commissioning and delivery of health and social care.

The Local Case for Change:

- *By 2021 the number of people aged 75-79 will increase* by 27% and the number of people aged over 90 will increase by 39%
- Of those aged over 65, half have a least 3 chronic conditions and 1 in 5 have 5 or more chronic conditions.
- Meeting the target performance for the number of permanent admissions to nursing and residential homes for people over 65 has been challenging in 13/14.
- Implementation of a local service to provide more personalised care for older people in nursing homes has led to a 40% reduction in unplanned admissions.
- National guidance regarding evidence based best practice care for older people published by NHS England and King's Fund.

Our Approach:

Years 1 - 2

We will embed and develop the Community Cluster Team model and active ageing service in 2014/15 and identify other opportunities for co-ordinating and developing responsive services for frail older people, E.g. the utilisation of the £5 per head monies for GP management of over 75s and the role of practice pharmacists to link in and support the Multi-disciplinary team process.

Years 3-5

This workstream has many components and will impact on all parts of the health and social care system. In the longer term will continue to strengthen our approach to the management of frail older people through a range of initiatives including:-

i. implementations of the House of Care approach,

ii. continuing to review the evidence base and needs of dementia patients

iii. undertaking a comprehensive review of the evidence base for telehealth and develop a commissioning strategy

The Better Care Fund will be a key enabler to helps us commission integrated, safe and compassionate care for frail older people.

Expected Impact	Measures of Success
• Patients receive a seamless and integrated response appropriate to their assessed health and social care needs	• *% of patients being case managed by the Community Cluster Teams with a personalised care plan.*
• Patients are supported to live independently with care and support in settings of their choice	• *Permanent admissions of older people (aged 65 and over) to residential and nursing homes per 100,000 population. Current baseline 971 (2012/13)* • *Proportion of older people(65 and over) who were still at home 91 days after discharge from hospital into reablement*
• Patients are efficiently prioritised, directed and seen by the right health and social care professional and receive the right care and support	• *Delayed transfers of care from hospital per 100,000 population (average per month) Baseline 3.51% in 2012/13*
• People experience reduced loneliness and isolation through timely and targeted intervention	• *Numbers of 80 – 85 year olds seen by the active ageing service*
• Ensure people have a positive experience of care and support • Treat and care for people in a safe environment and protect them from avoidable harm	• *National metric – patient and service user experience*
• Reduced unplanned hospital admissions.	• *11% reduction in unplanned admissions for patients over 75*

Timeline

2014/2015

- Commence new community cluster model from April ‘14
- Embed links with the RUH ACE Unit and the community cluster team model
- Launch redesigned social care pathway with expanded reenablement service from July ‘14
- Confirm strategy for investing the £5 per head for primary care
- Roll out the active ageing service from 01.04.14
- Roll out personalised care plans shared and held by primary care & Sirona
- Risk stratification tool to be used by active ageing service and community matron using agreed criteria
- Sirona to implement frailty CQUIN
- Quality team to oversee work with all providers on safe, compassionate care
- Review the falls pathway in light of active ageing service
- Every patient to have a SPN
- Patients in the last 12 months of life to be on the EoLC register with DNACPR orders

2015/2016

- Adapt the community cluster team model in light of first year learning.
- Scope other LTC pathways that could be aligned to the five practice clusters.
- Review the impact of the 2nd 12 months of the dementia challenge fund projects with a view to extending, in particular assistive technology.
- Implement changes to the falls pathway.
- Undertake a comprehensive review of the evidence base for telehealth and develop a commissioning strategy

2016/2017

- Commission telehealth subject to the outcome of the evidence base review.
- Implement other LTC pathway changes to reflect the five practice clusters.

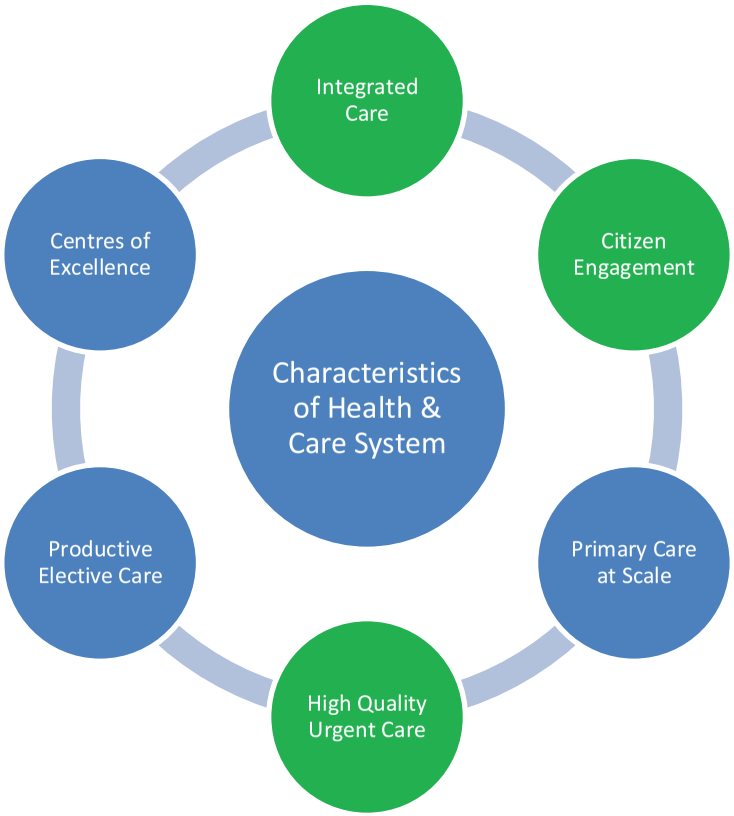
2017/2018

- Review potential to make further changes to the pathways for the frail elderly in light of evidence base and best practice.

2018/2019

Anticipated Impact On The Six Characteristics of A Future Health and Care System:

Commissioning integrated safe, compassionate pathways for frail older people



Denotes characteristics impacted

Citizen Empowerment and Engagement

Older people have choice and control and are involved in the decisions about their care and treatment. Their experiences and feedback about the quality or effectiveness of the services they have received will inform the commissioning of services.

Integrated Care

This will be achieved through an integrated approach from virtual teams of multidisciplinary staff based around the 5 practice and population clusters.

Primary Care Delivered at Scale

High Quality Urgent Care

The focus on risk stratification, care planning, special patient notes and the role of active ageing service should support a reduction in unnecessary emergency admissions to a secondary care setting and ensure that patients are treated in the right place.

Productive Elective Care

Specialist Services Concentrated in Centres of Excellence

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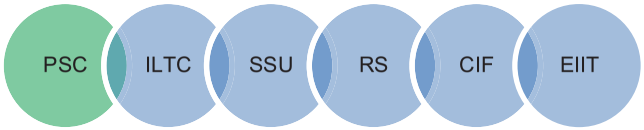


Ensuring the interoperability of IT systems across the health and care system

High level description of the priority area:

Improving the interoperability of electronic patient records systems to improve service efficiency, effectiveness and patient safety through better use of data so that patients and professionals can access the right information, in the right place, at the right time.

We are not looking to introduce common systems but rather focus on the application of shared data that will deliver improved communications between health professionals and better patient experiences and outcomes. The programme will include tactical gains through specific improvements to existing systems and the overall aim of ensuring patients know that any clinician treating them has access to any information relevant to their care.

Rationale for Inclusion:

- Clinical information relevant to a patient's care should be available to health and social care professionals at the time they are caring for the patient.
- Information should also be available to patients to promote patient empowerment and to improve accuracy.
- Clinical data is currently in separate silos across the BANES health community on a provider basis.
- The limited inter-provider record sharing that is in place has had positive feedback in terms of improvements to clinical care.
- Our 5 year strategic focus on the development of integrated models of care is predicated on the sharing of information across all care settings (including social care) and we need integrated solutions for care planning by 2016/17.

The Local Case for Change:

- Current IT infrastructure in BANES community is based in silos
- Our main local providers are in different places with regard to Electronic Health Records as evidenced in the NHS England sponsored Clinical Data Maturity Index
- There is limited technical and cultural interoperability of healthcare IT systems in place already. The approach is piecemeal with no agreed strategy across providers and commissioners as to the clinical vision for health record access and the means to deliver it

Our Approach:

This is a programme with long term aims and ambitions. As such the priorities in 2014/15 will be to establish the environment to deliver change.

This will include working with the West of England Academic Health Sciences Network to establish a pan-organisation working group. This working group will deliver an option appraisal identifying the individual organisations needs, potential technological solutions and identify learning from other healthcare communities.

This piece of work will act as the foundation for the health and social care community to develop a shared clinical vision for how record sharing will benefit our patients and local population.

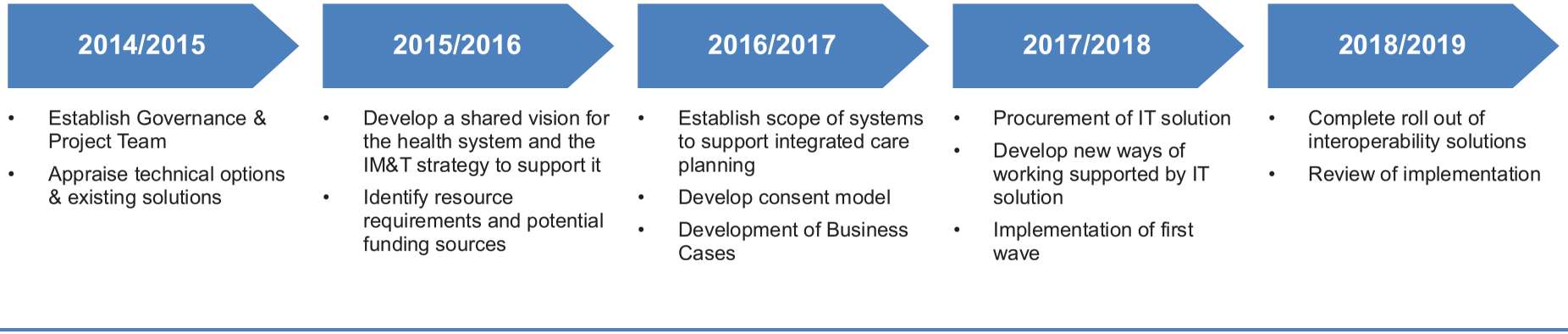
By the end of 2015/16 this clinical vision will be supported by a technical programme that delivers clearly aligned benefits.

During this period short term projects that are aligned with the overall direction of access to shared records will be actively sought and if appropriate pursued.

The success of this approach will stem from Interoperability of IT systems being seen not as an IT project but as a means of delivering improvements in patient care. As such the initial period will need to focus on engagement and goal-setting ahead of a technical phase to implement an IT solution.

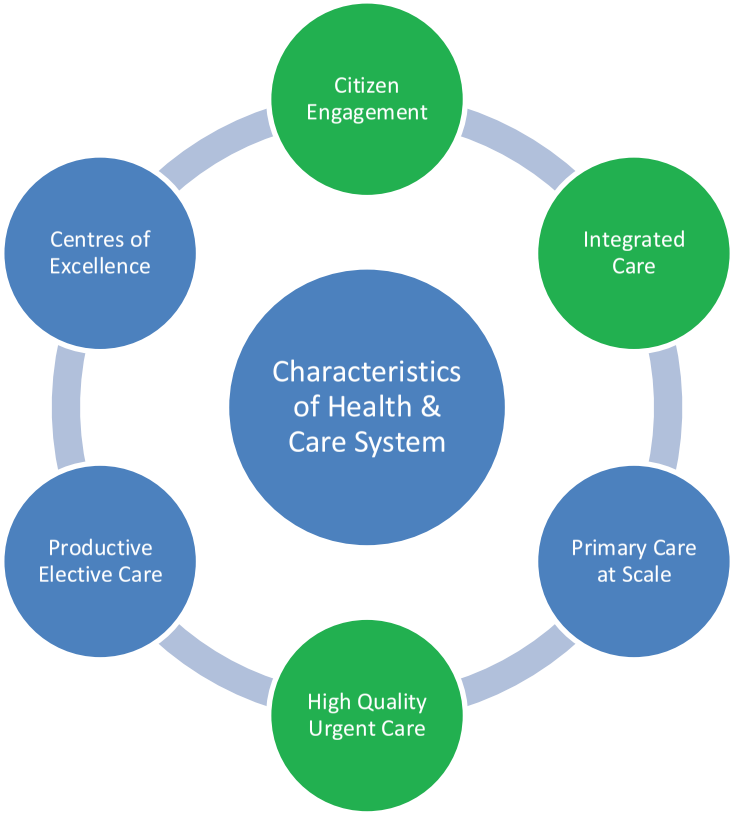
Expected Impact	Measures of Success
• Enable improvements in patient care due to shared information such as patient drugs to avoid medication errors and care plans to avoid unnecessary or delays in treatment	• *Depends on specific application. E.G. reduction in SUIs*
• Improve patient experience through the avoidance of repeating the same information to different professionals caring for the same patient	• *Friends and Family results*
• Reducing repetition across health and social care professionals can be seen to improve the efficiency of the workforce.	• *Improved work processes identified as part of the implementation E.G. removing dependency on fax*
• Increasing the secondary use of shared data would enable more informed commissioning decisions based on knowledge across care pathways	• *Commissioning decisions based upon data on pathways and not data silos*
• Despite the limited evidence base a reduction in unplanned short stay hospital admissions is expected	• *5% reduction in short stay emergency admissions* • *5% reduction in readmissions*
• The evidence base for improving interoperability is limited, one of the drivers for including this as a priority area is to assess/develop our own evidence base	• *Production of a discussion paper for publication that assesses the impact of work programme*

Timeline


2014/2015
• Establish Governance & Project Team
• Appraise technical options & existing solutions
2015/2016
• Develop a shared vision for the health system and the IM&T strategy to support it
• Identify resource requirements and potential funding sources
2016/2017
• Establish scope of systems to support integrated care planning
• Develop consent model
• Development of Business Cases
2017/2018
• Procurement of IT solution
• Develop new ways of working supported by IT solution
• Implementation of first wave
2018/2019
• Complete roll out of interoperability solutions
• Review of implementation

Anticipated Impact On The Six Characteristics of A Future Health and Care System:

Ensuring the interoperability of IT systems across the health and care system



Denotes characteristics impacted

Citizen Empowerment and Engagement

Patient access to their own records

Patients at the heart of the care model with relevant information flowing with them

Integrated Care

Care plans and treatment options being accessible (where appropriate) across organisations

Relevant health records being available to relevant health and social care professionals

Primary Care Delivered at Scale

High Quality Urgent Care

Decisions in urgent care made with access to more clinical information

Productive Elective Care

Specialist Services Concentrated in Centres of Excellence

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Anticipated impact of priority work programmes

	Quality	Financial
Increasing the focus on prevention, self-care and personal responsibility		
Improving the coordination of holistic, multi-disciplinary Long Term Condition management (focusing initially on Diabetes)		
Creating a stable, sustainable and responsive Urgent Care system		
Commissioning integrated safe, compassionate pathways for frail older people		
Redesigning Musculo-Skeletal pathways to achieve clinically effective services		
Ensuring the interoperability of IT systems across the health and care system		

Anticipated impact of priority work programmes - Key

	**Sustains** quality at current level	**Sustains** financial performance at current level
	**Marginal** improvement in quality	**Marginal** improvement to financial sustainability
	**Moderate** improvement in quality	**Moderate** improvement to financial sustainability
	**Significant** improvement in quality	**Significant** improvement to financial sustainability

Chapter 6 – The Impact of Our Plan on the Health and Care Economy

We want to ensure that the implementation plans to deliver our proposals are robust and have the support of the stakeholder organisations who will form part of our delivery team. These organisations, together with our patients and the public, will be those most likely to be impacted by our change programme. As a result, this section will continue to develop iteratively up until the 20th June submission date.

Throughout this strategy we have referenced our intention to continue to champion the promotion of integrated health and social care commissioning and delivery of services and our aspiration to shift resources from costly acute based services 'upstream' in order to focus on prevention and sub threshold interventions and where possible commission high quality services at lower unit costs that enable us to continue to meet the needs of our population within the bounds of our financial allocation.

As we continue to develop our implementation plans we will be mindful to consider the 'type' of care provided and the setting and skill mix required to provide that care, rather than focusing on specific institutions and will continue to focus on how our plan will impact on the following four domains:

Our local ambitions for the 7 Outcome Ambitions

The table below details our current performance against the seven outcome ambitions set by NHS England and the planned improvement we expect to see by the end of 2019.

.Outcome Ambition	Measure	Current Performance	Year 1 2014 / 15 Performance	Year 2 2015 / 16 Performance	Years 3 to 5 2016 / 17, 2017 / 18, 2018 / 19
Securing additional years to life for the people of England with treatable mental and physical health conditions	Potential year to life lost from conditions considered amenable to healthcare	Top 25% CCGs nationally (2012)	3.2% decrease from baseline, as quality premium target	1% decrease from 2014/15	Further 1% decrease each year
Improving the health related quality of life of people living with one of more Long Term Condition, including mental health conditions	Health related quality of life for people with Long Term Conditions (questionnaire)	Top 25% CCGs nationally (2012)	77.6% Slow increase to reflect high starting	77.8% point and rising expectations	78.0%, 78.2%, 78.4% Continuing slow increase.
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	A composite measure of: - Unplanned hospitalisation for chronic ambulatory care sensitive conditions - Unplanned hospitalisation for asthma, diabetes and epilepsy in U19s - Emergency admissions for acute conditions that should not usually require hospital admission - Emergency admissions for children with lower respiratory tract infections	Top 25% CCGs nationally (2012)	10% decrease from baseline	Further 5% decrease from 2014/15	Further 6%, 6%, 7% reductions by year Reaching 1,100 in 2018/19.
Increasing the proportion of older people living independently at home following discharge from hospital	Proportion of older people still at home 91 days after discharge from hospital into reablement / rehabilitation service.	86% (120/140) for 2012/13	83% (455/550) – significant growth in service	No target set	No target set
Increasing the number of people with mental and physical health conditions having a positive experience of hospital care	Patient experience of inpatient care - average number of negative responses per 100 patients	Top 25% CCGs nationally (2012)	Decrease to 121. 12% above current best CCG – from 14%	Decrease to 119. 10% above current best CCG.	Decrease to 117, 115, 114. Finishing 5% above best current CCG.
Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	Patient experience of primary care - average number of negative responses per 100 patients.	Top 25% CCGs nationally (2012)	Decrease to 3.7. 5% closer to the current best CCG	Decrease to 3.6. A further 4% closer to the current best CCG	Decrease to 3.5, 3.4, 3.3. Finishing 18% above current best CCG.
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	Measure in development	N/A	No target set	No target set	No target set

Ensuring Financial Sustainability

Through the implementation of our commissioning priorities we expect to create with our partners a health and social care economy which is able to meet the needs of our population whilst remaining financially sustainable. We will be confident that we are using our resources to deliver the safest and most effective care to meet patients' mental and physical health needs at the best obtainable value, and that we undertake proportionate checks to ensure this remains so. Where there are clear benefits to doing so, our resources will be differentially targeted to improve the likelihood of all members of our population accessing services effectively and obtaining good outcomes.

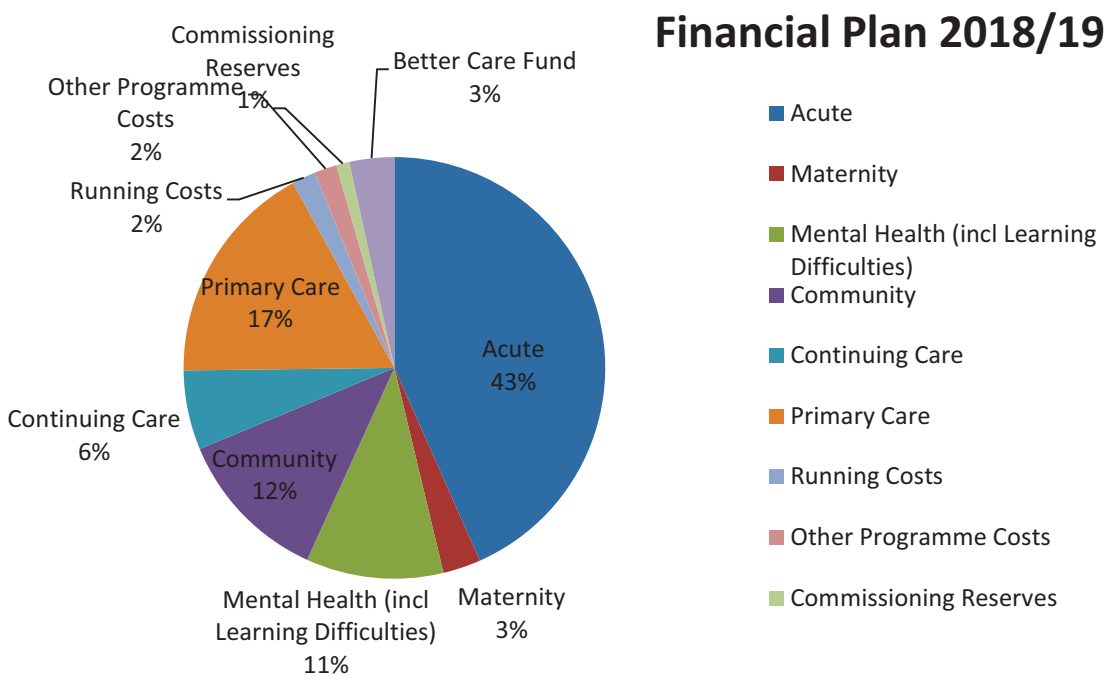
All providers who deliver good quality services which represent value for money will be able to thrive because they are fairly rewarded for their contribution to the health economy and they have the opportunity to work in partnership to share risks and gains and to drive beneficial change. For elective care, activity locations will be driven by objectively informed patient choice, allowing providers who offer the services required by commissioners in a way which is also attractive to patients to succeed. Core services will be delivered at a scale which protects clinical quality, maintains accessibility for patients, and allows providers to operate as efficiently as possible.

The Better Care Fund will be well established and functioning to support the expansion and consolidation of integrated care, with continuing carefully structured and sustainable transfer of funding into early and effective interventions to avoid cost at a later stage.

We will have in place longer term contracts which give providers confidence to invest in beneficial change, and will be using new forms of contract where these are the best way to reward and support providers to deliver innovative and effective care models. This will allow providers to pool their strengths and expertise across the traditional boundaries between secondary, community and primary care, increasing their organisational sustainability. Where necessary to sustain models of care which have demonstrated their benefits, we will be using the available flexibility to determine locally agreed prices if suitable national prices do not exist.

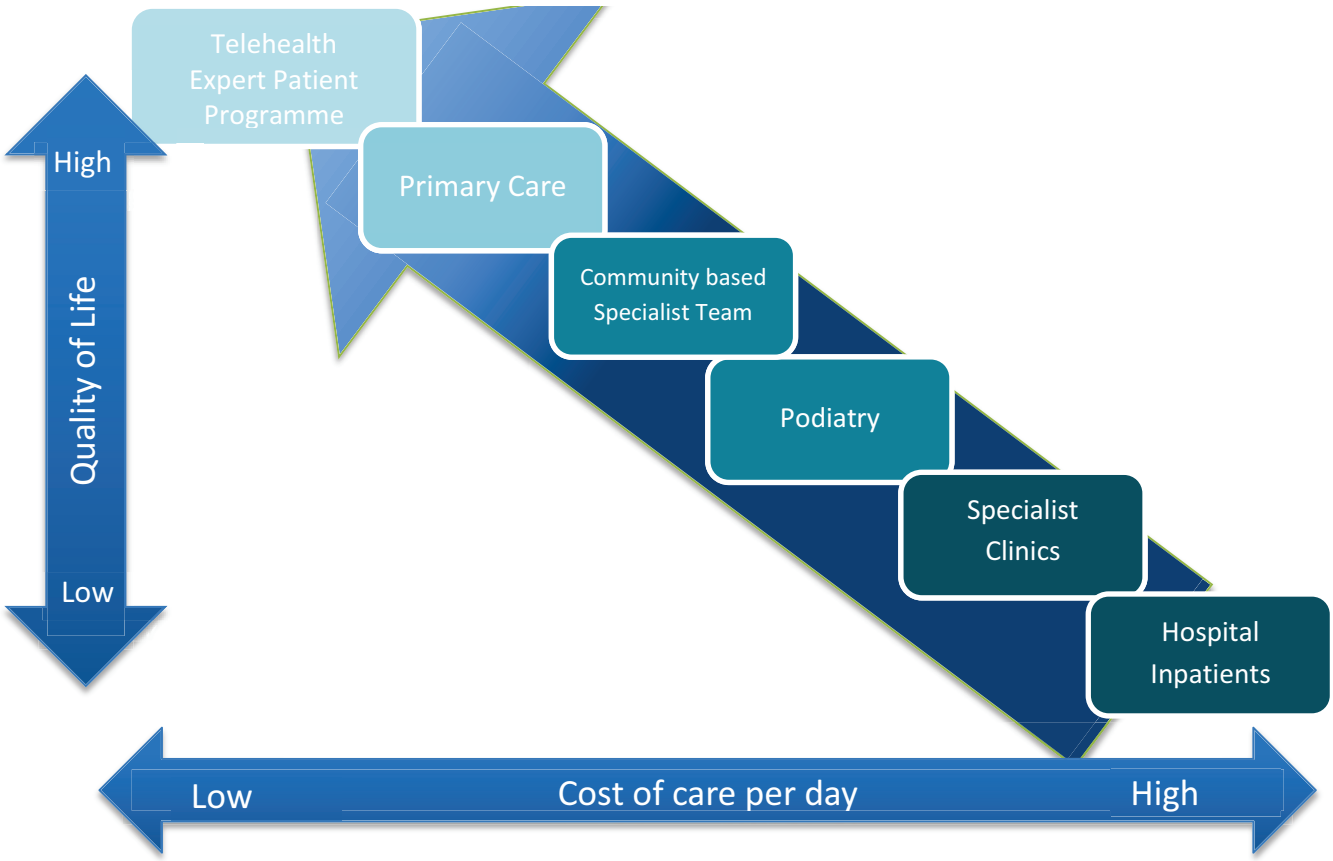
We will be spending more of our resources on community and primary care based services for both mental and physical health care, and seeing more people within these settings. We expect that the smaller number of people treated in hospital settings will have a higher unit cost of treatment than currently, as they will be the most poorly people in need of the most resource-intensive care. The chart below shows how we expect to spend our allocation by type of care in 2018/19.

Figure 19: Financial Plan 2018/19



The detailed impact of our financial plans is set out in Chapter 9.

Figure 20: Shifting Resources – LTC (Diabetes)



The impact of our plans on patients

Set out below are some illustrative examples of the impact of our plans on patients, these are shown as patient stories.

Increasing the focus on prevention, self-care and personal responsibility

(This is a live story and patient has consented via Sirona to give name)

Keeping up with her five grandchildren over the summer holidays has made Anne realise how much she has gained from tackling her smoking habit. From Gromit-hunting in Bristol to long days out exploring, Paulton resident Anne, 58, says the youngsters have been keeping her busy – but now she can take it all in her stride.

She said: “When we were out looking for Gromits we walked miles and miles up hills! Before, I would get halfway up a hill and have to stop because I couldn’t breathe. You suddenly notice the difference and think ‘I couldn’t have done that before.”

Despite not having had a cigarette for 16 weeks Anne, who began smoking at the age of 14, says she is still taking it one day at a time. “I had tried to give up before and it would be a month if I was lucky,” she said. “I think this time I have looked at it differently. I won’t say I’ve given up, I just say I haven’t smoked for however many days or weeks, then you don’t set yourself up for a fall. I am quite pleased with myself for reaching 16 weeks.”

“The girls up there are absolutely brilliant,” she said. “There is no pressure on you and you can have a laugh and a joke with them. “You aren’t just in a little room with the advisor, you meet other people who are giving up, too, and you don’t feel awkward about butting in to say ‘Have you tried this or that?’ “Afterwards we will all sit down and chat generally about how we are doing, which is what I like.”

Anne has used a combination of patches, sprays, an inhalator and lozenges to beat the cravings – but found she has had days recently where she hasn’t needed anything at all.“ Before, if I knew I didn’t have any cigarettes in the house I would go to bed and feel panicky all night,” she said. “Smoking was like a comfort blanket and if I can get this far then I know other people can do it.”

Anne is also attending a Weight Watchers slimming club through the Healthy Lifestyle Service, losing 11 pounds so far. If you would like to find out more about beating your smoking habit or slimming advice, contact Sirona’s Healthy Lifestyle team on 01225 831852 or visit www.sirona-cic.org.uk.

Our pledge is to continue to work in partnership to ensure continued person centred and innovative services

Urgent Care System

(The name of the patient has been changed)

Innovative working between the South West Ambulance Foundation Trust and local GPs has already had a positive benefit on patient safety and improved outcomes for patients. Earlier

senior clinical decision making taking place has enabled patients to access the right services earlier in their journey

Recently GP support of a patient and his family at the end of his life enabled everyone to make what was felt to be the right decision for him which was to remain at home. Even while he was very ill Stephen had insisted on remaining independent, walking to the pharmacist to collect his medication and cleaning the car on Sundays. He wanted to remain at home to die with his family around him. He deteriorated more quickly than was expected however and his family were afraid for him and the pain they knew he was in. In the early hours they called 999 for him to be taken to hospital. Strong competent decision making between the paramedics and the GP however supported Stephen and his family in these difficult circumstances and enabled the appropriate support to be given enabling Stephen to be cared for at home throughout

Our pledge is to continue to work in partnership with our patients and their families to ensure continued person centred, safe compassionate care given in the right place at the right time by the right people

PART C

Making Change Happen

Chapter 7 - How we will commission services

We have invested time as a Clinical Commissioning Group in agreeing our collective understanding of what excellent commissioning looks like, and determining a set of key principles and values which will define the way in which we lead the health care system.

We believe that our primary role as commissioners is to deliver change that drives improvements in the performance and productivity of systems and services so that the patients we serve have healthier and longer lives.

Although there is a temptation to look towards bigger, bolder and more radical change schemes or seek confidence in a high volume of schemes we believe that our strategy is best be achieved by a number of prioritised carefully sequenced change programmes that will release early benefit.

We will be more sophisticated in driving performance, sequencing change and using clinical and patient engagement:

- To tune our system to the demand that is placed upon it
- To ensure our pathways are designed so that patients are eased from sub-optimal to more appropriated care setting and that there are multiple opportunities to do this along each pathway
- To embed support for health management and self-care within provider contracts
- To align incentives for improved outcomes and nullify the impact of perverse incentives
- To put in place the enablers of integrated working and care delivery.

We are keen to define a new model of commissioning that plays to the strengths of the CCG. This means more reliance on clinical engagement, partnership working and clinical productivity improvement. We do not believe in confrontational approaches to commissioning that have the potential to slow implementation.

Similarly, we will expect providers to seize the opportunities they have to deploy more efficient and effective models of care, exploit new technologies where there is a clear investment case and drive benefits through co-operative working with other organisations for the benefit of local people.

We believe this five year plan enables us to seize the opportunities of strong historic performance to make a step change in improvement in the care delivered to local people.

Chapter 8 – Our Financial Plan

The Context

The existing financial position of the CCG is characterised by:

A stable financial position founded on the predecessor PCT's history of achieving financial balance and delivering savings targets year on year, and linked with allocation levels identified as above target for our population

Key local providers emerging successfully from periods of financial challenge and difficulty in meeting targets

Established use of section 75, section 10 and section 256 flexibilities to support integrated commissioning and provision and the associated delivery of improved quality seamless services representing better value for money

Our available financial resource to deliver our commissioning priorities over the next five years will be influenced by:

Limited increases in allocation as a result of national economic constraints and a national commitment to move all CCG's allocations closer to the target level for their population

Demographic growth which is below the national average overall, but shows a disproportionate increase in the oldest members of our population, who are likely to be more frequent and more intensive users of health services

An increase in the numbers and life expectancy of people with complex or multiple disabilities or conditions, who are also likely to have a higher level of need for health services

The local effect of national economic constraints in areas which impact on health service use, including a £27m savings target faced by our Local Authority partners and an estimated £40m adverse impact on the local economy of welfare reform

Our vision is to create a sustainable health system within a wider health and social care partnership in which we are confident that the following principles hold true:

Resources are used to deliver the safest and most effective care to meet patients' mental and physical health needs at the best obtainable value

Providers are able to thrive because they are paid fairly and equitably for delivering good quality, value for money services which meet the needs of our population

Core services are delivered at a scale which protects clinical quality, maintains accessibility and choice for patients, and allows providers to operate as efficiently as possible

Change is achieved through a shared understanding and ownership of goals, delivery mechanisms and risks, supported by clever use of incentives and flexibilities

The Better Care Fund is well established as a truly effective method of expanding and

consolidating integrated care, reaching far beyond its initial mandated scale, and drawing strength from the involvement of a wide range of partners

The key elements of our strategy to deliver this are:

Realistic financial planning to meet both commissioning objectives and statutory duties and targets, which takes into account risks, sensitivities and delivery capacity and anticipates how these will be managed

Active management of the provider market, where appropriate in collaboration with our Local Authority partners and other health commissioners

Use of the levers and incentives available to us to encourage and facilitate innovative change in line with our commissioning strategy, for example by supporting pilots to test the effectiveness of proposals where no evidence exists, or through aligned CQUIN schemes across providers

Effective use of our non-recurrent resources to support providers in responding to change, for example by allowing a phased reduction in costs to maintain stability as income reduces, or by funding additional costs to ensure a smooth and safe change to a new service model

Exploiting the particular opportunities offered by the Better Care fund to develop further a broad based and sustainable integrated care system

Resolution in taking difficult decisions, for example to disinvest in an ineffective service where this is in the best interests of patients and of the wider health and social care community

A move away from traditional approaches to both delivering and paying for care, where this best supports improvements in quality and cost-effectiveness. We will look towards the use of emerging innovative contracting and payment mechanisms such as Single Accountable Provider contracts, use of tariff flexibilities, and subscription based payment models

Seeking an equitable sharing of risks and gains between partners within the system, where they work together to deliver beneficial change

Use of clinical intelligence, stakeholder intelligence, analysis of comparative and other data, and procurement mechanisms to continually test whether resources are directed to best effect

Financial Plan Forecasts

We have developed our financial plan to support the achievement of our strategic commissioning objectives and the delivery of the transformation programmes focused on our six priority areas outlined in chapter 6 within a sustainable and successful health economy, whilst meeting our statutory financial targets and duties.

A summary of our planned Income and Expenditure position, for the outturn year 2013/14 and the forecast years 2014/15 to 2018/19, is set out in the table below.

Table 9: Income and Expenditure Position

Revenue Resource Limit						
£ 000	**13/14**	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**
Recurrent Programme Allocation	207,544	208,980	212,584	216,411	220,089	223,831
Non-Recurrent Allocation	7,778	3,062	3,167	2,233	2,262	2,299
Running Cost Allocation	4,660	4,655	4,178	4,166	4,151	4,137
Total	**219,982**	**216,697**	**223,274**	**226,155**	**229,847**	**233,612**
Income and Expenditure						
Acute	118,455	109,976	106,364	105,367	103,122	100,931
Mental Health	22,100	23,028	22,912	22,650	22,791	22,869
Community	22,043	22,972	22,592	22,514	22,428	22,395
Continuing Care	13,175	14,184	21,405	21,694	21,780	21,754
Primary Care	28,104	30,292	31,371	32,424	33,578	34,842
Other Programme	8,600	7,341	9,987	12,817	17,401	22,013
Total Programme Costs	**212,477**	**207,793**	**214,631**	**217,467**	**221,101**	**224,804**
Running Costs	4,440	4,654	4,176	4,164	4,149	4,135
Contingency	-	1,083	2,233	2,262	2,298	2,336
Total Costs	**216,917**	**213,530**	**221,040**	**223,893**	**227,549**	**231,275**
£ 000	**13/14**	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**
Surplus/(Deficit)	3,065	3,167	2,233	2,262	2,299	2,337
Surplus/(Deficit) %	1.39%	1.46%	1.00%	1.00%	1.00%	1.00%
Net Risk/Mitigation		1,866	1,733	362	598	636

Risk Adjusted Surplus/(Deficit)	5,033	3,966	2,623	2,897	2,973
Risk Adjusted Surplus/(Deficit) %	2.32%	1.78%	1.16%	1.26%	1.27%

The forecast financial position presented above is based upon the following key assumptions:

Revenue Resource Limit: for 2014/15 and 2015/16 is the notified resource allocation for the year. We have applied the national growth assumption of 1.8% for 2016/17 and 1.7% each year thereafter.

Running costs: for 2014/15 and 2015/16 is the notified resource allocation including a 10% decrease in 2015/16, reducing by a marginal amount each year thereafter, in line with the national guidance.

Provider efficiency: 4% p.a. in line with the national guidance.

Provider inflation acute: in line with the update to Everyone Counts guidance, issued on 24 January 2014 (2.8%, 2.9%, 4.4%, 3.4%, 3.3% 2014/15 to 2018/19 respectively).

Provider inflation non-acute: in line with Everyone Counts guidance (2.2%, 2.2%, 3.0%, 3.4%, 3.4% 2014/15 to 2018/19 respectively).

Primary care prescribing inflation: 4% p.a. based on local determination (in range of the national assumption).

Continuing Health Care inflation: 2% p.a. based on local determination (in range of the national assumption).

Demographic growth: based on ONS 2011 mid-year population projections, modelled at HRG level for inpatients and specialty level for outpatients.

General contingency: 0.5% in 2014/15, then.1% p.a. which meets the minimum national requirement.

Non-recurrent headroom: set aside at 2.5% in 2014/15, with 1% to be applied to transformative schemes including preparatory work associated with the Better Care Fund. Set at 1% in subsequent years, in line with national requirements.

CQUIN: Available to providers at 2.5% p.a. in line with the national guidance.

£5/head for GP practices to support their work with over 75s: in line with national guidance.

Surplus: 1% p.a. in line with the national assumption, with a further £1.0m in 2014/15 relating to maintaining the additional surplus generated in 2013/14. Recurrent underlying surplus in excess of 2% in line with national requirements

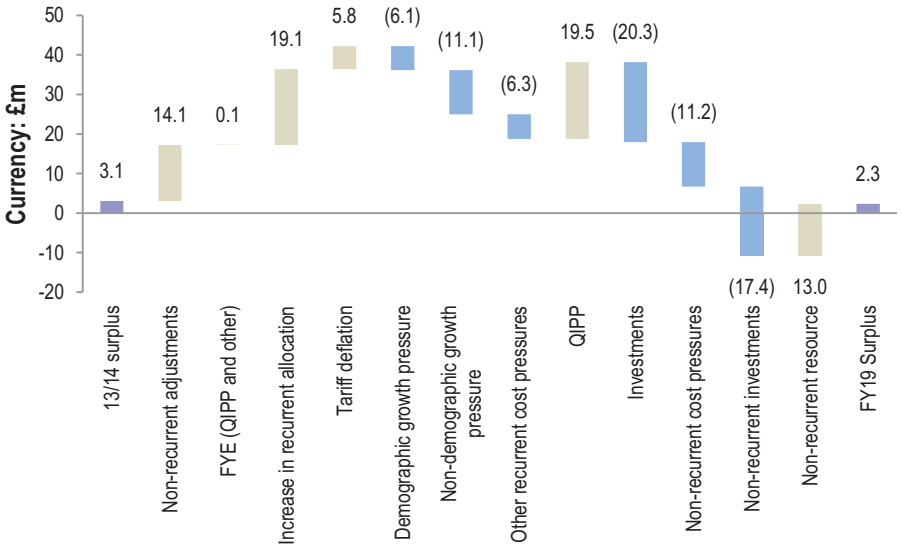
Better Care Fund: CCG contribution to establish the Fund at a value of £12.0m in line with the published allocation requirement.

Activity: where we anticipate activity changes resulting from the above assumptions and our QIPP and investment schemes, the financial impact is based on a costed assessment of the movement in activity

Where we have not yet confirmed the allocation by programme of investment, resource releasing schemes (QIPP) or contingency in future years, these are included within Other Programme costs in the Table.

The bridge chart below summarises the key movements between the 2013/14 outturn position and the planned position by the end of 2018/19.

Figure 21: Bridge Analysis of Key Movements 2013/14 to 2018/19



QIPP

As identified in the bridge above, to achieve our 1% annual surplus, whilst delivering the change associated with our commissioning priorities, we have a resource releasing (commissioner QIPP) requirement of £19.5m over the period 2014/15 to 2018/19.

We have developed delivery plans to release resources to this level which align with our vision for the future shape of services. 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 presented in the table below. Whilst provider efficiency requirements will be delivered through internal cost improvement initiatives, it is essential to ensure that these are understood alongside commissioner QIPP plans.

Table 10: Commissioner QIPP					
£ 000	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**
Transactional productivity and contractual efficiency					
Acute contracts	1,134	-	-	-	-
Mental Health	266	-	-	-	-
Prescribing	302	250	-	-	-
Other programme services	80	109	-	-	-
Sub Total	**1,782**	**359**	**-**	**-**	**-**
Transformational service re-design and pathway changes					
Acute contracts	2,135	2,510	2,194	1,534	1,520
Community	-367	222	285	111	111
Continuing Care Services	200	200	276	526	636
Prescribing	150	150	400	350	350
Other programme services	67	-			
Mental Health	-	260	250	150	150
Run costs	-	478	-	-	-
Sub Total	**2,185**	**3,820**	**-**	**-**	**-**
Unidentified QIPP			**868**	**883**	**711**
Total Commissioner QIPP	**3,967**	**4,179**	**4,273**	**3,554**	**3,478**
Provider Efficiency	6,187	6,105	5,997	5,940	5,879
Total Health Community Savings	**10,154**	**10,284**	**10,270**	**9,494**	**9,357**

The table shows the net impact of commissioner QIPP including investment to deliver schemes, where this is required. A negative figure therefore denotes a net investment in a programme area to support delivery of schemes in other programme areas in that year.

Our 2014/15 plans focus largely on the completion of schemes already in place, which are consistent with the overall direction of our strategic priorities but not all directly linked to their delivery. Our key areas of change are redesigned elective care pathways, referral support, the opening of the Urgent Care Centre, and the community cluster team model. In subsequent years our plans are more directly aligned to the six specific priority areas we have identified, although we continue to test all areas of spend to ensure any resources not being put to best use are identified and released.

Investments

We have set aside recurrent and non-recurrent funding to support delivery of our strategic priorities and to address unavoidable cost pressures during each year of our plan. The

value of funds earmarked for general investment and a summary of our plans for using them is provided in the table below.

Table 11: Recurrent Investments					
£ 000	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**
Acute contracts	300	125	-	-	-
Community	513	425	292	142	100
Local Authority	25	-	-	-	-
Mental Health	815	741	167	242	250
Primary Care Services	1,002	650	492	142	100
Other programme services	114	349	249	449	450
Better Care Fund	-	7,845	-	-	-
Sub Total	**2,769**	**10,135**	**1,200**	**975**	**900**
Held for in year priorities	**473**	**170**	**169**	**169**	**168**
Investment to be identified	**-**	**-**	**830**	**1,095**	**1,210**
Total Recurrent Investment	**3,242**	**10,305**	**2,199**	**2,239**	**2,278**

Table 12: Non-Recurrent Investments					
£ 000	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**
Acute contracts	1,777	1,024	1,128	567	100
Community	486	158	167	67	67
Continuing Care Services	-	50	-	-	-
Mental Health	422	83	67	67	67
Primary Care Services	960	618	167	67	67
Other programme services	629	51	499	449	399
Sub Total	**4,274**	**1,984**	**2,028**	**1,217**	**700**
Held for in year priorities	**127**	**175**	**170**	**169**	**169**
Investment to be identified	**-**	**-**	**-**	**848**	**1,403**
Total Non-Recurrent Investment	**4,401**	**2,159**	**2,198**	**2,234**	**2,272**

In addition to these general investment sources, we recognise the following:

£5 per head of population for GPs – this has been set aside recurrently from 2014/15 and we will agree plans for its use with our GP practices which fairly reward extra work undertaken in support of the over 75s which delivers measurable benefits. We will focus particularly on implementing the accountable lead professional role and in reducing emergency admissions for this age group.

Quality Premium – we have excluded both funding and expenditure from our financial plans at present because the annual value we might receive is unknown. We intend to apply the full value available to quality-related initiatives in line with our strategic priorities and to use the opportunity to focus on areas which may be less successful in attracting funding from other sources.

Readmissions – we have committed to reinvest funding withheld from providers in respect of avoidable readmissions in services which are linked to improvement in this area, for as long as such funding is generated through the application of tariff rules.

Non-elective threshold – we have committed to reinvest funding withheld at 70% of the full cost of non-elective activity above a set threshold, to support providers in schemes linked to effective management of emergency activity, for as long as such funding is generated through the application of tariff rules.

Better Care Fund

We have agreed a plan with our Local Authority partners which commits to preserving and building on our existing financial commitments to the delivery of integrated care to create the Better Care Fund as a minimum at the nationally mandated value. Alongside this we will sustain our existing pooled budget arrangements and will consider whether and to what timescale the creation of a larger and more encompassing Better Care Fund might be beneficial. Our priority is to use the stability afforded us by our historical investment in integrated care and the sophistication of our joint commissioning arrangements to ensure the additional funding committed to the Fund in 2015/16 is able to deliver effective transformational change for service users, patients and their carers, reducing the pressures on both social care and acute health care services.

Capital Expenditure

Having reviewed our priority programmes of work in consultation with NHS Property Services, we do not anticipate any significant changes to existing estate as a result of our plans and have not included any capital expenditure in our financial plan, except for one low value capital grant. Our focus in the early years of the plan is to work with NHSPS to ensure excess or underutilised space is either disposed of or tenanted, removing costs of vacant space chargeable to the CCG. This forms part of our resource releasing plans.

Balance Sheet and Cashflow

We have prepared balance sheet and cashflow projections for 2014/15 and 2015/16. We do not anticipate any difficulties with either working capital or cashflow during the planning period.

Financial Risk and Mitigation

We have reviewed our financial plans to assess and quantify the level of risk to delivery, and to ensure a sufficient value of available mitigations is in place to manage any risks which materialise whilst sustaining a balanced financial position and continuing to deliver our commissioning priorities. As demonstrated in Table 9, we are confident that our net risk position is positive, i.e. that we have sufficient value of mitigation to offset identified planning risks and still deliver our target surplus.

We will undertake more detailed sensitivity analysis on our financial planning assumptions in the course of finalising our strategic plan.

We have identified a number of areas of potentially significant risk throughout the planning period:

- Unanticipated demand in excess of that directly linked with demographic change, particularly in non-elective activity, and including acuity as well as volume factors
- QIPP plans do not deliver the expected activity shifts or reductions and corresponding cost release
- Tariff does not deliver the expected provider efficiencies locally
- Running costs are not contained within the notified allocation due to higher than anticipated legal or procurement costs, or failure to deliver planned cost reductions
- Newly designed and introduced services do not have the expected impact or volumes

The following actions have been identified to avoid, manage or mitigate the impact of those risks which materialise. We will:

- Maintain an appropriate level of general and specific recurrent contingency reserve
- Divert uncommitted investment funds
- Postpone approved investment schemes due to start in year
- Prioritise uncommitted spend to enable prompt and flexible response to either limitation or opportunity
- Identify future year savings schemes which can be accelerated if required, or introduce new schemes
- Enter into risk and gain sharing arrangements with partner organisations
- Bid for funding from additional sources in where it is available to meet specific risks or pressures, for example winter funding

Sensitivity Analysis

Sensitivity analysis has been carried out against a number of key planning assumptions within the 5 year plan to assess the financial impact of a variation to existing assumptions.

The key planning assumptions flexed for this analysis are:

- CHC price inflation increasing to the midpoint of the nationally expected range
- Prescribing price inflation increasing to the midpoint of the nationally expected range
- Demographic growth increasing above the anticipated rate by 25%
- Acute tariff not delivering locally in line with national %'s, with inflation flexed by 0.5%

The current programme expenditure and surplus over the 5 year period 2014/15 – 2018/19 is included within the table below, followed by the impact of changing each assumption in isolation.

Current summary

Total Programme expenditure	207,793	214,631	217,467	221,101	224,804
Surplus	3,167	2,233	2,262	2,299	2,337
Surplus %	1.46%	1.00%	1.00%	1.00%	1.00%

5 year plan modelled with CHC to 3.5%

Total Programme expenditure	207,951	214,956	217,967	221,782	225,669
Cumulative cost pressure above plan	158	325	499	681	865
In year pressure	158	167	174	181	184

5 year plan modlled with prescribing to 5.5%

Total Programme expenditure	208,147	215,372	218,626	222,717	226,912
Cumulative cost pressure above plan	354	741	1,158	1,616	2,108
In year pressure	354	387	417	457	493

5 year plan modelled with demographic growth increase by 25%

Total Programme expenditure	208,170	215,331	218,467	222,364	226,311
Cumulative cost pressure above plan	377	700	999	1,262	1,507
In year pressure	377	323	299	263	244

5 year plan modelled with acute tariff under delivering locally by 0.5%

Total Programme expenditure	208,347	215,722	219,092	223,234	227,420
Cumulative cost pressure above plan	554	1,091	1,624	2,133	2,617
In year pressure	554	537	533	509	484

In the worst case scenario, should the impact of each of the amended assumptions flex as listed above, the in year pressure to the CCG would be around £1.4M per year:

All factors above

Total Programme expenditure	209,236	217,489	221,758	226,812	231,931
Cumulative cost pressure above plan	1,443	2,858	4,291	5,711	7,127
In year pressure	1,443	1,415	1,433	1,420	1,417

To ensure that the CCG meets its surplus requirements each year, mitigations have been considered to ensure that the surplus requirement can still be met. As demonstrated in the table below, there are a number of mitigations in excess of the likely cost pressure which the CCG can consider utilising. The largest single mitigation is the additional local contingency which the CCG has included within the 5 year plan although this is not available in 2014/15 due to high confidence levels of the current assumptions being accurate and reliable.

Mitigations:

Additional in year QIPP	250	100	100	100	100
Uncommitted recurring investment held	400	200	200	200	200
Uncommitted reserves	650	-	-	-	-
Transition arrangement (PbR issue)	277	269	267	254	242
Local contingency	-	1,117	1,131	1,149	1,168
Total	1,577	1,685	1,698	1,703	1,710

Chapter 9 – The Better Care Fund

Our plan for whole system integration, with the Better Care Fund as a key enabler, is ambitious and ground-breaking, reflecting and building on the established integration of commissioning and provision. Our plans encompass not only mental health, physical health, social care, public health and housing but also further alignment of the resources, services and partners that influence the wider determinants of health and wellbeing. We have looked far beyond service and organisational boundaries to ensure community connectivity, mutual learning and support.

We have a longstanding history of integrated commissioning with the Local Authority in BaNES. Our commitment to the model of pooled and aligned budgets and common commissioning goals was re-affirmed in April 2013 in a partnership agreement between the CCG and Council. From October 2011 the community services formerly provided by the PCT and Council have operated as an independent Community Interest Company (Sirona Care & Health CIC). Integrated health and social care services to people with mental health problems are provided by multi-disciplinary teams that are co-located through partnership arrangements between the Council, CCG and Avon & Wiltshire Mental Health Partnership NHS Trust (AWP). Our vision of the future is predicated on the existing levels of integration within BaNES with the Better Care Fund acting as a further enabler and structure to build on and expand integrated commissioning and provision.

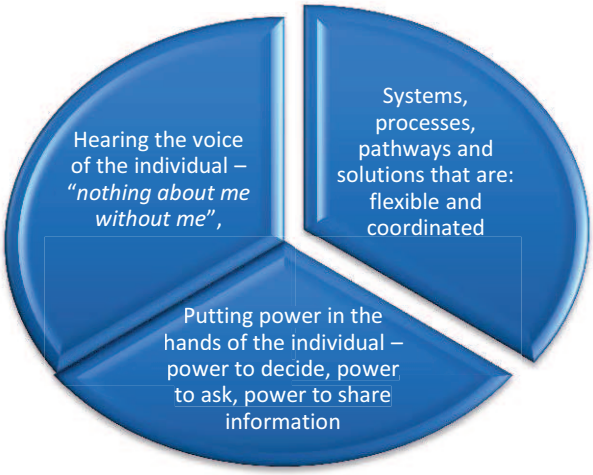
We see daily the benefit of close working between health, social care and third sector partners and we know from our experience the energy required to maintain an integrated approach to care. Our focus for the future is on further alignment of resources that influence the wider determinants of health and wellbeing. To this end, we will maintain a focus on developing patterns of behaviour in our communities that promote active aging, positive reablement and strong, empowered citizens.

In the current climate we believe that harnessing the good will, commitment and energy of our partners and our communities to co-produce solutions will deliver the best outcomes for local people.

Our vision and plan for whole system integration has been developed and endorsed by a broad range of partners, including: The Care Forum, host of HealthWatch BANES; the Royal United Hospital Bath; Dorothy House Hospice; Sirona Care & Health CIC; Curo Housing Group; Age UK BANES; Avon & Wiltshire Mental Health Partnership NHS Trust; BaNES Council and BaNES Clinical Commissioning Group.

In order to create a community where individuals have the power to choose and control their own integrated solutions, we are embarking on a radical and exciting transformation of the way we all work together.

Key elements of this transformation are:



We have framed our thinking about local whole-system integration in the context of the emerging "House of Care" model for BaNES which we will continue to develop and embed over the next five years. Key components of our integrated system are:

- Integrated reablement
- Community Cluster teams
- Social care pathway redesign
- Wellbeing College
- Social prescribing
- Liaison Services – alcohol, mental health primary care, psychiatric
- Intensive home from hospital support
- Step down accommodation
- Support for carers
- Independent living service

Impact of the Better Care Fund

We have identified a range of additional projects, using the new contribution from health resources into the Better Care Fund, which enable us to build and expand on the success of our existing schemes to further develop integrated services which benefit service users and their carers and enable more effective use of resources across health and social care.

The Better Care Fund Schemes can be categorised into the following groups:

7 Day Working

Protection of Adult Social Care Services

Integrated Reablement & Hospital Discharge

Admission Avoidance

Early Intervention & Prevention

We have assessed the impact of our Better Care Fund plans on local health services, in particular the acute sector, to ensure our success is not delivered at the cost of destabilising

the important services provided by our partners in this sector, and believe it to be deliverable without destabilising otherwise sustainable organisations.

We are confident that in the longer term, by further embedding and developing our model of integrated care, we will relieve pressures on our acute services and help to eliminate the costs that arise from failures to provide adequate help to those at greatest risk. Over time, we expect there to be a reduction in the volume of emergency and planned care activity in hospital through enhanced early intervention and preventative services and improved support in the community.

Chapter 10 – Enabling Plans

We have developed an ambitious strategy for the next five years and a challenging programme of transformation change to achieve this. Although we recognise that we are starting from a position of strength, we understand that successful implementation will require a number of enabling programmes across the health and care system.

We believe that these programmes can be grouped into five categories:

1. Quality
2. OD and workforce
3. IT infrastructure
4. Commissioning support

Quality

Quality in Everything We Do

Our commitment to quality is central to the CCG values and we are committed to providing a culture of continuous improvement and innovation with respect to patient safety, clinical effectiveness and Patient experience. We strive to embed these within all of our commissioned services as well as within the organisation itself as reflected in both A *Call to Action* and *Everyone Counts*, we are committed to ensuring that quality is central to our plans and this is underpinned by effective partnership working.

We will achieve high quality clinical services by ensuring patient pathways are evidenced based and clearly demonstrate how patients progress, as planned, towards achieving the best possible outcome.

The lessons learnt from the Francis Report, Winterbourne View and the Berwick Report are that quality is as much about our behaviours and attitudes to patients as it is about the transactions we make in ensuring service improvement. Improving quality is a wide-ranging agenda and in order for this to be implemented efficiently and effectively it is essential to maintain awareness with regards to the diversity of health and care requirements of our population in BaNES. It requires the development of a co-operative approach with our key areas being achieved through the involvement of our stakeholders including patients, their families and carers. They help us to set a pace of change that is comfortable and achievable by all.

The Current System

Bath and North East Somerset CCG has a comprehensive Quality Strategy which can be found on our website or through the link below;
http://www.banesccg.nhs.uk/sites/default/files/080913-14Quality-Strategy.pdf

The implementation of our strategy and its development plan contributes to enabling improvements to take place, and describes how we ensure high standards of care through effective monitoring. The CCG continues to work in partnership with the Council, NHS

England, neighbouring CCGs, the public and other key stakeholders and we are committed to continuously improve the quality of services for residents in BaNES

Quality is core to our services and through our governance structure we continue to:

- Adopt a patient-centered approach that includes treating patients, their family and carers courteously and with compassion, involving them in decisions about their care, keeping them informed and learning from them.
- Provide a framework where everybody assumes responsibility for the quality agenda.
- Establish a positive, open and fair and lifelong learning culture.
- Ensure that the values underpinning equality, diversity and human rights are central to our policy making, service planning, employment practices and community engagement and involvement
- Achieve continuous improvements in patient centered care which is safe, effective, timely, efficient, and equitable and that outcomes are measurable and that areas of variation are reduced.
- Meet the needs of the population we serves
- Ensure staff are properly inducted, trained and motivated and there is a high level of staff satisfaction

The Patients' Experience

Public and Patient Engagement (PPE) is a core priority for the CCG and is integral to its quality and patient safety responsibilities We are committed to achieving a modernisation and re-shaping of services for BaNES and are engaged in NHS England's '*The NHS belongs to the people: a call to action'* with further events planned. Consultation with the public over each proposed change is at the very core of all new service proposals and this is reflected in the setup of the 'Your Health, Your Voice' Group.

We recognise patients are the "experts" in the care they receive and are at the centre of service planning and delivery. Through improved partnership, people, including children and young people with their families will be able to exercise their rights, roles and responsibilities to best effect in delivering and receiving healthcare of the highest quality.

Engaging with patients and delivering equality, diversity and human rights is embedded throughout the work of the CCG and in our partnerships as it is integral to achieving our objectives. Our participation activities take into account barriers associated with language, age, access to information and disability etc. We will plan our participation to ensure it reaches people who find it difficult to get their views heard.

We work closely with HealthWatch as an independent body made up of patients and others from the local community. Their core remit is to find out what patients and carers think about the services they use, to monitor the quality of services from the patient perspective and to work with the CCG to bring about improvements. Direct feedback includes using patient surveys, focus groups and complaints and we are open and transparent in publishing what we receive. Our HealthWatch representative is also a proactive member of the CCGs Quality Committee.

Another forum we use to integrate patient views is through the involvement of a lay member on our Board. This allows members of the public, patients and carers to communicate directly with the CCG's Board.

The Quality Committee

The Quality Committee is accountable for the clinical governance and quality functions of the CCG and reports to our Board. It provides assurance on the quality of services commissioned and works closely with the other CCG Board level Committees to ensure there is alignment of activity to avoid duplication

A number of subgroups and/or standing agenda items have been aligned to the CCGs Quality Committee to provide regular assurance reports. This ensures the Committee has oversight of the following areas on behalf of the CCG Board.

- Safeguarding children and young people and Looked After Children (aligned to the Local Children's Safeguarding Board)
- Safeguarding Adults (Aligned to the Local Adults Safeguarding Board)
- Serious Incidents, never events and homicide reports/unlawful killing
- Patient experience reports including complaints reports, patient survey results and the NHS Friends and Family Test
- Quality of care in providers i.e. performance against quality schedules/CQUINs/Quality Accounts and patient and staff satisfaction outcomes
- Information Governance and Caldicott
- Research Governance and evaluation to improve outcomes and spread innovation
- Infection Prevention and Control with a zero tolerance of MRSA bloodstream infections and ongoing focus on reducing Clostridium Difficile infections
- Quality of care in care homes
- Quality of primary care provision
- Priorities set out in the Operating Framework 'Everyone Counts' relevant to quality
- External assurances via audit reports, peer reviews and inspection reports i.e. Care Quality Commission (CQC), Monitor, National Sentinal Audit Outcomes
- Quality impact assessment of service redesigns
- Quality impact assessment of Provider Cost Improvement Programmes
- • Equality and Diversity
- Safe and effective medicines management
- • Compliance with NICE where appropriate and relevant
- Implementation of the recommendations from the key publications including the '*Francis Report', the 'Berwick review into patient safety', The National Quality Board's How to ensure the right people, with the right skills, are in the right place at the right time* and *Transforming Care: A national response to Winterbourne View Hospital*
- Compassion in Practice and supporting providers through the adoption of the 6Cs

Improving Outcomes

It is essential when reviewing services and deciding priorities that the CCG draws upon data from a variety of sources, both hard (quantitative) and soft (qualitative) data, to *triangulate* this data and obtain a rounded view of quality. This analysis also includes identifying where

there is unwarranted variation in quality within the BaNES area compared to areas elsewhere.

Data sources available to us include:

- National Quality Dashboard and NHS Choices
- Performance data supplied by providers as per the contract e.g. performance against the National Quality Requirements for out of hours services and indicators set out in the Service Specification.
- NHS England commissioning data e.g. CCG OIS
- Data on the quality of primary care e.g. GP Patient Survey
- CQC warning notices and inspection activity or Patient and staff satisfaction surveys
- Results from Clinical Audits undertaken by providers
- Deanery / Local Education and Training Board reports
- Monitor risk ratings
- HealthWatch intelligence
- Output from peer reviews
- Quality Accounts
- Staff feedback e.g. from surveys
- Public Health England Intelligence
- Health Service Ombudsman complaints data
- Information provided to the Quality Surveillance Groups from Health and Wellbeing Boards, Safeguarding Boards, Clinical Networks and Senates
- Benchmarking data e.g. Primary Care Foundation
- Learning from safety incidents which providers should be reporting to the CCG as part of the contract reporting dataset.

Safeguarding Vulnerable Children, Young people and Adults

Working with partner organisations and health providers to protect vulnerable children, young people and adults is a key priority for BaNES Clinical Commissioning Group. Some patients and members of the public may be unable to uphold their rights and protect themselves from harm or abuse. They may have greatest dependency on our services and yet may be unable to hold services to account for the quality of care they receive. In such cases, we have particular responsibilities to ensure those patients receive high quality care and their rights are upheld.

We work with our partners including local police, social care, education, care homes, local statutory and voluntary organisations and our GP practices to strengthen arrangements for safeguarding adults and children in BaNES. Within the CCG, Children's and Adults' safeguarding issues are considered in detail at the Serious Incident, Complaints and Safeguarding Committee which reports to the Quality Committee and, in turn, to the CCG Board.

BaNES CCG is the major commissioner of local health services for the BaNES community and is responsible for safeguarding quality assurance through contractual arrangements with all provider organisations. All BaNES CCG contracts for commissioned services include safeguarding adult and children standards.

Children and Young People Safeguarding

For children and young people, the key legislation includes the Children Act 1989 and the Children Act 2004 Sections 11 and 13 of the 2004 Act have been amended through the Health and Social Care Act 2012 so that the NHS Commissioning Board (CB) (now known as NHS England) and CCGs have identical duties to those previously applying to Primary Care Trusts (PCT) and Strategic Health Authorities (SHA) – i.e. 'to have regard to the need to safeguard and promote the welfare of children and to be members of Local Safeguarding Children Board'. The revised edition of *Working Together to Safeguard Children* (2013) sets out expectations as to how these duties should be fulfilled. *Safeguarding Vulnerable People in the Reformed NHS Accountability & Assurance Framework (2013)* provides further guidance on accountabilities for safeguarding children in the NHS

Adult Safeguarding

The term Safeguarding Adults covers everything that assists an adult at risk to live a life that is free from abuse and neglect and which enables them to retain independence, well-being, dignity and choice. It is about preventing abuse and neglect, as well as promoting good practice for responding to concerns

The CCG Adult and Children's Safeguarding service is designed to ensure that the BANES population are in receipt of safe, high quality services. Integral to this is assurance for people who use services, and their carers that the delivery of services is based on the following themes:

a. Quality care
b. Partnership working
c. Robust contract management

Acknowledging that the Local Authority remains the safeguarding lead, the CCG Safeguarding Action Plans also considers work that the CCG can usefully achieve by pooling resources, producing joint policy and procedures, and working together where it makes sense and is appropriate to do so.

Key Safeguarding Priorities

The challenges for safeguarding over the next five years is to continue to develop, expand and embed safeguarding practice within the core work of the CCG; and to further develop partnership working with the local authority, local health providers, the CQC and NHS England.

We will ensure that BaNES CCG continues to meet all its statutory safeguarding children responsibilities and is compliant with the NHS England Accountability and Assurance Framework, and that the safer recruitment processes are complied with

We will work with GP Practices in strengthening their engagement with safeguarding children and adults processes by:

- Developing a training programme in partnership with NHS England Area Team
- Support the implementation of the general practice-based domestic violence and abuse (DVA) training support and referral programme (Identification & Referral to Improve Safety- IRIS) which has been funded by the CCG in partnership with the Police and Crime Commissioner

There is also continued engagement with Public Health to ensure the Joint Strategic Needs Assessment (JSNA) appropriately identifies the needs of whole population including those with Learning Disabilities and that these needs are incorporated into the commissioning strategy. This ensures the CCG will continue to implement the requirements of Transforming Care: a national response to Winterbourne View Hospital.

Research within providers

NHS Providers are required in their Quality Accounts to provide a statement on the number of patients receiving NHS services provided or sub-contracted by the provider that were recruited during year to participate in research approved by a research ethics committee. The CCG reviews these Quality Accounts annually

Academic Health and Science Networks (AHSNs)

The development of Academic Health and Science Networks (AHSNs) was recognised as a centre for innovation which could bring together research, education, informatics and innovation to translate research into practice. Dr Ian Orpen - CCG Chair is a member of the West of England AHSN and regularly reports updates to the Board.

NHS Health Education South West Clinical Academic Training Programme

Health Education South West (HESW) is undertaking a programme of work to enable practitioners gain experience and training equipping them to develop a clinical academic career which ensures that knowledge gained through research is applied to practice.

HESW is developing two programmes of work in Liaison with the Higher Education Institutions to support this initiative:

- Clinical Academic Training Programme Internships
- Research Innovation and Improvement Capability Project

Both of these pieces of work are directed towards nurses, midwives and allied health professionals. Funding will be allocated to organisations to support individuals at postgraduate level and the following areas for the project align to the CCGs strategic priorities:

- Patients and clients with dementia
- Meeting the needs of the frail older person
- Delivering care closer to home

A CCG Pharmacist is being supported by the CCG to apply to undertake a MRes Clinical Research Studentships for a project which will be based within primary care in BaNES.

Organisational Development & Workforce

The CCG will develop its organisational development plan to ensure it is well placed to deliver the changes required across the system over the next five year period. We will need to apply best practice methodologies but also approaches and techniques that may be new and unfamiliar to us.

At the time of authorisation our Organisational Development plan reflected the five domains that CCG's were required to evidence to demonstrate our ability to deliver our statutory functions. These were:-

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

These five areas are still relevant and applicable to the CCG's and wider health and social care community's effective delivery of our five year plan. The following table summarises some of the mechanisms we will use ensure that delivery is supported through effective organisational development processes.

Table 13: OD Process

Domain Area	Mechanisms to Support
Clinical Focus & Added Value	• Clinically led pathway and sub-groups linked to each initiative • Review of CCG led engagement processes with practices and primary care
Engagement with patients & Carers	• Development of role of CCG's Patient & Public Engagement group • Refresh of CCG's Public and Patient Engagement Strategy • Develop a CCG – Patient centred organisational development framework
Capacity & capability	• Development of Programme management and project management capability across the system • Development of a cohort of change and facilitation experts via Leadership SouthWest • Review of CCG Organisational Structures and role of commissioning support functions to underpin delivery

Collaborative Arrangements	• Creation of a Transformational Leadership Board • Shared programme management arrangements for shared priorities
Leadership Capacity & Capability	• Build Organisational Development skills and Competencies • Review of talent management across the system • Review of Organisational Development requirements across organisations and across the system

Workforce Planning

We recognise that we have a number of key strategic workforce issues to address if we are to successfully implement our five year Strategic Plan. Our internal CCG Leadership Team and its workforce must be equipped and ready to lead and deliver the stretching range of commissioning initiatives and responsibilities outlined in our plan, and our partner provider organisations must re-shape their current and planned workforces to meet the changing requirements for service provision which we have described in our strategic commissioning intentions.

Of particular relevance to provider workforce planning, our Strategic Plan calls for:

- Enhanced primary, community and mental health services provided on a 7 day a week basis, focused on our practice clusters and delivering care closer to home wherever appropriate
- Specialist and hospital based services supporting community based services with their expertise
- Innovative pathways of care with self-care and personalised care planning

Our stakeholder events have helped us to prioritise a number of key project areas which we know will impact upon provider staffing models, including a focus on:

- Prevention, self-care and personal responsibility
- Long Term Condition Management, focussing initially on diabetes to develop new models of care
- Musculo-skeletal services, and
- Urgent care

Each of these key workstreams will require a change in the way we deliver healthcare to the people of the BaNES area, whether it is a change in location, or in the hours of service access, or indeed a fundamental change in the nature of the care we provide. And some of the elements of service re-design will in turn necessitate a change in the nature and the skill set of the workforce deployed to deliver the service.

We anticipate that the shape of our providers' professionally trained workforces will therefore need to adapt over time to reflect the new approach, and we recognise the need to work closely with the Local Education Training Boards so that we can contribute to the debate about the volumes and the content of future professional training programmes.

Developing our CCG Workforce

We recognise that our staff represent our greatest asset. We also know that our success as an organisation depends upon our ability to create a supportive and highly productive environment which directly aligns our strategic commissioning objectives with those of our employees.

Our aim then is to create an engaged, highly motivated and skilled workforce; thriving in a challenging and stimulating environment as we lead the development of the whole healthcare system in BaNES.

We will achieve this by developing a clear workforce plan as an enabling plan to our Strategic Plan. This will identify the new or enhanced skills we will require as commissioners so that we may seek to recruit, retain and develop people with the best skills, knowledge and potential and who reflect our organisation's core values and behaviours.

During our first year as a new commissioning organisation we have had a clear emphasis upon supporting, involving and developing our staff to help them do the best possible job for us.

We have therefore focussed upon communicating and engaging our staff through:

- regular all-staff meetings
- structured team briefings
- a monthly newsletter
- Clinical Chair updates, and
- developmental multi-disciplinary project-work opportunities

And in the coming months we plan to run a staff engagement survey in order to provide staff with another opportunity to express their views and contribute to the development and the success of this organisation.

We have established an organisation-wide Performance Management process which directly links individual objectives to the goals and outputs of our annual Business Plan. We will build on this to ensure objectives are also aligned to our longer-term goals described in our Strategic Plan.

The Performance Management process is supported by the production of a Personal Development Plan for all of our staff, and we will be working towards the creation of a Learning and Development Plan to address identified development needs for the coming year. This plan must and will include addressing the changing skills needs for our commissioning staff who are charged with leading, developing and performance managing the local healthcare system.

Alongside this, with our Central Southern CSU partner we have established a Training Needs Analysis process which identifies and meets all statutory and mandatory training requirements.

Our intention is now to build on these foundation stones to focus on talent management and succession planning for the future. Our aim is to achieve a positive blend of 'growing our own', together with going out to market for the recruitment of key - sometimes scarce - skills.

We will also continue to focus upon Executive Team and Board development, building further on the workshops we have already run to begin addressing this.

Developing the Provider workforce to deliver future models of healthcare

Whilst there are undoubtedly staffing pressures in the local healthcare system right now, the required developments and changes in the design and delivery of healthcare called for by our Strategic Plan will inevitably create significantly greater pressure on our provider organisations to re-think current staffing models. Resources will need to be realigned to create a flexible, skilled and responsive workforce which is able to meet the changing needs of our local population.

We recognise that the ambitions we have outlined in our five year Strategic Plan will impact significantly upon the workforces of all of our providers, as we disinvest in established sectors and seek to invest more in other sectors of the healthcare system. Resources will inevitably move from acute, hospital (and bed) -based services, to community and primary-care settings.

More specifically, we have indicated a wish to focus on reviewing and redesigning certain care pathways and delivery models – particularly MSK, diabetes and Urgent Care. We recognise that this work will impact upon a number of hospital based specialities, including orthopaedics and rheumatology amongst others.

We welcome the opportunity to work collaboratively with our local providers on this important issue. We will ask them to work with us in assessing the impact of our plans upon their current staffing models and to tell us how they plan to address these consequences. We would also want to see an understanding of the potential risks involved in this transition, and to have confidence in the contingency plans to maintain safe and high quality services throughout.

Our intention therefore is to work closely with our main providers to support this service redesign programme, and to support them in preparing for the significant operational and staffing changes which will be required, including the identification of the new skill sets required to support the new care pathways and models of healthcare.

As Commissioners, we will further support this programme of work by establishing a sound reporting framework built on clear people management indicators to give us the assurance that this staffing transition is being well-managed throughout the period of change.

Structure of the CCG and Commissioning Support

The CCG is a relatively small lean organisation consisting of 43 employers and 34 whole time equivalents. Our running costs budget is £4.655m and will need to reduce by 10% from April 2015.

Following our first year of operation we are in a position of reflecting on the structure of the CCG and the provision of commissioning support functions in response to the requirements of delivering both our 2 year operational plan and our five year strategy.

At the point of authorisation and our current split of in-house support and support shared or commissioned with the BANES Local Authority, Wiltshire CCG and from a Commissioning Support Unit (currently Central Southern Commissioning Support Unit) is as follows:-

Table 14: Provision of Commissioning Support

CCG (In house)	Share with Wiltshire CCG	Share with Local Authority	Commissioning Support
Strategic Service Planning & QIPP Delivery	Communications & Patient Engagement	Integrated commissioning:-	Contracting & Provider performance management
Organisational Development		Children's Services	Business Intelligence
Medicines Management		Mental Health	Financial support services
Commissioning Support Management		Learning Disabilities & People with Sensory Impairment	Support for Quality assurance
Individual Funding Decisions		Community Health & Social Care Services	Service re-design support
Adults Safeguarding		CHC/FNC* Via contract with Sirona CIC	Procurement
Children's Safeguarding			Corporate Services (PALS, Complaints & FOI)
			HR & Workforce

We anticipate agreeing a Service Level Agreement with Central Southern Commissioning Support Unit beyond September 2014 to March 2016 to create stability in the commissioning system and to enable current arrangements to further develop. This will include a detailed review of service specifications, ways of working and joint organisational development activities.

It is anticipated that the CCG may make some changes to the configuration of some of these arrangements in light of a review of our current and future needs.

Commissioning support functions will need to evolve in response to the requirements of our five year plan and a joint impact analysis will be carried with CSCSU as part of the final submission of our plan.

Estates

We have considered the impact of our strategic plans and priority programmes for delivery on the health economy estate in consultation with NHS Property Services, who own and manage the non-acute estate within the BaNES area, and with the acute providers responsible for their own estate. The starting position is of some excess and underutilised capacity in community-based estate, and an identified requirement to reconfigure use of the acute estate as part of the long-term solution for the services currently provided by the RNHRD, and to allow for more effective use of the RUH site. Following the principle of ensuring resources are put to the most effective use, our plans include the intention to:

- Dispose of properties which have no potential to support delivery of the health community's plans. We anticipate NHS Property Services disposing of a number of residual Learning Disabilities properties and terminating a lease for a former mental health property by the end of 2014/15. This will remove charges incurred by the CCG for the cost of vacant clinical properties in the BaNES area, releasing the funds for reinvestment

- Use our commissioning knowledge to support NHS Property Services in identifying suitable tenants for underutilised space in community properties to be retained. We expect instances of this to occur throughout the planning period and it is our intention to minimize any gaps in occupancy through effective communication and coordination. This will remove or avoid charges incurred by the CCG for the cost of vacant clinical space, releasing funds for reinvestment in patient care

- Work with acute providers to support estate plans which align with our commissioning strategy and the health community's longer term goals, understanding and assessing the service and resource impact of changes from a system leader perspective. We anticipate that acute providers will use their own capital and estates resources to facilitate changes to their own property, with commissioners supporting the management of transition risk if necessary

- Work with Local Authority and primary care partners to explore opportunities for shared or varied use of the wider health and social care estate as detailed delivery plans develop

We have not identified any aspect of our priority programmes for delivery which requires significant change to existing estate during the five year planning period, although some areas may be put to different use over time. We will therefore focus our activities on ensuring the existing estate is of the right size, with each area occupied to the best effect.

IMT Infrastructure

Our IMT strategy recognises the need for an excellent Information Management & Technology (IMT) infrastructure of information, tools & technologies in order to support our employees as we deliver our goals. We want our team to see technology as liberating them to work effectively and imaginatively.

We anticipate agreeing a new SLA with Central Southern CSU in September 2014 enabling us to build on the economies of scale such a service can offer in this technical field. Working in partnership with CSCSU we will exploit new technology to enable a more flexible workforce. We will review the network operating at our St Martins site as well as the hardware offering to staff. These changes will be adopted with the support of appropriate policies in Information Governance and Information Security and the development of a Bring Your Own Device (BYOD) strategy and policy. This will assure our IMT security while we benefit from innovation.

Governance of the IMT programme will adapt to ensure IMT is embedded in all commissioning developments. Potential benefits from technology and an awareness of the need for strong information governance will become part of how services are commissioned. We will use data as part of the commissioning process to ensure that as an organisation we take action on the basis of fact and evidence. We will ensure we have implemented robust monitoring of our actions to understand their impact.

The effectiveness of, and strategy for, our IMT infrastructure will be monitored and adapted within our IMT Steering Group.

Chapter 11 – Managing Risk

We have a Risk Management Strategy which details our approach to the management of risk. This includes a risk management framework, details our risk appetite and culture and our intent to integrate risk management into all strategic and operational activities.

In the context of the five year strategy, the risks we have identified fall into the following categories:

- Delivery
- Financial
- Patient Experience and Outcomes
- Communications

The risk register below describes a provisional set of these risks, with our assessment of impact and probability and our proposed approach to ameliorating these risks. The Transformational Leadership Board will regularly review risks to delivery of the 5 year plan. During stakeholder consultation about our five year strategy, it was agreed that transformational change can be delivered more successfully, maximising benefits for all the participating organisations if the change programme is managed on a system wide basis. Therefore we will be establishing a Transformational Leadership Board to oversee the implementation of our strategy. Further information about the governance arrangements are detailed in Chapter 13. At a further workshop on 13th March, to discuss the governance arrangements for the system wide change programme, stakeholders reviewed this risk register and confirmed the risks.

These are high level risks and more detail regarding financial risks in particular are detailed in Chapter 9 of this plan.

Detailed Risk Registers will be prepared for each of the priority workstreams and the Transformational Leadership Board will monitor high level risks and issues, to ensure regular review of risks and issues that could impact on the programme. Reporting will be by exception to the participating governing bodies regarding any risks, issues and exceptions related to the programme.

Risk Category	Description	Impact	Probability	Countermeasures
Delivery	The implementation of the five year strategic plan is a complex multi-stakeholder transformation programme. There is a risk that individual organisations take decisions on the basis of their own short term priorities rather than those of the system as a whole. This would impact on achievement of the five year vision for the planning unit.	High	Medium	The early agreement of the five year strategic vision has enabled the CCG and health economy partners to focus on the delivery management and associated risks. Each member of the Transformational Leadership Board will have delegated decision making authority for their organisation and responsibility for workstream leadership. Peer challenge has been implemented successfully in unscheduled care improvement and we believe this will help organisations work together at the required pace and with commitment to the joint vision.
	The complexity of the programme will stretch the management capacity of the health system	Medium	Medium	The Transformational Leadership Board will review progress on a regular basis and continuously review strategic and operational priorities. There is sufficient management capacity in the system so the governance structure has been designed to share implementation responsibilities within a best practice programme structure based on MSP principles
	The agenda in 'Everyone Counts' is significant and there will a need to demonstrate progress on all identified priorities as well as the smaller set of workstream priorities identified in the plan.	Medium	High	Organisations will need to implement all aspects of NHS policy and guidance alongside the five year strategic plan. The Transformation Leadership Board will focus on the areas that require a system-wide response and where implementation of guidance cannot be achieved by organisations working alone.
	There is a risk that the programme completes to an agreed timetable but the expected benefits are not realised	Medium	Medium	In line with MSP practice, there will be a benefits register created to record the expected benefits, dependencies and benefits owners. These will be tracked regularly with regular formative evaluation throughout the programme

Risk Category	Description	Impact	Probability	Countermeasures
	This is the first five year strategic plan for BaNES CCG and the wider health and care economy. Because there have been similar initiatives previously, there may be a temptation to use 'old' techniques from previous commissioning models rather than to exploit the opportunities of clinical commissioning	Medium	Medium	The involvement of the Health and Well Being Board and the prominent role of clinical leaders in the change programme will enable progress to be achieved through new change levers suited to clinical commissioning
	There is a risk that the complexity and interrelationship of our initiatives makes it difficult to really monitor and understand which schemes are delivering effectively and which are not, so we might continue supporting ineffective services or withdraw support from effective services.	Medium	Medium	Robust identification of expected impacts and of the relationship between different schemes (good programme and detailed project arrangements) and developing monitoring to match. These will be reviewed regularly by the Transformational Leadership Board.
Financial	The strategic plan is predicated on the achievement of short term efficiency improvements to invest in long term integrated care initiatives that will the system to address demand in a more efficient and effective way. Failure to succeed in the first two years will severely impact overall success	High	Medium	The Transformational Leadership Board will recognise the importance of the 2 year window. The strategy builds on the current productivity programme that is already achieving efficiency improvements and specific workstreams are designed to accelerate achievement of additional economies so that the longer term initiatives can start early for later payback. The CCG will lead a stronger and more prudent approach to tracking the achievement of short term productivity improvement

Risk Category	Description	Impact	Probability	Countermeasures
	The health system cannot afford 'double running costs' of both new and old clinical models and pathways	Medium	Medium	The Programme Management Office will need to sequence the achievement of workstream milestones alongside the achievement of productivity improvements. Individual organisations will be expected to support reduction in capacity and associated costs as new services are introduced and to do this in a way that safeguards service continuity. The early productivity improvement programme is designed to generate financial headroom that can be used alongside the Better Care Fund to accelerate the pace of early transformation work
Patient Experience and Outcomes	The five year transformation programme is seen as a management-challenge and it becomes disconnected from patient experiences and outcomes. There is a risk that workstreams milestones are achieved but the expected improvements in patient experiences and outcomes are not realised	High	Medium	The five year strategic plan and the Transformational Leadership Board is supported by a PMO that carries responsibility for benefits realisation. Each workstream PID will include impact KPIs that will be used to ensure valued improvements in experiences and outcomes over and above nationally managed indicators. The implementation of the Quality Strategy, which underpins the work of the CCG, will continue apace and there will be appropriate interface with the transformational programme.
	The priorities of local people change through the course of the five year plan	Medium	High	The CCG Board is confident about the high level expectations of the public in terms of accessibility, quality and safety of services and these are reflected in the design of the priority workstreams in the five year plan. It is inevitable that specific and more granular priorities of patients (and organisations) will change over the five year period. The Transformational Leadership Board and the constituent workstreams will be supported by a single patient and public engagement programme so that alignment can be maintained and priorities adjusted.

Risk Category	Description	Impact	Probability	Countermeasures
	There is a risk that the programme reinforces variations and gaps in inequalities across the local health economy	High	Medium	Each significant change in health care services will need to be subject to an impact assessment and risk analysis. There will be a focus on the benefits of the overall programme and the issue of health inequalities will be addressed in the success measures of the programme
Communications	This is a complex, multi-stakeholder long term change programme. There is a risk that different stakeholders and staff within those organisations misunderstand the key communications messages, the purpose, the benefits and the way change will be addressed	Medium	Medium	In line with MSP practice, the Transformational Leadership Board will need to be supported by communications resources that provide regular information and updates to all those impacted through agreed channels in a way that can be consistently delivered in all stakeholder organisations.

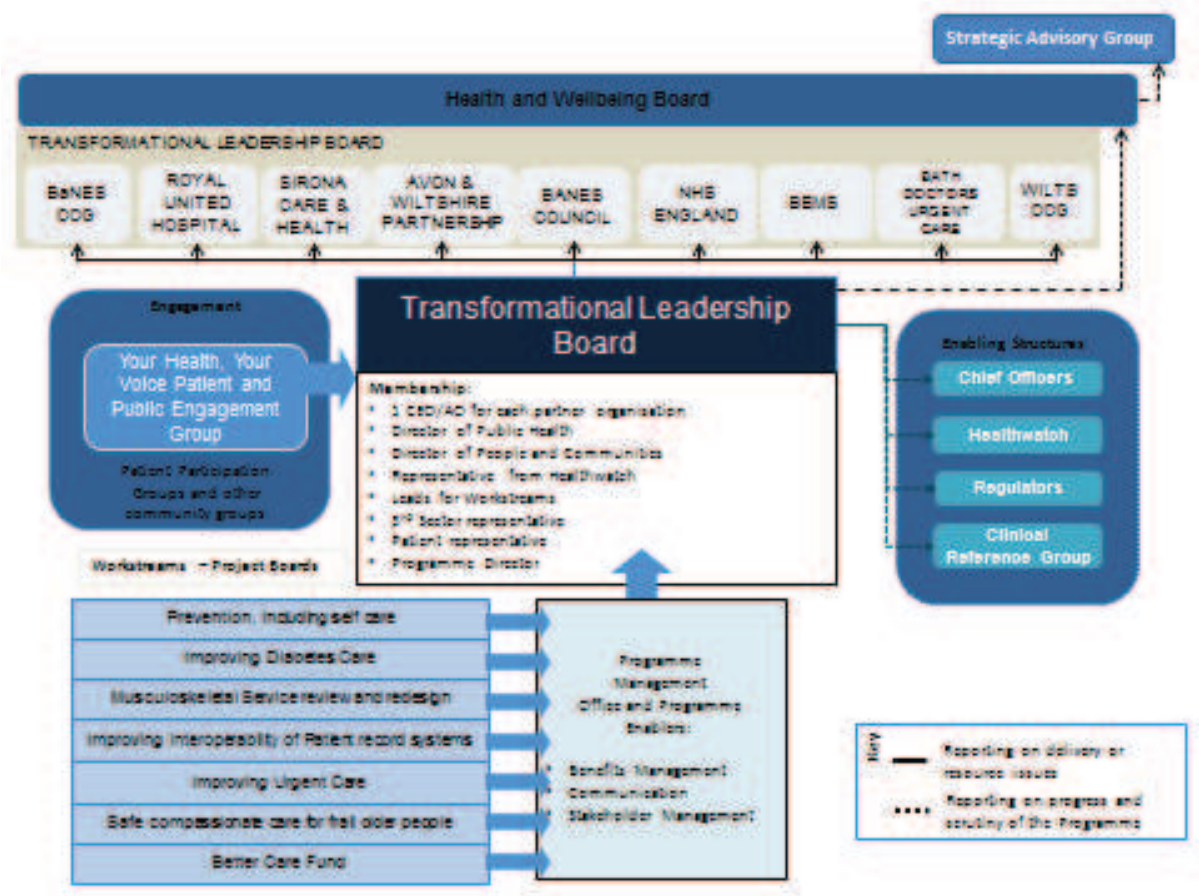
Chapter 12 – Governance and Delivery Plans

Governance

We have developed our strategy in partnership with local commissioning and provider organisations and are confident in the level of support across the health and care system for the change programmes we have outlined in chapter 6 of this document, focused on our six priority areas.

We have designed a governance structure that is rooted in sound change management principles and the philosophy of Managing Successful Programmes (MSP). The governance structure was signed off by senior leaders of our health and care system at the final workshop on 13th March 2013.

Figure 22: Governance Structure



A Transformation Leadership Board will be established with membership from partner organisations – see programme structure above. The Leadership Board will be chaired by the Clinical Accountable Officer of the CCG and the membership will include the CEO's of constituent organisations and the clinical leaders of the work stream project groups. The Transformation Leadership Board is accountable to the participating organisations governing bodies but will also report to the Health and Wellbeing Board.

The Leadership Board will oversee the delivery of the overall programme and the contributions of the individual work streams. The priority work streams for delivery of the five year strategy have been developed and endorsed by stakeholders but there may be additional work streams which providers feel would also benefit from system wide management and delivery. The Better Care Fund will also be managed via these governance arrangements to ensure appropriate integration within the strategy. The role of the group may evolve over time to address other system-wide issues for which there is currently no suitable forum.

The Steering Group will be supported by a Programme Director and Programme Management Office (PMO). The PMO will support the Transformation Leadership Board ensuring progress and benefits are tracked and variances, risks, dependencies and issues are identified, managed and addressed across the whole programme. The costs of this support will be apportioned across the participating organisations on a proportional basis consistent with the anticipated benefits to these organisations.

The CCG Patient and Public Engagement Working Group- 'Your Health, Your Voice' will ensure the patient voice is heard across all areas of the programme and to commission the development of specific pieces of engagement and consultation work as required by individual work streams. A communications lead will work within the PMO to ensure there are regular and consistent updates of progress to the wider group of stakeholders and organisations with a role to scrutinise.

A more detailed description of these arrangements with Terms of Reference for the Transformational Leadership Board has been prepared.

Delivery Plans

Within the context of our governance arrangements for delivery of our strategic plan priorities, we will develop detailed implementation plans for each project or group of associated projects within each of the six priority areas.

In accordance with accepted change management principles and using good practice techniques and tools such as the NHS Change Model, our implementation plans will use structured project management approaches which are relevant and proportionate to the scale of each project. Development and delivery of the implementation plans will be supported by a capable and experienced Programme Management Office function.

We envisage that our implementation plans will include the following:

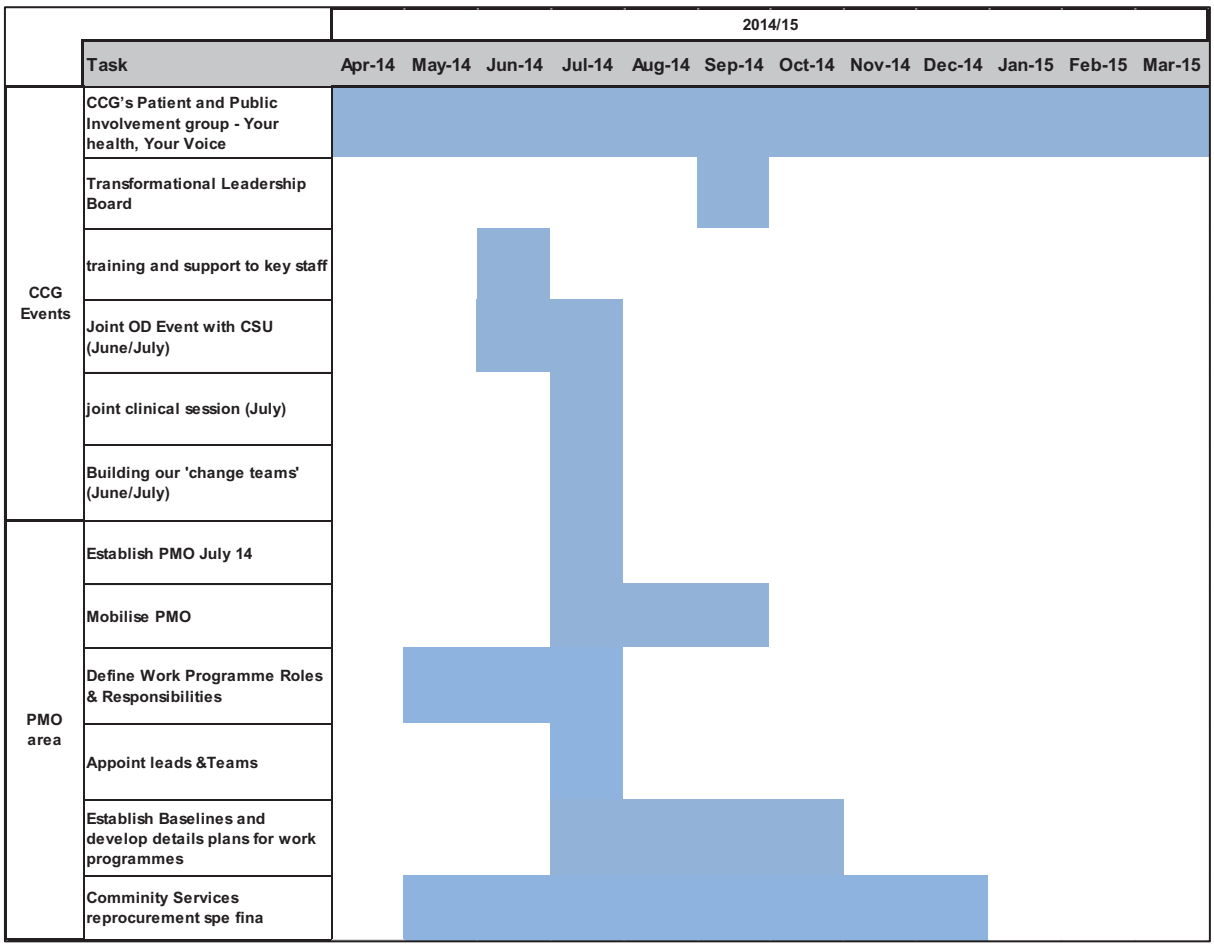
- Clear articulation of individual delivery roles and responsibilities
- Description of which stakeholders are engaged with each project and to what degree
- Delivery accountability mechanisms
- Reporting mechanisms including monitoring of progress, risks and issues
- Detailed delivery plans which include sequenced actions and recognise interdependencies
- Key milestones
- Qualitative and quantitative key performance/delivery indicators
- Benefits realisation criteria

- Assessment of the transitional impact of implementation and identification of the resource required to manage it
- An operational, or handover, plan to ensure the smooth transition from planning to a live service

care system partners, and recognising the crucial contribution of provider stakeholders in delivering our plans in an effective and timely manner. We will engage with key stakeholders to create, agree and progress our implementation plans.

The implementation plans developed for each priority area will also recognise, where relevant, the need to develop key enablers and supporting functions. The Programme Management Office will ensure that multiple requirements relating to enablers and supporting functions are managed in an appropriate and coherent manner.

Figure 23: Key steps for implementation plan



Chapter 13 – Communication and Engagement Plan

Citizen Participation & Empowerment

"We must put citizen and patient voice absolutely at the heart of every decision we take in purchasing, commissioning and providing services".

Tim Kelsey, national Director of Patients and Information, NHS England

In this Section we will discuss how we will develop our approach to Citizen Participation & Empowerment

Our Approach to Encouraging Citizen Participation

The findings from our engagement activities described in Chapter 14 provide a framework for us to consider how we will take forward Citizen Participation & Empowerment. To continue to support the public mandate for change within the local NHS, we need a seismic shift in how we engage with individuals and communities. Our ambition is to continue to hold regular events with our stakeholders and members of the public, providing them with the opportunity to hear and see our plans through traditional events, meetings and focus groups. However, we need to ensure that a wide range of perspectives are heard and we therefore have plans to ensure local activity is flourishing, co-ordinated, accessible and appealing across our entire demographic - and most importantly, which flows both ways.

Our patients, members of the public and stakeholders have told us they want to be involved in the following ways:

- By an approach/channel which suits them; reflecting their individual interests and lifestyle
- To keep them up to date and allow them to 'dip in and out' when it suits them
- By providing a variety of options to make their views heard
- To be kept informed about what others think
- To receive feedback about what has been done as a result of their input and involvement.

To achieve these aims we intend to further develop our engagement activity through the establishment of a Patient and Public Involvement Group, "Your Health, Your Voice" and our online patient communication which supports BANES CCG to:

- Build a community of interest through membership
- Engages with people on their chosen topic of interest
- Tracks relationships and member activity
- Reaches new audiences – not just the usual suspects
- Records and analyses feedback from online, social media and other engagement activity
- Let's people know the outcomes
- Creates a continuous dialogue that is available 24/7

As a result this will:

- Build community interest and involvement
- Improve accessibility and increases participation by broadening our reach and the variety of channels in which the public can engage through
- Ensure we're talking about what really matters to the public
- Extends the conversation to ensure that all generations and ages are included
- Share outcomes; enabling continuous and flowing dialogue
- Capability to track, connect, record and analyse activity, behaviours, demographic etc. which will feed into reporting.

Participants will be able to:

- Register as a member and choose the topics of interest
- Get updates and be involved in surveys, polls, events, documents, consultations and other activities
- Give their view online - it all counts
- Respond anonymously if they prefer
- Invite the CCG staff to their community group and discuss issues in person
- Get feedback about what has happened as a result of their involvement

The benefits to the CCG mean that we will:

- Access quick and cost effective community dialogue and feedback
- Ability to target different groups and individuals for specific topics, e.g. Long term conditions
- Reach new audiences through multiple platforms and new media
- Gather a body of evidence on patient and public activity and participation
- Use tools to analyse and report on online AND traditional engagement, e.g. focus groups, meetings, correspondence - to save time and money
- Promote and easily publish outcomes - what is heard and what is done as a result.

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Glossary and Abbreviations

Acute Providers / Care

Acute care refers to short-term treatment, usually in a hospital, for patients with any kind of illness or injury.

ADHD

Attention Deficit Hyperactivity Disorder –problems with attention, hyperactivity that are inappropriate.

AQP Any Qualified Provider

This is an approach to commissioning where any provider who is able to deliver a specific service and meet the required minimum standards can be listed as a possible provider. Patients choose which provider on the AQP list they wish to see. No provider is guaranteed any volume or exclusivity. AQP was previously referred to AWP (any willing provider). The change in name reflects the emphasis on providers meeting sufficient standards.

Authorised

A CCG that is established and has fully satisfied the NHS Commissioning Board of the matters set out in the Act as is necessary in order for an application to be granted.

AWP

Avon & Wiltshire Mental Health Trust.

BaNES

Bath and North East Summerset

Berwick Report

Published by the National Advisory Group on the Safety of Patients in England (August 2013)

BGSW

Bath, Gloucestershire, Swindon and Wiltshire.

CAMHs

Child and Adolescent Mental Health Services.

CCG

Clinical Commissioning Group

Census Estimates

Population estimates provided the Office of National Statistics.

CHD

Coronary Heart Disease.

CIC

A Community Interest Company ia an Independent Company which exists to benefit the community rather than private shareholders

CMT Community Mental Health Team

A multi-disciplinary team based in the community that provides assessments and purchases care for people who have a mental illness.

COF Commissioning Outcomes Framework

A proposed framework of indicators. Will provide transparency and accountability about the quality of services that CCGs commission and the outcomes achieved for their local populations. CCGs commission and the outcomes achieved for their local populations. CCGs will be able to use information on baseline performance against these indicators, to help identify local priorities and create commissioning plans that are meaningful at local level.

Commissioners

A group who analyse needs make purchasing decisions and monitor outcomes.

Commissioning for Value Packs

Comprehensive data packs to support CCGs in their commissioning activities.

Community Interest Company (CIC)

A special type of limited company which aims to benefit the community rather than private shareholders.

Community Providers

Organisations who provide services within the communities they serve.

COPD

Chronic obstructive pulmonary disease.

Council Health and Well Being Board

Forum where council chiefs, the NHS and other experts join forces to tackle a borough's health inequalities

CQC

This is an organisation funded by the Government to check all hospitals in England, to make sure they are meeting government standards and to share their findings with the public.

CQOG Clinical Quality and Outcomes Group

A joint initiative between the national Caner Intelligence Network (NCIN) and the National Cancer Action Team to encourage, establish and maintain operational links between those producing data on the activity, perform and outcomes of cancer services and those responsible for improving the quality of cancer services in the NHS.

CQUIN

Commissioning for Quality and Innovation

CQUIN

Commissioning for Quality and Innovation.

CSI Commission for Social Care Inspection

Former inspection/registration body for social care, now incorporated in CQC

CSU Commissioning Support Units

Commissioning Support Units provide commissioning and technology support services to a range of commissioners and providers across the NHS

Elective Care

Care scheduled in advance because it does not involve a medical emergency.

EoLC

End of Life Care

EPP

Expert Patient Programme.

Established

A legal term meaning a CCG is created as a statutory body under the Health & Social Care Act 2012. CCGs covering the whole of England must be established by April 2013, when PCTs are abolished. Established CCGs may be (fully) authorised with conditions, or established in shadow form.

Everyone Counts: : Planning for. Patients

Originally published by the NHS in Dec 2012 and updated each year.

Exception Reporting Rates

Exception reporting is used to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.

FOI

The Freedom of Information Act gives everyone the right to access information held by public services

Foundation Trust

NHS Foundation Trusts are not directed by government so have greater freedom to decide, with their governors and members, their own strategy and the way services are run. They can retain their surpluses and borrow to invest in new and improved service for patients and service users.

Francis Report

Since Robert Francis's report into the failings at the Mid Staffordshire Foundation Trust was published in February 2013.

Friends and Family Test

The Friends and Family Test (FFT) aims to provide a simple headline metric which, when combined with follow-up questions, is a tool to ensure transparency, celebrate success and galvanise improved patient experience.

Health and Wellbeing Board

Established and hosted by local authorities, health and wellbeing boards bring together the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch, to plan how best to meet the needs of their local population and tackle local inequalities in health.

Health Inequalities

Differences and gaps in standards of health from area to area, often linked to poverty and other social issues

HealthWatch

Healthwatch is a consumer champion for both health and social care. It will exist in two distinct forms – local Healthwatch, at local level, and Healthwatch England, at national level.

HWB Health & Wellbeing Board

Health & Wellbeing Boards are being established in every upper-tier local authority to improve health and care services and health and wellbeing of local people. They will bring together the key commissioners in an area, including representatives of CCGs, directors of Public Health, Children's Service and Adult Social Services, with at least one democratically elected councillor and representative of Health Watch. The Boards will assess local needs and develop a shared strategy to address them, providing a strategic framework for individual commissioner's plans.

Integrate

A principle of this programme which refers to creating more co-ordinated care for the patient, making sure all parts of the NHS and social services work more closely and effectively together.

ISTC Independent Sector Treatment Centre

Centres that have a contract with the NHS to perform certain treatments

IT / ICT - Information Technology

Computers and associated communications technology

JSNA

Joint Strategic Needs Assessment.

JSNA Joint Strategic Needs Assessment

These are the primary process for local leaders to identify local health and care needs and build a robust evidence base on which local commissioning plans can be developed

KPI Key Performance Indicator

Targets that are agreed between the provider and commissioner of each service, which performance can be tracked against.

KPIs

Key Performance Indicators.

LA

Local Authority / Unitery Authority / Local Council

LD

Learning Disabilities.

Length of Stay

Period that a person is in hospital

Lower Super Output Area

Super output areas (SOAs) were designed to improve the reporting of small area statistics and are built up from groups of output areas (OAs). Statistics for lower layer super output areas (LSOAs) and middle layer super output areas.

LRTI

Lower respiratory tract infection.

LTC Long Term Conditions

There are around 15 million people in England with at least one long term condition – a condition that cannot be cured but can be managed through medication and/or therapy. There is no definitive list of long term conditions – diabetes, asthma, coronary heart disease, chronic obstructive pulmonary disease (COPD) and mental health issues can all be included.

Managing Successful Programmes (MSP)

A Government Framework and Standards for Managing Successful Programmes.

MH

Mental Health

MIU

Minor Injuries Unit.

Monitor

The independent regulator of NHS Foundation Trusts. Until 2016, it will have a continuing role in assessing NHS Trusts for a Foundation Trust status and for ensuring that Foundation Trusts are financially viable and well led. Under the recent NHS changes Monitor will adopt a new role as economic regulator for healthcare and competition regulator for health and social care.

Morbidity

A diseased state, disability, or poor health due to any cause.

Mortality

Mortality is the state of being mortal, or susceptible to death.

Mortality rate

A measure of the number of deaths (in general or due to a specific cause) in a defined population, scaled to the size of that population, per unit time.

Multi-disciplinary Team

These are groups of professionals from primary, community, social care and mental health services who work together to plan a patient's care.

NBT

North Bristol Trust.

NHS Constitution

The Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled and the pledges which the NHS is committed to achieve, together with the responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services are required by law to take account of this Constitution in their decisions and actions.

NHS England

National body that commissions a range of Health services across England and holds the Genral Practitioner Contracts.

NHS Health Check

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia.

NICE National Institute for Clinical Excellence

Non departmental public body of DH in the UK which develops and publishes policies on clinical guidelines, technology in NHS, Clinical Practice, guidance for public sector workers on health promotion and guidance for social care services and users.

Nursing Home LES

Local Enhanced Health Care services provided in Nursing Homes.

Obese

Obesity is a medical condition in which excess body fat has accumulated to the extent that it may have a negative effect on health, leading to reduced life expectancy and/or increased health problems.

OD Organisational Development

Work concerned with developing and improving the organisation – its structures, systems or working, skills and culture – to undertake its more role more effectively.

ONS

Office for National Statistics.

Operating Framework

National (and/or regional) framework setting out targets, priorities and expectations of NHS organisations on an annual basis.

Outlier Population

An outlier is an observation point that is distant from other observations.

Outpatient

A patient who attends an appointment to receive treatment without actually needing to be admitted to hospital, unlike an inpatient. Outpatient care can be provided by hospitals, GPs and community and providers and is often used to follow up after treatment or to assess for further treatment.

Overview and Scrutiny Committee

Local Authority Committee with the power to scrutinise performance and changes in health and care services.

Package of Care

A term used to describe a combination of services put together to meet a person's assessed healthcare needs. It outlines the care, services and equipment a person needs to live their life in a dignified way

PALS Patient Advice and Liaison Service

A free service to support and signpost patients.

Patient Pathway or Journey

This is the term used to describe the care a patient receives from start to finish of a set timescale in different stages. There can be integrated care pathways which include multi-disciplinary services for patient care.

PbR Cost

Payment by Results (PbR) is the tariff based payment system that has transformed the way funding flows around the NHS in England.

PPE

Patient, Public Engagement

Prevalence

The proportion of individuals in a population who have the disease at a specific instant or during a specified time.

Prevalence

The proportion of individuals in a population who have the disease at a specific instant or during a specified time.

Primary Care

Services which are the main or first point of contact for the patient, provided by GPs, community providers ETC

Primary Providers

Providers based in the communitywho are the first point of contact for patients and the public.

Programme Management Office (PMO)

The Programme Management Office provides support and coordintion across several projects and sometimes more than one comissioning body so that jined-up services can be designed and delivered.

PROMs

Patient Reported Outcome Measures

Provider and Commissioner Resource Utilisation Gains

Improvements in service delivery that derive from the most efficient use of comissioner and provider resources.

Provider Landscape

The nature and extent of the provision of health and care services within a locality.

Public Health

The science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society (Acheson 1988)

QOF Quality and Outcomes Framework

The QOF is a voluntary incentive scheme that rewards GP practices for implementing systematic improvements in quality of care for patients, based on their performance against indicators. The QOF is part of the General Medical Services Contract

Quality Premium

This will be an element of income which is linked to the performance of the CCG. It is proposed that the quality premium will be paid to the CCG from the NHSCB if it performs well. The Health and social care Act 2012 now states that Regulations may prescribe how any payment made to a CCG in respect of quality may be spent, including the distribution amongst the CCG's

Quintiles

A statistical value of a data set that represents 20% of a given population. The first quartile represents the lowest fifth of the data (1-20%); the second quartile represents the second fifth (21% - 40%) etc.

QUIPP Quality, Innovation Productivity and Prevention

Quality, Innovation Productivity and Prevention (QUIPP) is the response to the challenge of improving the quality of care the NHS delivers, whilst at the same time making these savings

Rate

The number of observed events per total number in whom this event might occur over a specified time period, often expressed as per 1,00 or per100,00 (persons, male, female, children etc.)

Red Performance Recovery Plan

A plan that is agreed with a provider where their performance is below the national or local minimum threshold.

Registered Population

Is the population registered with a general practice constituent practice of a CCG.

RHU

Royal United Hospital (Bath)

RNHRD

Royal National Hospital for Rheumatic Diseases NHS Foundation Trust

RNHRD Royal National Hospital for Rheumatic Diseases

Specialist NHS Hospital (Foundation Trust)

RTT

Referral to Treatment Time

RTT Referral to Treatment

The period of time to the start of specialist treatment.

RUH Royal United Hospital NHS Trust

Local acute hospital in Bath, serving BANES and parts of Somerset and Wiltshire

Secondary Care

Hospital or specialist care that a patient is referred to by their GP or other primary care provider

Secondry Health Care

Usually refers to hospital treatment but increasingly secondry care is provided in a variety of community based settings including a patient's home.

SEND

Special Educational Needs. Any learning difficulties which calls for Special Educational provision to be made.

Service Level Agreement (SLA).

A service level agreement is a negotiated agreement between two parties. It is not commonly legally binding although it may form part of a formal contract. SLAs would commonly include definition of services, performance measurement, problem management and termination agreement.

Sirona

Sirona Care and Health Community Interest Company (CIC) is an independent organisation providing publicly-funded health and social care services.

SMART

Specific – target a specific area for improvement, Measurable – quantify or at least suggest an indicator of progress, Assignable – specify who will do it, Realistic – state what results can realistically be achieved, given available resources and Time-related – specify when the result(s) can be achieved.

Socio-economic inequality

The gap between the top and bottom of a rating of the socio economic characteristics of a population within an area that lead to differences in health outcomes.

SWASFT

South West Ambulance Services Foundation Trust

Top Decile

The top 10% of a measure.

Transformational Leadership Board (TLB)

A BaNES sub-group of the Health and Wellbeing Board that oversees the implementation of the this 5 year Strategic Plan.

UHB

University Hospitals Bristol

Unify Templates

Planning Template as part of their formal planning submission to NHS England.

Unitary Authority

A unitary authority is a type of local authority that has a single tier and is responsible for all local government functions within its area or performs additional functions which elsewhere in the relevant country are usually performed by national government or a higher level of sub-national government.

Urgent Care

Urgent care offers treatment wher the patient is unable to be seen by their General Practitioner of Practice Nurse where the need for treatment has not been viewed as an "emergency", for example wher not receiving treatment at an emergency centre is not life threatening but.

Winterbourne View

Winterbourne View was a private hospital in South Gloucestershire where abuse occurred to people with learning disabilities and challenging behaviour.

APPENDICES

Appendix 1 – 2 Year Operational Plan
Appendix 2 – National Quality and Safety Measures
Appendix 3 – Equality Impact Assessment

Bath and North East Somerset Clinical Commissioning Group "Operational Plan on a Page" 2014 – 2016 **Appendix 1**

OUR VISION AND MISSION

Healthier, Stronger, Together

"to lead our health and care system collaboratively through the commissioning of high quality, affordable, person centred care which harnesses the strength of clinician led commissioning and empowers and encourages individuals to improve their health and well being status".

SERVICE PLANS

Urgent Care:
- Embed the new integrated urgent care centre and out-of-hours services model
- Review the role of the minor injury unit in light of the new service model and NHS 111
- Complete the DVT procurement and ensure new service is mobilised by September
- Explore opportunities to develop ambulatory care pathways that work across primary and secondary care
- Evaluate the impact of the 2013/14 winter pressure initiatives with a view to commissioning on a substantive basis to create additional capacity in the system
- Commence the vulnerable adults out-reach worker service as a two year pilot
- Ensure the on-going development of the urgent care system is integral to the development of out of hospital services to support the frail elderly and people with long term conditions to ensure pathways are joined up

Mental Health:
- Review and improve rehabilitation pathways of care
- Further integrate primary/ community services e.g. talking therapies & primary care liaison
- Scope options for improvement of acute mental health inpatient environment
- Implement Wellbeing College pilot alongside independent evaluation
- Move towards parity of esteem in all services, ensuring equal focus on improving mental health as physical health & patients with mental health problems do not suffer inequalities

Primary Care:
- Complete a review of local enhanced services to ensure they are "fit for purpose".
- Continue process of quality review of primary care in conjunction with NHS England and support practices to reduce variation
- Develop a local Primary Care Strategy
- Bed in new relationships with LMC and provider organisations
- Work with NHS England to make emerging Local Professional Networks a success with primary care contractors

Children's Services:
- Work to reduce paediatric non-urgent appointments (planned care)
- Ensure health visitors, school nurses, CAMHS in-patient bed provision meet local needs
- Work with education & social care to implement the Special Education Needs and Disability (SEND) Reforms for children and young people aged 0-25.
- Improve diagnostic pathway & support services for children/ young people with Autistic Spectrum Conditions
- Pilot on-line YP counselling service part of support package around emotional H & WB
- Ensure that all commissioned services adhere to local safeguarding standards
- Consider a new model for children's general community nursing service
- Develop strengthened strategies in health and in partnership for helping children and families cope with transition and change

Medicines Optimisation
- Improve quality of Clinical Medicines Reviews for our most vulnerable
- Continue work on getting best value from CCG commissioned high cost drugs
- Improve appropriate utilisation of antibiotics in our health system
- Roll out Electronic Prescription Service successfully across health community
- Maximise the benefits of Medicines Optimisation Services in Community Pharmacy

Long Term Conditions & Frail Older Person:
- Embed community cluster model, active ageing service & redesigned adult social care pathway
- Work with primary care to continue to improve dementia diagnosis rates
- Evaluate impact of dementia challenge fund initiatives with view to commission long-term
- Establish diabetes working group, design new pathway and agree requirements to meet the needs of the growing number of people with diabetes
- Review the falls and bone health pathway in light of the roll out of the active ageing service
- Develop clinical model for IMPACT (community COPD service) to support patients with non-cystic fibrosis bronchiectasis in the community in conjunction with Sirona and RUH
- Implement the NHS England model 'Safe compassionate care for frail older people using an integrated care pathway'

End of Life Care:
- Electronic Palliative Care Coordination System (EPaCCS) is embedded across all organisations to ensure patients are managed appropriately
- Ensure all end of life patients have advanced care plans in place and do not attempt pulmonary resuscitation (DNAR) orders in place

Planned Care:
- Develop proposals for an integrated MSK service, to include pain management and a community model for Rheumatology in conjunction with current providers.
- Jointly review Ophthalmology services with the RUH and Wiltshire CCG.
- Work with the newly appointed Macmillan GP to develop shared care and primary care support for cancer patients. This will focus on early diagnosis and cancer survivorship following treatment.
- Set up a Referral Support Service across BaNES. This will be supported by Map of Medicine which will be fully implemented across all GP practices during 2014/15.
- Review the provision of physiotherapy services across BaNES and then develop a service specification in preparation for the re-tendering of the community services contract.

Maternity and New Born:
- Work with providers and Wiltshire CCG as lead commissioner to embed the newly procured maternity service
- Work with providers, GPs & health visitors to agree and implement pathways ensuring close communication
- Review ambulance transfers and transfers from community centres to hospital care

Learning Disabilities
- Primary Care to continue to offer annual health checks to adults with LD (+ LD nurses)
- Improve access to screening and reducing health inequalities
- Embed commissioning and service delivery of LD mental health services into mainstream contracting with AWP.
- CCG to maintain joint commissioning arrangements with LA as lead commissioner, utilising pooled budget
- Ensure that recommendations arising from Winterbourne View serious case review are implemented locally with clear actions and lead responsibilities
- Develop local response in relation to the findings of the Confidential Inquiry into Premature Deaths of people with learning disabilities

QUALITY OBJECTIVES

Quality objectives - We Will:
- Adopt a patient-centred approach that includes treating patients, families and carers courteously and with compassion, involving them, keeping them informed and learning from them
- Foster a culture of continuous improvement and innovation with respect to patient safety, clinical effectiveness and patient experience
- Work collaboratively with our local providers to ensure that staff are delivering high quality, safe , compassionate care for all with increasing focus on frail older people
- Ensure that both patient and staff satisfaction with local services is monitored and that areas for improvement are identified and implemented at the earliest opportunity
- Ensure there is consistent access to effective treatments for patients in line with evidence based clinical policies, underpinned by clinical practice audit.
- Ensure our research, evaluation and development programmes contribute to improving outcomes and spreading innovation
- Ensure that equality, diversity and human rights values underpin and are central to our policy making, service planning, employment practices and community engagement and involvement
- Continue to establish effective early warning systems to ensure detection and prevention of serious failures and harm
- Establish a positive, open and fair and lifelong learning culture and ensure that staff are properly inducted, trained and motivated
- Ensure the principles and values of the NHS Constitution and NHS Mandate are integral to everything we do by providing safe care & ensure people experience better care

Safety outcomes:
- Reduce incidence of VTE
- Reduce incidence of community wide pressure ulcers in BANES
- Reduce the number of bed days occupied as a result of avoidable infection
- Improve quality of safeguarding practice by ensuring lessons learned and actions agreed as a result of safeguarding interventions are implemented by agreed timescales

Effectiveness outcomes:
- Reduce emergency admissions within 30 days of discharge
- Increase number of social care providers who have completed a satisfactory Quality Assurance process
- Improve the outcomes for people using mental health and LD services
- Implementation of new QOF and impact on referral management
- Implement vascular health checks programme
- Maximise functional recovery in hospital for elderly care patients
- Improve outcome on Friends and Family Test (FFT) including staff survey

Patient/ service user/ carer experience outcomes:
- Improve patient experience to top quartile and maintain high performance
- 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

PREVENTION & SELF CARE

- Analyse key health problems
- Develop self-care strategy
- Create health inequalities framework
- Identify current and new high impact programmes
- Identify appropriate outcome and process metrics
- Commission agreed priority programmes – mix of primary & secondary prevention

ENABLERS

- Citizen participation and empowerment
- Interoperability – integration of information systems
- Organisational Development Plan
- Integrated care – e.g. *House of Care*
- Personal Health Budgets
- Primary Care Development including referral support for General Practice
- Commissioning Support
- Contractual levers including incentivising innovation, improvement and integration

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Appendix 2

NHS
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Table 5: NHS Constitution Access to Services Metrics

Short Description	Target	Performance						Trend	To improve	Providers YTD				Supporting Narrative
		In period			Year to date					RUH	UHB	NBT	Sirona	
i. The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period on an adjusted basis	90%	94%	G	⇩ Dec	94%	G		⇧	90%	93%	92%	-	Admitted pathways have performed above target in all months except July 2013. In July 2013 the RUH undertook an exercise to clear their backlog and dropped to 78% bringing the BaNES figure down to 89.7% in July, just below target.
ii. The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period	95%	97%	G	⇧ Dec	96%	G		⇧	96%	92%	95%	99%	Non-admitted pathways have been above target for BaNES every month in 2013/14 to date. UHB have struggled to meet the target and have been amber or red in all but 1 month. At the beginning of the year, UHB took over services including the Head and Neck waiting lists from NBT. This already included long waiters and UHB have a recovery plan in place to improve performance.
iii. The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period	92%	94%	G	⇩ Dec	94%	G		⇧	94%	91%	92%	99%	Incomplete pathways have been above target for BaNES every month in 2013/14 to date. UHB has been mostly amber. (See comments above.)
Diagnostic test waiting times - under 6 week waits	99.0%	99.7%	G	⇩ Dec	99.3%	G		⇩	99.6%	98.4%	98.3%	94.7%	Diagnostic performance is very good this year. This indicator was amber in June but otherwise has been green. Waiting lists are on a downwards trend and in Dec are at the lowest level this year (2,882). The number of people waiting for more than 6 weeks at the month end has been below 10 for the last 3 months , better than the earlier months this year and all of 2012/13.
A&E Department - % of A&E attendances under 4 hours (RUH)	95%	94%	A	⇩ Dec	94%	A		⇧	94%	94%	92%	95%	This is the RUH results as combined provider scores are not available for A&E attendances. For the RUH the year to date Amber reflects poor performance in April. Though performance has not hit target ever month, it is better than 2012/13 particularly for the winter period. NBT has struggled with this indicator for the last few months and UHB had their poorest performance in December.
Ambulance clinical quality – Category A (Red 1) 8 minute response time (SWAST)	75%	66%	R	⇩ Dec	70%	R		⇧					The Ambulance Indicators have all got worse across the year, missing the targets in many months. SWASFT are targetted on total Trust results not by locality. SWASFT are working with commissioners on a red recovery plan for their North Area. The CCG are working to improve the results for the BaNES area.
Ambulance clinical quality – Category A (Red 2) 8 minute response time (SWAST)	75%	69%	R	⇩ Dec	72%	A		⇧					
Ambulance clinical quality - Category A 19 minute transportation time (SWAST)	95%	94%	A	⇩ Dec	95%	A		⇧					
Mixed Sex Accommodation (MSA) Breaches (RUH)	0	5	R	⇧ Dec	11	R		⇩					This shows the RUH results only. The RUH have had 1 incident in September and 2 in December. These were all in the MAU when the Emergency Department was very busy. Actions have been put in place to improve the patient management in MAU but occasionally patient safety has been put first.
Cancelled Operations - not rebooked within 28 days (RUH)	1.0%	0.0%	G	⇔ Dec	21.5%	R		⇩					This indicator is reported quarterly for the RUH. Quarter 1 results were poor but Quarter 2 and 3 are both on target at 0%. The 1% target is locally set.
Mental Health Measure – Care Programme Approach (CPA) 7 day follow up on discharge	95%	97%	G	⇩ Dec	97%	G		⇔					This indicator has been above target all year.

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Table 6: NHS Constitution Access to Cancer Services Metrics

Short Description	Target	Performance						Trend	To improve	Supporting Narrative
		In period			Year to date					
All Cancer 2 week waits	93.0%	95.1%	G	⇧ Dec	96.0%	G			⇧	This indicator has performed above target in all months of 2013/14 to date.
Two week wait for breasts symptoms (where cancer was not initially suspected)	93.0%	93.5%	G	⇩ Dec	98.2%	G			⇧	This indicator has performed above target in all months of 2013/14 to date
Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat')	96.0%	94.6%	A	⇩ Dec	98.2%	G			⇧	This indicator has performed below target in December 2013 only. In December their were 3 breaches out of 56 patients, 1 each at NBT, RUH and UHB.
31-day standard for subsequent cancer treatments-surgery	94.0%	93.3%	A	⇩ Dec	98.8%	G			⇧	This indicator has performed below target in December 2013 only. In December their was 1 breach (at UHB) out of 15 patients.
31-day standard for subsequent cancer treatments-anti cancer drug regimens	98.0%	100.0%	G	⇔ Dec	99.4%	G			⇧	This indicator has performed below target in June 2013 only at 95%.
31-day standard for subsequent cancer treatments-radiotherapy	94.0%	100.0%	G	⇔ Dec	99.2%	G			⇧	This indicator has performed above target in all months of 2013/14 to date
All cancer two month urgent referral to first treatment wait	85.0%	95.7%	G	⇧ Dec	91.6%	G			⇧	This indicator performed below target in May (81%) and November (84.8%) 2013.
62-day wait for first treatment following referral from an NHS cancer screening service	90.0%	100.0%	G	⇧ Dec	91.6%	G			⇧	This is the worst performing indicator with 2 amber months (June and Sept) and 2 red months (Oct and Nov). The numbers of patients on this pathway is usually small. In November 3 patients out of 10 breached - 70%. All breaches were at UHB.
62-Day wait for first treatment for cancer following a consultants decision to upgrade the patient's priority	90.0%	100.0%	G	⇔ Dec	97.8%	G			⇧	This indicator has performed above target in all months of 2013/14 to date

The Cancer waiting time standards are performing well in 2013/14. There are targets that are not hit on a monthly basis. The small numbers of patients on these pathways with individual circumstances and choice make it difficult to hit every target every month but we will continue to work with providers to improve results where possible.

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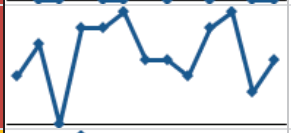
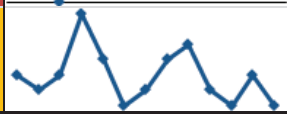
Table 7: National Quality and Safety Standards

Short Description	Target	Performance In period			Year to date		Trend	To improve	Provider split YTD RUH	RNHRD	Sirona	Supporting Narrative
Incidence of newly acquired category 2,3 and 4 pressure ulcers (RUH)		3		⇧ Dec	30			⇩	30		-	This is the monthly snap shot from the NHS Safety Thermometer. The Median for the RUH for July 2012- Dec 2013 stands at 0.6%, which is lower than the national median of 1.0% prevalence of patients with newly acquired pressure ulcers.
Number of Never Events	0	0	G	⇔ Dec	0	G		⇩				There have been no never events with the providers where we are lead commissioner.
Friends and family test response rate (RUH)	15.0%	21.4%	G	⇩ Dec	23.1%	G		⇧	23.1%			The RUH have met the combined response rate target in all months except April. In December this was with 44.9% for inpatient and 10.69% for A&E. UHB has been hitting this target since September 2013. NBT results are still mixed as the roll out continues.
Percentage of all adult inpatients who have had a VTE risk assessment (RUH)	95%	96%	G	⇧ Nov	95%	G		⇧				The RUH are meeting their VTE risk assessment trajectory, currently achieving 95.6% for Q3 . There is a 1 month data lag.
WHO Surgical Safety Checklist completed for 100% of procedures (RUH)	100.0%	99.8%	G	⇩ Nov	99.9%	G		⇧				The RUH met their target for Q2, and are currently achieving 99.8% in Q3. There is a 1 month data lag.
Fracture Neck of Femur - % in theatre within 36 hours (RUH)	80.0%	75.4%	A	⇩ Dec	80.3%	G		⇧				The RUH just missed the target for Q3 with 79.1% but year to date are meeting the target.
Healthcare acquired infection (HCAI) measure (MRSA) (All CCG patients)	0	0	G	⇔ Dec	3	R		⇩	0		0	There have been 3 instances of MRSA this year. All have been investigated and reviewed.
Healthcare acquired infection (HCAI) measure (c. difficile) (All CCG patients)	4	4	G	⇧ Dec	43	R		⇩	28		4	The BaNES HCAI collaborative are taking actions to reduce c.difficile infections, including focussing on appropriate anti-microbial prescribing. The CCG year end target of 46 cases is expected to be missed.
Healthcare acquired infection (HCAI) measure (c. difficile) Adjusted after consulation with CCG (RUH) (Post 72 hour)	2	1	G	⇩ Dec	22 plus 6	A		⇩				22 denotes the number of hospital acquired c.difficile counted towards the RUH annual trajectory of 29. The good performance in December brings the RUH almost back in line to meet the full year target.

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NHS
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Combined Tool:
Equality Impact Assessment / Equality Analysis
Quality Impact assessment tool
Privacy impact assessment

Please refer to the combined guidance document for any assistance in completing this (Appendix 1)

Title of service or policy	NHS BaNES CCG – 5 Year Strategic Plan
Name of directorate and service	NHS BaNES CCG
Name and role of officers completing the Impact Assessments	Dawn Clarke- Director of Nursing and Quality Val Janson- Senior Manager for Quality & Patient Safety
Date of assessment	21 May 2014

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

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

The Quality Impact Assessment Tool
This involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 6 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is greater than (>) 8 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 8 must go on to a detailed assessment at stage 2.

Privacy Impact Assessment
Privacy impact assessments (PIAs) are a tool that you can use to identify and reduce the privacy risks of your projects. A PIA can reduce the risks of harm to individuals through the misuse of their personal information. It can also help you to design more efficient and effective processes for handling personal data

1.	**Identify the aims of the policy or service and how it is implemented**	
	Key questions	**Answers / Notes**
1.1	Briefly describe purpose of the service/policy including • How the service/policy is delivered and by whom • If responsibility for its implementation is shared with other departments or organisations • Intended outcomes	Seizing Opportunities- A Five Year Strategy 2014-2018 responds to the national guidance *Everyone Counts: 'Planning for Patients'* published in December 2013 requiring CCGs to develop 5 year strategies. The document describes the vision of how the health services for the people of Bath and North East Somerset needs to change over the 5 years from 2014 to 2019, and how this will be achieved. NHS Bath and North East Somerset CCG needs to show this with clarity of direction in its role as local system leaders, while working closely with both partners in the commissioning of related services and providers of health and social care. At all times the CCG will keep in focus our patients and public. The intended outcomes of the 5 years strategy are as follows: 1.Increasing the focus on prevention, self-care and personal responsibility

		2.Improving the coordination of holistic, multi-disciplinary Long Term Condition management 3.Creating a stable and sustainable Urgent Care system that can respond to changes in demand 4.Redesigning musculo-skeletal pathways to achieve clinically effective services 5.Commissioning integrated safe, compassionate pathways for frail older people 6.Ensuring the interoperability of IT systems across the health and care system
1.2	Provide brief details of the scope of the policy or service being reviewed, for example: • Is it a new service/policy or review of an existing one? • Is it a national requirement?). • How much room for review is there? •	The CCG became a statutory organisation in April 2013.This is the first five year strategy. Responding to the national drivers and imperatives, it is a locally determined strategy which guides health related interventions from across the area. It pays significant attention to the underlying economic situation (analysed from data collected for the Joint Strategic needs Assessment and national and local health related priorities). It is a national requirement that the CCG develops a five year strategy, however there is room for future review depending on changing healthcare needs.
1.3	Do the aims of this policy link to or conflict with any other policies of the CCG?	The strategy is the overarching strategy for BaNES CCG and is aligned and interlinked with the Joint Health and Wellbeing Strategy, as produced by the Health and Wellbeing Board and the 'Better Care Fund' Other policies and strategies within the CCG are aligned to this plan
2. Consideration of available data, research and information		

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

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

	Key questions	**Data, research and information that you can refer to**
2.1	What is the equalities profile of the team delivering the service/policy?	Age Profile of the CCG: 20-39 - 26% 39-49 - 42% 50+ - 32% Total - 100% Gender Profile: Male - 28% Female - 72% Total - 100% The CCG is very small with approximately 40 members of staff, it is not possible to provide further details of the equality profile without identifying individuals.
2.2	What equalities training have staff received?	CCG Staff are required to undertake the mandatory online Equality and Diversity training. This is monitored through appraisal and audit.

2.3	What is the equalities profile of service users?	The population age and sex profile remains largely consistent compared with previous years, with a 49%/51% male/female split. The age profile is largely consistent with the UK as a whole, except for the 20-24 age bracket which accounts for 10% of the population as opposed to 7% seen nationally. A larger proportion of people are in this age bracket range are as a result of the student population at two universities in BaNES.[1] The 2011 census showed our population to be 90% White British, with the next two largest groups being 3.8% (approx 6,600) Other White, and 2.6% (approx 4,500) Asian or Asian British descent. Bath and North East Somerset is less ethnically diverse than the UK as a whole but more so than the South West.[1] The population of BaNES is expected to increase to 185,663 (a 5.8% increase) by 2021.
2.4	What other data do you have in terms of service users or staff? (e.g results of customer satisfaction surveys, consultation findings). Are there any gaps?	A number of data sources were used to develop the plan including the Joint Strategic Needs Assessment (JSNA), the Commissioning for Value Pack, CCG and LA Outcomes Tools, Levels of ambitions Atlas, 'Any Town' Health System Model and local analysis of current performance and patterns of spending.
2.5	What engagement or consultation has been undertaken as part of this EIA and with whom? What were the results?	8 specific events and workshops took place between 16th October 2013 and 13th May 2014, involving just over 100 members of the public. A comprehensive report of the outcomes of the engagement events has been prepared. The contributions are reflected in the development of our plans. There was broad consensus for the proposed direction of travel. In addition, 3 stakeholder events took place during February and March 2014 involving a wide range of stakeholders including local

		provider organisations, neighbouring CCGs, voluntary bodies, NHS England, Healthwatch and the Local Authority. The outcome of these events was support for the priority areas identified by the CCG for transformation. In addition we have been provided with an independent analysis of progress by an economist against the strategy's core indicators.
2.6	If you are planning to undertake any consultation in the future regarding this service or policy, how will you include equalities considerations within this?	Our five year Transformation Leadership Board (TLB) will oversee the different work streams within the scope of the five year plan and will be led by the CCG. It will comprise a multidisciplinary group of Directors and Clinical Leaders from our constituent organisations. The TLB will be supported by a Programme Management Office [PMO] led by a programme director. The PMO will ensure that progress and benefits of the work streams are tracked and variances, risks, dependencies including equalities considerations and issues are identified, managed and addressed

3. Assessment of impact: 'Equality analysis'			
	Based upon any data you have considered, or the results of consultation or research, use the spaces below to demonstrate you have analysed how the service or policy: • Meets any particular needs of equalities groups or helps promote equality in some way. • Could have a negative or adverse impact for any of the equalities groups		
		Examples of what the service has done to promote equality	**Examples of actual or potential negative or adverse impact and what steps have been or could be taken to address this**

3.1	**Gender** – identify the impact/potential impact of the policy on women and men.	Gender- All services commissioned by the CCG need to ensure they are delivered in a way that ensures equal access and are appropriate to the needs of particular groups, rather than one size fits all	The plan will be universally applied to all BaNES residents and it is not expected to have an impact relating to gender
3.2	**Pregnancy and maternity**		The plan will be universally applied to all BaNES residents and it is not expected to have an impact relating to .pregnancy and maternity
3.3	**Transgender –** – identify the impact/potential impact of the policy on transgender people		The plan will be universally applied to all BaNES residents and it is not expected to have an impact relating to transgender.
3.4	**Disability** - identify the impact/potential impact of the policy on disabled people (ensure consideration both physical and mental impairments)	Disability-	The plan will be universally applied to all BaNES residents and it is not expected to have an adverse impact relating to disability
3.5	**Age** – identify the impact/potential impact of the policy on different age groups	The CCG is aiming to commission integrated safe, compassionate pathways for frail older people, this is one of the strategic objectives and fits with the JSNA profile of an increasingly older frail population in Banes	The plan will be universally applied to all BaNES residents and it is not expected to have an adverse impact relating to age.
3.6	**Race** – identify the impact/potential impact on different black and minority ethnic groups		The plan will be universally applied to all BaNES residents and it is not expected to have an adverse impact

			relating to .race
3.6	**Sexual orientation -** identify the impact/potential impact of the policy on lesbians, gay, bisexual & heterosexual people		The plan will be universally applied to all BaNES residents and it is not expected to have an impact relating to sexual orientation
3.7	**Marriage and civil partnership –** does the policy/strategy treat married and civil partnered people equally?		The plan will be universally applied to all BaNES residents and it is not expected to have an impact relating to . marriage and civil partnership
3.8	**Religion/belief** – identify the impact/potential impact of the policy on people of different religious/faith groups and also upon those with no religion.		The policy will be universally applied to all BaNES residents and it is not expected to have an impact relating to .religion/belief
3.9	**Socio-economically disadvantaged** – identify the impact on people who are disadvantaged due to factors like family background, educational attainment, neighbourhood, employment status can influence life chances		Our plans acknowledge these impacts on the health status of our population. Elements of our plans are specifically aimed at addressing health inequalities.
3.10	**Rural communities** – identify the impact / potential impact on people living in rural communities		Our plans do not specifically address issues of rurality.

Bath and North East Somerset Clinical Commissioning Group: Quality Impact Assessment Tool

Overview

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 6 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is greater than (>) 8 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 8 must go on to a detailed assessment at stage 2.

Scoring

A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

The following tables define the impact and likelihood scoring options and the resulting score: -

LIKELIHOOD		IMPACT	
1	RARE	**1**	MINOR
2	UNLIKELY	**2**	MODERATE / LOW
3	MODERATE / POSSIBLE	**3**	SERIOUS
4	LIKELY	**4**	MAJOR
5	ALMOST CERTAIN	**5**	FATAL / CATASTROPHIC

Risk score	Category
1 - 3	Low risk (green)
4 - 6	Moderate risk (yellow)
8 - 12	High risk (orange)
15 - 25	Extreme risk (red)

A fuller description of impact scores can be found at appendix 1.

		IMPACT				
		1	2	3	4	5
LIKELIHOOD	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

Stage 1

The following assessment screening tool will require judgement against the 6 areas of risk in relation to Quality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations. Where an adverse impact score greater than (>) 8 is identified in any area this will result in the need to then undertake a more detailed Quality Impact Assessment. This will be supported by the Clinical Quality & Nursing team.

Answer positive/negative (P/N) in each area. If N score the impact, likelihood and total in the appropriate box. If score > 8 insert Y for full assessment

Area of Quality	Impact question	P/N	Impact	Likeli-hood	Score	Full Assessment required
Duty of Quality	Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	P				
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care?	P				
Patient Safety	Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?	P				
Clinical	Could the proposal impact positively or negatively on evidence	P				

Area of Quality	Impact question	P/N	Impact	Likeli-hood	Score	Full Assessment required
Effectiveness	based practice, clinical leadership, clinical engagement and/or high quality standards?					
Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	P				
Productivity and Innovation	Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	P				
Vacancy impact	Could the proposal impact positively or negatively as a result of staffing posts lost?	P				
Resource Impact	Could this proposal impact positively or negatively with regard to estates, IT resource, community equipment service or other agencies or providers e.g. Social care/voluntary sector/District nursing	P				

Please describe your rationale for any positive impacts here: The 5 year strategy describes the CCG intended outcomes, in order to meet these the CCG will need to take into account the above within its commissioning and procurement processes. The CCG will continue with its core work in relation to quality, safety and patient experience to ensure that local service provision has a positive impact on the population.

Privacy impact assessment screening questions

These questions are intended to help you decide whether a PIA is necessary. Answering 'yes' to any of these questions is an indication that a PIA would be a useful exercise. You can expand on your answers as the project develops if you need to.

PIA Screening Questions	Yes	No

Will the project involve the collection of new information about individuals?		N
Will the project compel individuals to provide information about themselves?		N
Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?		N
Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		N
Does the project involve you using new technology that might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition.		N
Will the project result in you making decisions or taking action against individuals in ways that can have a significant impact on them?		N
Is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For example, health records, criminal records or other information that people would consider to be private.		N
Will the project require you to contact individuals in ways that they may find intrusive?		N

If you have answered yes to any of the questions above please complete the following template, you may find it helpful to refer to the guidance document which sets out the data protection principles

Summarise why the need for a PIA was identified (from screening questions above)	
Describe the information flows: You should describe the collection, use and deletion of personal data here and it may also be useful to refer to a flow diagram or another way of explaining data flows. You should also say how many individuals are likely to be affected by the project	Information used to inform the development of the five year plan was from nationally published information and locally published information within the Joint Strategic Needs Assessment. New workstreams arising from the strategic planning process will undertake individual PIAs
Consultation requirements: Explain what practical steps you will take to ensure that you identify	

<table>
<tr><td>and address privacy risks. Who should be consulted internally and externally? How will you carry out the consultation? You should link this to the relevant stages of your project management process.

You can use consultation at any stage of the PIA process</td><td></td></tr>
<tr><td>Identify the privacy and related risks:
Identify the key privacy risks and the associated compliance and corporate risks. Larger-scale PIAs might record this information on a more formal risk register.</td><td><table><tr><th>Privacy issue</th><th>Risk to individuals</th><th>Compliance risk</th><th>Associated organisation / corporate risk</th></tr><tr><td></td><td></td><td></td><td></td></tr></table></td></tr>
</table>

Identify privacy solutions: Describe the actions you could take to reduce the risks, and any future steps which would be necessary (eg the production of new guidance or future security testing for systems).	**Risk** / **Solution(s)** / **Result:** is the risk eliminated, reduced, or accepted? / **Evaluation:** is the final impact on individuals after implementing each solution a justified, compliant and proportionate response to the aims of the project?
Sign off and record the PIA outcomes: Who has approved the privacy risks involved in the project? What solutions need to be implemented?	Risk / Approved solution / Approved by

Integrate the PIA outcomes back into the project plan: Who is responsible for integrating the PIA outcomes back into the project plan and updating any project management paperwork? Who is responsible for implementing the solutions that have been approved? Who is the contact for any privacy concerns that may arise in the future?	

Bath and North East Somerset Council & B&NES CCG
Equality Impact Assessment/ Quality Impact Assessment and privacy Impact assessment Improvement Plan

Please list actions that you plan to take as a result of this combined assessment. The actions need to be built into your service planning framework. Actions/targets should be measurable, achievable, realistic and time framed.

Issues identified	Actions required	Progress milestones	Officer responsible	By when

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

Signed off by: (Divisional Director or nominated senior officer)

Date:

MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**04/06/2014**
TYPE	**An open public item**

Report summary table	
Report title	NHS England: BGSW Area Team operational plan for 2014/15 and 2015/16
Report author	Douglas Blair, 0113 825 1505
List of attachments	BGSW Area Team operational plan for 2014/15 and 2015/16
Background papers	None.
Summary	NHS England is responsible for directly commissioning a number of services: • Primary care services (including GP services, dental , optometry and pharmacy services) • Secondary care dental services • Secondary healthcare services for armed forces serving personnel and families • Public Health services under Section 7a • Specialised healthcare services • Healthcare services for offenders and those within the justice system This draft delivery plan sets out the strategic framework for the development of health services in the Bath, Gloucestershire, Swindon and Wiltshire (BGSW) area commissioned by NHS England. This report is to provide the Health and Wellbeing Board the opportunity to comment prior to the final plan being submitted in June as well as consider the longer term implications of the plan and allow the Board to hold NHS England to account in delivering against this plan over time.
Recommendations	The Board is asked to • Consider the draft report • Provide any comment on the content of the plan and recommend any amendments to the plan. • Note any implications on the Strategy for the Board.

Rationale for recommendations	The plan for health services directly commissioned by NHS England is intrinsic to the overall delivery of the strategy for Bath and North East Somerset.
Resource implications	-
Statutory considerations and basis for proposal	-
Consultation	The draft has been shared with the CCG.
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

THE REPORT

1.1 NHS England (known legally as the NHS Commissioning Board) is an independent organisation that operates across England, at arms-length from government.

1.2 The Bath, Gloucestershire, Swindon & Wiltshire ("BGSW") Area Team is responsible for commissioning Primary Care Services, Secondary Care Dental Services and Public Health services under Section 7a for the population of BGSW and Secondary Healthcare services for armed forces serving personnel and their families for London and the South region.

1.3 The Bristol, North Somerset, Somerset & South Gloucestershire ("BNSSSG") Area Team is responsible for commissioning Specialised Healthcare Services and healthcare services for offenders and those within the justice system for services provided out of the BGSW Area, together with the BNSSSG and Devon Cornwall and the Isles of Scilly Areas.

1.4 The attached plan sets out the operational plan for commissioning of the above services for BGSW.

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BaNES, Gloucestershire, Swindon and Wiltshire Area Team

Commissioning Plan 2014/15 and 2015/16

CONTENTS

SECTION 1: INTRODUCTION

Introduction

1.1. NHS England (known legally as the NHS Commissioning Board) is an independent organisation that operates across England, at arms-length from government. Through its 27 local area teams, NHS England is responsible for directly commissioning:

- Primary care services (including GP services, dental , optometry and pharmacy services)
- Secondary care dental services
- Secondary healthcare services for armed forces serving personnel and families
- Public Health services under Section 7a
- Specialised healthcare services
- Healthcare services for offenders and those within the justice system

1.2. This delivery plan sets out the strategic framework for the development of commissioned health services in the Bath, Gloucestershire, Swindon and Wiltshire (BGSW) area. The BGSW area team work closely with the Clinical Commissioning Groups (CCGs) and their member practices to define a model of care that fits with the national strategic framework while being responsive to local populations. This joint working utilises local knowledge and understanding of the needs of local patients to commission a wide range of services. The model of care supports the delivery of the wider health and wellbeing strategy for the local population.

1.3. NHS England's focus for direct commissioning is on improving health outcomes for patients and ensuring equity and consistency in the provision of health services, but with services tailored to meet local need. This includes establishing national service specifications and commissioning intentions, which are then tailored locally.

The national context

1.4. The Government's NHS mandate[1] originates in the NHS Outcomes Framework which describes the five main categories of better outcomes we want to see within the health service:

- We want to **prevent people from dying prematurely**, with an increase in life expectancy for all sections of society.

[1] https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015

- We want to make sure that those people with long-term conditions, including those with mental illnesses, get the **best possible quality of life**.
- We want to ensure patients are able to **recover quickly and successfully** from episodes of ill-health or following an injury.
- We want to ensure patients have a **great experience** of all their care.
- We want to ensure that patients in our care are **kept safe** and protected from all avoidable harm.

1.5. The health needs and expectations of our population are changing and in order to meet these, the whole health and social care sector will need to move away from outdated divisions of care. Collectively, we are moving towards a system of integrated care, where clinicians work together in flexible teams formed around the needs of the patient, their families and the communities in which they live. The aim is to deliver high quality, cost effective and resilient systems of care that achieve best health outcomes for the population of BGSW.

1.6. The BGSW area has relatively good health outcomes when compared to the England average. However, there are pockets of deprivation across the geography and there are opportunities to improve access to healthcare and reduce inequalities across the whole geography. The age profile of the population and the predicted growth in the over 50s by 2011 means that there are opportunities to improve the management of long term conditions and management of patients with multiple comorbidities.

1.7. NHS England launched *A Call to Action* in July 2013 which set out the challenges and opportunities faced by the health and care systems over the next five to ten years. Ways to raise the quality of care to the best international standards need to be identified for all in our communities, while closing a potential funding gap of around £30 billion by 2020/21. This will require transformational change in how and where health and care services are delivered.

1.8. On the 20th December NHS England issued planning guidance to CCGs and NHS England direct commissioners titled Everyone Counts: Planning for Patients 2014/15 to 2018/19. This sets out how it is proposed to invest the NHS budget so as to drive continuous improvement and to ***make high quality care for all, now and for future generations*** into a reality[2].

1.9. Change will need to be achieved through:

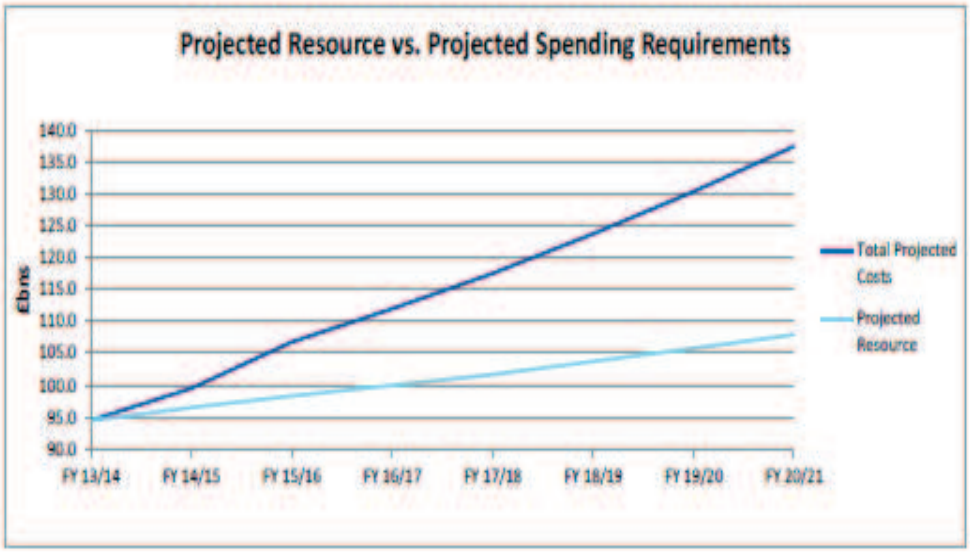
- Listening to patient views
- Delivering better care by realising the benefits of the digital revolution

[2] http://www.england.nhs.uk/2013/12/20/planning-guidance/

- Transparency and sharing data about local health services
- Transforming primary care services
- Ensuring tailored care for vulnerable and older people
- Delivering care in a way that is integrated around the individual patient
- Ensuring access to the highest quality urgent and emergency care
- A step change in the quality of elective care
- Providing specialised services concentrated in centres of excellence
- Improving access to services (e.g. moving to seven day service provision)
- Supporting research and innovation
- Developing an integrated training model

The financial challenge

1.10. Nationally there is a forecast national financial gap of circa £30 billion by 2020/21. This is shown on the graph below. This details projections around the raising costs of NHS healthcare, largely due to an aging population (described later in this document) and projected resources (i.e. funding) that will be available to meet this demand.



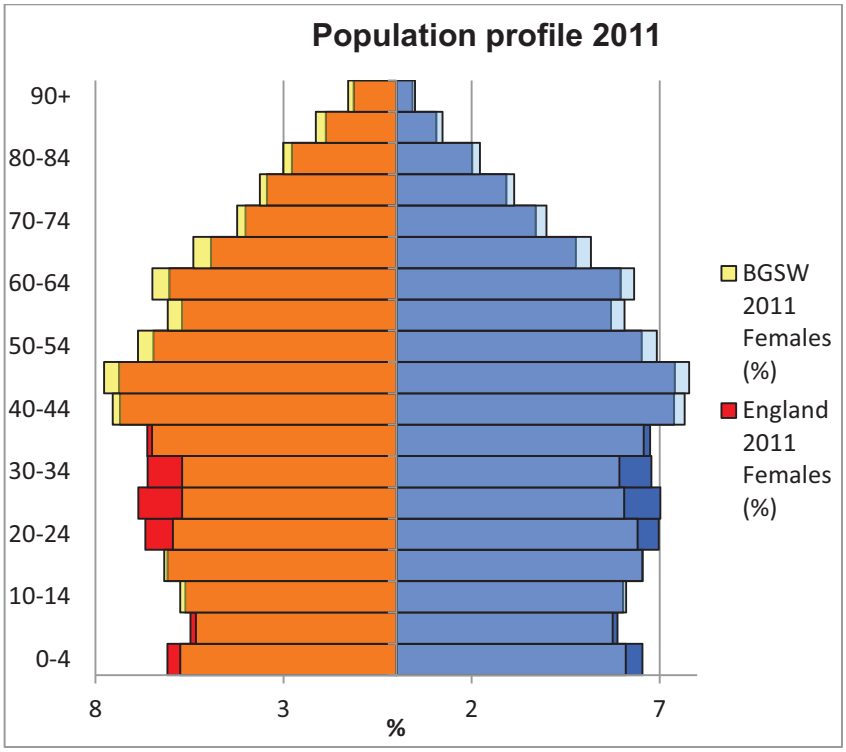
1.11. As a crude approximation the Bath, Gloucestershire, Swindon, and Wiltshire weighted population is 2.5% of the national population, so our financial challenge is circa £0.75 billion of the £30 billion call to action challenge across all NHS commissioners.

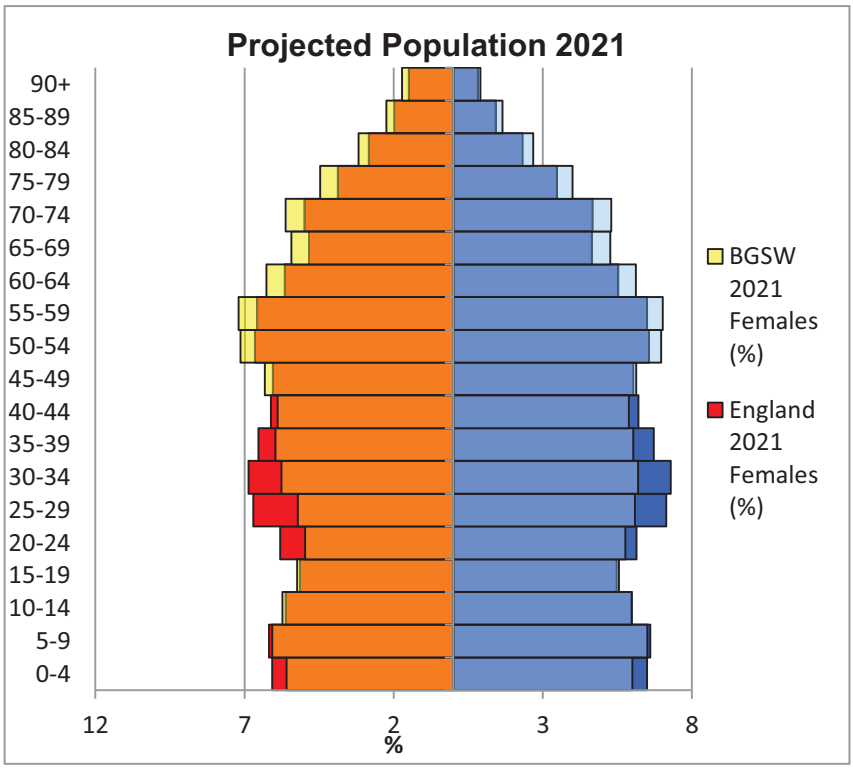
1.12. The affordability challenges (or more accurately the demand challenges) in 2014/15 and 2015/16 are real and urgent. The prospect of resources being

outstripped by demand, driven largely by an ageing population and an increasing prevalence of chronic diseases, presents a significant challenge to the way we currently commission and provide care.

SECTION 2: THE DEMOGRAPHIC OF THE BGSW POPULATION

2.1. By 2021 it is projected there will be a 7.6% increase in the total BGSW population, which is shown broken down by gender and age in the following graphs:





2.2. Whilst this increase in total population in itself is significant, it masks a more significant issue in that it is projected that over the same time period there will be a significant increase in number of people aged over 65 years and more specifically over 85 years.

2.3. In practice this means the percentage of older people in the total population is increasing; this is often referred to as “an aging population”. This presents two challenges in that older people generally require more health and social care support, plus the percentage of the population who are of working age and paying taxes diminishes (i.e. there is less income from taxes to fund public services). It is this situation that is driving the financial challenge that was outlined earlier in this plan.

Inequalities

2.4. Health inequalities are the result of a complex and wide-ranging network of factors. People who experience material disadvantage, poor housing, lower educational attainment, insecure employment or homelessness are among those more likely to suffer poorer health outcomes and an earlier death compared with the rest of the population.

2.5. Health inequalities start early in life and persist not only into old age but subsequent generations. Tackling health inequalities is a top governmental and local priority for NSH England, as well as for our partners. Tackling health inequalities is focused on narrowing the health gap between disadvantaged groups, communities and the rest of the country, and on improving health overall.

2.6. The 4 areas of BGSW show the differences in deprivation levels based on national quintiles of the Index of Multiple Deprivation 2010 by Lower Super Output area). Generally, deprivation is much lower than the national average in the BGSW area, however there are significant pockets of deprivation, most notably in Swindon and this means there are opportunities to improve outcomes and reduce health inequalities in these areas.

Health Outcomes/Needs	Deprivation	
Source(s)	**Public Health observatory - interactive maps**	IMD
BaNES	Deprivation	4
Gloucestershire	Deprivation	7.2
Swindon	Deprivation	14.3
Wiltshire	Deprivation	2
ENGLAND Comparator	*England Average*	20.3
	England Worse	83.7

SECTION 3: MAINTAINING A FOCUS ON QUALITY

3.1. Everyone Counts describes the key components of quality (effectiveness, patient experience and safety). This focuses on the fundamental principles of the:

- Francis report and the need to improve high quality, safe care.
- Berwick report and the need to foster a safety culture
- Winterbourne report describes core specifications for commissioners and providers to improve quality and safety standards for patients with learning disabilities.

3.2. Intelligent, collaborative commissioning will be undertaken with partners, including regulators of health care services. Within BGSW we will manage a quality work programme for Primary Care and contribute to that for Armed Forces.

Safety

3.3. Knowing that patients are safe in our care is of paramount importance and one of the main categories from the NHS Outcomes Framework relates to keeping patients safe and protecting them from avoidable harm.

3.4. In response to the need to continuously improve patient safety and reduction of avoidable harm we will continue:

- Host the Quality Surveillance Group oversight across BaNES, Gloucestershire, Swindon and Wiltshire
- Implement the new patient safety alerting system
- Continue to drive to reduce the incidences of HCAI
- Implement the new Patient Safety Collaborative Programme
- Implement the new patient safety thermometers
- Take prompt action in response to Care Quality Commission notices and enforcement notices
- Take prompt learning and quality improvement for Serious Incidents and Death in Custody reviews
- Innovate and utilise national models to support safe staffing delivery

Quality in primary care

3.5. We intend to support clinicians to provide optimum care for patients by facilitating the development of a strong governance culture throughout the area. This will include more integration to prevent clinical isolation and the development of stronger processes to identify variation in performance and offer early support and intervention. To improve the quality of primary care and to keep patients as safe as possible from avoidable harm, our areas of focus are:

- To work with CCG's in order to support the implementation of robust reporting on adverse events and serious incidents requiring investigation (SIRI) in primary care settings utilising the national database of National Reporting and Learning System (NRLS) which will also support practices with regular reports to support their CQC registration.
- To improve the way that safeguarding training is implemented to ensure that everyone who needs training has been trained. In addition, to improve the way the safeguarding training is embedded in practice so that people really understand what it means and how and when to raise a concern.
- To improve the way in which informed consent is given by patients for procedures performed in primary care.
- To empower all clinical staff to challenge inappropriate or questionable behaviour.
- To embed better two way communication about concerns with Care Quality Commission
- To ensure that GPs with Special Interests (GPwSI) are appropriately monitored for the work that they do.

3.6. We believe that we have a robust system of appraisal and revalidation in place in BGSW, which we will continue to develop in conjunction with our lead appraisers. The system is appropriately quality assured and assists with raising quality of primary care and in triangulation of any concerns that are raised.

Patient Experience

3.7. Wherever possible we will support people in maintaining their own health and thus not requiring healthcare services but where necessary. We want to ensure that every patient has a positive experience of health care therefore we will continue to:

- Improve the complaints systems for primary care, ensuring that verbal complaints (not just written ones) and concerns are recorded, considered and acted upon, and reported to identify trends by subject matter practice and practitioner and share learning

- Ensure the patients voice in heard, listened to and responded to which includes supporting the development of fit for purpose Patient Participation Groups
- Improve the experience of carers in line with the national NHS commitment to carers
- Support the implementation of Friends and Family Test across Primary care services
- Further develop the concept of no decision about me without me and implement patient centred approach
- Implement the Compassion in Practice and methodology of the 6 Cs
- Safeguard those patients who are the most vulnerable working collaboratively with multi-agency partners; having clear process on how staff working in primary care services can access relevant training and support
- Work with organisations to increase the ability of patients and the public to care for their own health
- Promote full respect for patient autonomy in decision making and ensure patients can access advanced care planning options.
- Ensure our systems are simple and straightforward to access and that appropriate choices and option are clearly signposted

Quality in Public Health

3.8. To improve the quality of the public health services commissioned by NHS England (BGSW) and to keep patients as safe as possible from avoidable harm, our areas of focus are to ensure that:

- All services are commissioned in line with revised national service specifications and monitored through robust clinical governance frameworks,
- Programmes participate in the national public health quality assurance programme and that learning and feedback from national Quality Assurance team is acted upon.
- Any quality concern identified through the screening and immunisation committees, and the national quality assurance report are acted upon and information shared appropriately.
- All providers use Serious Incident reporting frameworks and that incident reporting and investigation is robustly managed with findings and lessons learned acted upon to improve services and programmes.
- Incident reporting and investigation involves all relevant organisations, Public health England, commissioners, Local authority and providers.

Safeguarding

3.9. To help ensure the most vulnerable people in our communities feel safe, our vision for Primary Care for the next 5 year plan is to:

- Introduce a training framework and strategy for all Primary Care staff that enables all GPs to be trained to level 3 in both adult and child safeguarding.
- Work with GPs to ensure the impact of this training strategy is felt within safeguarding practice by continuing to work closely with Safeguarding teams within CCGs in supporting GPs in developing their reflective practice skills in their own safeguarding practice within their day to day work and also in their annual appraisal process.
- Work in a more integrated way with the Care Quality Commission to understand the needs of the practices that need support to ensure their safeguarding practice is compliant with the full requirements.
- Provide a series of events/opportunities for practice staff to ensure the learning from national serious case reviews and local safeguarding. incidents across BGSW is understood and recommendations responded to
- Introduce a series of audits that will assess improvement in practice from the above and compliance that will then in turn, inform the fuller 5 year training and activity strategy.

3.10. We will achieve this through the continuation of our work with Clinical Commissioning Groups and Local Authority partnerships to ensure that safety of vulnerable people is mainstream activity within the commissioning and contracting process.

SECTION 4: PRIMARY CARE SERVICES (e.g. core services from general practitioners, community pharmacies, dentists and optometrists)

Introduction

4.1. The delivery of core primary care ser vices is largely covered through nationally negotiated contracts (e.g. general medical services (GMS) contracts) or nationally determined regulations (e.g. regulations governing the process for reviewing applications to open a new community pharmacy).

4.2. Primary care exists to contribute to preventing ill health, providing early diagnosis and treatment, managing on-going mental and physical health conditions and helping recovery from episodes of ill health and injury. Primary care professionals are best placed to make effective preventative interventions and to impact positively on the quality and efficiency of the whole health service.

Strategic intention

4.3. NHS England's ambition is to deliver, through excellent commissioning:

- A common, core offer for patients of high quality patient-centred primary care services.
- Continuous improvements in health outcomes and a reduction in inequalities.
- Patient engagement and empowerment and clinical leadership and engagement visibly driving the commissioning agenda.
- The right balance between standardisation/consistency and local empowerment/flexibility.

4.4. This document should be read in conjunction with NHS England (BGSW) draft Primary Care Delivery Plan.

4.5. We can achieve this vision through our new commissioning arrangements, our approach to engaging with and understanding our patients, strengthened primary care clinical leadership and by developing innovative approaches that challenge the ways of the past.

4.6. A clear case for change, coupled with a desire from general practice to transform services, has emerged and has been reinforced through the *Call to Action* on primary care:

- Population changes - including an aging population, an increase in people living with multiple long term conditions and changing public expectations – are increasing demand for health services.

- Improving our primary care services will improve patient care and will cost less. Better care, closer to home is the only way to maintain quality of care in the face of increasing demand and limited resources.
- Addressing inequalities in access, quality and outcomes will require new and innovative ways of coordinating services.
- Action is needed to address emerging workforce pressures including recruitment and retention problems for GPs and practice nurses.

4.7. NHS England (BGSW) believes the areas discussed in this plan (and in our Draft Primary Care Delivery Plan) can be used to draw some conclusions on the future configuration and role of general practice. These conclusions are emerging and will need to be kept under ongoing review.

4.8. A federated model of general practice, delivering integrated primary care services to large populations and communities, would appear to be a potential solution to the future configuration and role of general practice. This is an emergent approach that has been proposed by the RCGP and others within the profession.

4.9. It is suggested that general practice is on a journey that will take it along a development path, progressing through a number of stages:

- Current state
- An extended skill mix in practices and across a range of primary care providers
- Federation of practices
- Colocation of practice / merger of practices to form larger partnerships / primary care units
- Development of large integrated primary and community services hubs, incorporating social care (covering populations that are generally significantly larger than most current practice populations)

4.10. The Everyone Counts sets out the following key characteristics of high-quality care in primary care:

- Proactive coordination of care, particularly for people with long-term conditions and more complex health and care problems.
- Holistic care: addressing people's physical health, mental health and social care needs in the round.
- Ensuring fast, responsive access to care and preventing avoidable emergency admissions and A&E attendances.
- Preventing ill-health, ensuring more timely diagnosis of ill-health, and supporting wider action to improve community health and wellbeing.

- Involving patients and carers more fully in managing their own health and care.
- Ensuring care is of a consistently high quality: effective, safe and with a positive patient experience.

Partnership working

4.11. Our aim is to create sustainable NHS services that provide more integrated care for patients, built around the registered populations served by groups of practices. To do this NHS England is developing joint arrangements for commissioning with CCGs and also with local authorities who hold some primary care contracts.

4.12. It is important that this co-commissioning approach is developed to ensure the right balance between standardisation and flexibility in order that local primary care services can be planned in the context of CCGs' commissioning strategies, health and wellbeing strategies, JSNAs, PNAs and so citizens and communities can influence and challenge how services are provided

.

4.13. Local professional networks (LPNs) for pharmacy, dentistry and eye health are being established and chairs recruited. Their objectives are aligned to NHS England's commissioning by ensuring representative and robust clinical input to decision making and leading the profession in peer review and support, maximising performance, addressing inequalities and driving continuous improvement.

4.14. We are working closely with Health Education England to ensure a more integrated approach to training of health care professionals in particular with respect to mental health and patient empowerment and have a programme to support Practice Nurse development.

Primary care support services

4.15. NHS England BGSW is responsible for primary care support (PCS) services. These services were successfully outsourced in 2012 and are managed through a programme board. BGSW is continuing to work with other Area teams to ensure that a national solution is achieved.

Secondary Care Dental

4.16. National criteria and care pathways are currently being developed by NHS England for all dental specialties following which commissioning of secondary and primary care services will be reviewed. Until these are in place steady state commissioning will continue with existing providers.

4.17. Referral management arrangements are in place for oral surgery and endodontic treatment as ongoing QIPP delivery and are currently under review. Once national care pathways are in place, it is anticipated that further referral management will be introduced for other dental specialties.

Priorities

4.18. For general practice services a number of changes have been agreed to the national GMS contract, including:

- **Having a named, accountable GP for people aged 75 and over.** As part of a commitment to more personalised care for patients with long-term conditions, all patients aged 75 and over will have a named, accountable GP with overall responsibility for their care.
- **Out-of-hours services.** There will be a new contractual duty for GPs to monitor and report on the quality of out-of-hours services and support more integrated care, e.g. through record sharing.
- **Reducing unplanned admissions.** There will be a new enhanced service to improve services for patients with complex health and care needs and to help reduce avoidable emergency admissions. This will replace the Quality and Outcomes Framework (QOF) quality and productivity domain and the current enhanced service for risk profiling and care management and will be funded from the resources released from these two current schemes. The key features of the scheme will be for GP practices to:

  - improve practice availability, including same-day telephone consultations, for all patients at risk of unplanned hospital admission;
  - ensure that other clinicians and providers (e.g. A&E clinicians, ambulance services) can easily contact the GP practice by telephone to support decisions relating to hospital transfers or admissions;
  - carry out regular risk profiling, with a view to identifying at least two per cent of adult patients – and any children with complex needs – who are at high risk of emergency admissions and who will benefit from more proactive care management;
  - provide proactive care and support for at-risk patients through developing, sharing and regularly reviewing personalised care plans and by ensuring they have a named accountable GP and care coordinator;
  - work with hospitals to review and improve discharge processes; and
  - undertake internal reviews of unplanned admissions/readmissions.

- **Choice of GP practice.** From October 2014, all GP practices will be able to register patients from outside their traditional boundary areas without a

duty to provide home visits. This will give members of the public greater freedom to choose the GP practice that best meets their needs. NHS England's area teams will need to arrange in-hours urgent medical care when needed at or near home for patients who register with a practice away from home.

- **Friends and Family Test.** There will be a new contractual requirement from December 2014 for practices to offer all patients the opportunity to complete the Friends and Family Test and to publish the results.
- **Patient online services.** GP practices will be contractually required from April 2014 to promote and offer patients the opportunity to book appointments online, order repeat prescriptions online and gain access to their medical records online. The current enhanced service for patient online services will cease and the associated funding transfer into global sum payments for local GP practices.
- **Extended opening hours.** The extended hours enhanced service will be adapted to promote greater innovation in how practices offer extended access to services.
- **Patient participation.** The patient participation enhanced service will be adapted to promote greater innovation in how practices seek and act on patient insight and feedback, including the views of patients with mental health needs.
- **Transparency of GP earnings.** The British Medical Association's General Practitioners Committee (GPC) will join a working group with NHS England and NHS Employers to develop proposals on how to publish (from 2015/16 onwards) information on GPs' net earnings relating to the GP contract. The first published data would be based on 2014/15 earnings and publication of this information will be a future contractual requirement.
- **Diagnosis and care for people with dementia.** There will be changes to this enhanced service to promote more personalised care planning and allow greater professional judgement in which patients should be offered assessment to detect possible dementia.
- **Annual health checks for people with learning disabilities.** There will be changes to this enhanced service to extend its scope to young people aged 14-17 to support transition to adulthood and to introduce health action planning.
- **Alcohol abuse.** There will be changes to this enhanced service to incorporate additional assessment for depression and anxiety.

4.19. NHS England holds 121 GMS contracts , 76 PMS contracts and 2 APMS contracts across the Area Team patch. GMS contracts are nationally negotiated contracts in which price and service requirements are determined through discussions between NHS Employers (on behalf of the Department of Health and NHS England from 2014/15) and the General Practitioners Committee (on behalf of the BMA).

Supporting investment and redesigning incentives

4.20. To support the changes in Primary Care, we will need more than new ways of working to be effective. We will need to invest in better information systems and technology, improved primary care estate and significant workforce development. We will also need to put in place stronger governance systems to hold providers of care out of hospital to account and to assure that the commitments and standards to which we aspire are delivered.

4.21. To support the change and the delivery of our Primary Care Commissioning plan we have identified five key enablers:

- Financial resource, contracts and incentives
- Early Adopter Communities
- Information technology
- Organisational and workforce development including skill mix
- Estate development.

4.22. We have further recognised that the delivery of this strategy will represent a significant programme of organisational change across Primary Care.

Financial resources, contracts and incentives

4.23. Supporting investment and redesigning incentives: supporting a shift of resources towards general practice and ‘wrap-around’ community services and developing innovative new forms of incentives that reward the best health outcomes.

4.24. BGSW are already actively engaged with the CCGs in developing strategic plans that place a much greater emphasis on care outside hospital, and many intend to use general practice as a major component of more accessible and integrated systems of care.

4.25. We are working with the CCGs to explore the with greater clarity the different enablers that we can use to support safe, controlled investment in general practice services, in particular:

- services commissioned by CCGs under the NHS Standard Contract;
- enhanced primary care services commissioned by CCGs under delegated authority from NHS England;
- QOF flexibilities ;
- additional investment through PMS or Alternative Provider Medical Services (APMS) contracts, managed by NHS England but potentially drawing on funding that has been pooled with CCGs;
- The use of the £5 per head of population funding and
- A shift in funds from secondary to primary care

Early Adopter Communities

4.26. As part of the drive by the Primary Care Commissioning Team to invigorate and support innovative integrated care proposals, the AT will be working with the CCGs to identify funding in order to support early adopter sites. We are working with the 4 CCGs and member practices to develop local models of care that will provide the wider Primary Care offer.

4.27. To deliver the aspirations set out in the Primary Care Commissioning Strategy and associated integrated care plans, there will need to be a step change in investment in care out of hospital. We will with CCGs refine and further develop sources of evidence to inform the anticipated quantum shift of activity from hospital (and other care institutions) to primary and community based settings. This includes:

- Understanding the effect of the agreed out of hospital standards on the potential shift of activity
- A review of evidence behind models of integrated care and primary care.
- Alignment of the CCG plans to the Early Adopter objectives.
- An assessment of the anticipated effect of the implementation of the in hospital models of care on out of hospital care
- The completion of a detailed cost benefit analysis framework by all localities across BGSW reflecting emerging understanding of the shift of activity anticipated between in hospital and out of hospital care.

Information systems

4.28. Information and communications technologies have the potential to revolutionise patient experience, transforming how and where care is delivered. We will work with partners in health and social care to align BGSW's IT strategy as a key enabler of the Primary Care Delivery Plan and local integrated care plans. It is widely recognised that the ability to share data across health and social care, and critically with patients and their carers, will be a crucial success factor in the delivery and transformation of out of hospital

care. We will work with key stakeholders across BGSW in the delivery of integrated health and social care records.

4.29. We will capitalise on the transformational improvements in the quality of information technology to enable the delivery of the commitments aspired to within the Primary Care Delivery Plan. This includes the development of shared decision-making tools, transparent and public sharing of benchmarked data. With partners, we will develop and deliver a digital technology strategy to drive down the level of unnecessary face to face contacts, enabling care to be delivered safely and more conveniently.

4.30. The work that we are currently doing with the CSU and the CCGs will result in the development of patient online services described above ('Empowering Patients and the Public') and in developing strategies to share information more effectively between general practice and other providers to support integrated care.

4.31. It is envisaged that the new General Practice Systems of Choice replacement framework (GPSoC- R) will enable general practice to extend its world-leading position in the use of electronic systems by general practitioners and also enable delivery of increasingly rich online services for patients, supporting increasing involvement of patients in their own care and of patients and GPs in shared decision-making

Organisational and Workforce Development

4.32. BGSW recognise that in order to support the change in Primary Care and be able to respond the activity shift that is anticipated, work is underway with Health Education England to understand the workforce implication across the health and social care system. We recognise that the delivery of the Primary Care Delivery Plan will require both a review of current roles and a potential increase in workforce capacity within Primary Care.

4.33. Whilst we are working closely with the Deanery and Health Education England to understand current trajectories for GP and Practice Nurse training, recruitment and retention, we also recognise that many of the developments described may be delivered by allied health and social care professionals and other primary care professionals (with the exception of Dentistry), with the GP as the co-ordinator of care.

4.34. Our workforce development programme will be supported initially by an externally commissioned baseline assessment to encompass future primary care workforce projections and the shift of culture and leadership required to support front line staff to co-ordinate and deliver whole person focused interventions. It is recognised that a robustly developed and credible

workforce plan, including transition plan, is a key requirement for the successful implementation of the Primary Care Commissioning Strategy

Premises

4.35. Based on a broader understanding of the scale of the transformation of care out of hospital, including primary care, work is underway with NHS Property Services, CCGs and with Local Authority partners to understand the estates implication across the health and social care system.

4.36. As members of the 4 Local Authority Spatial Planning groups we are working closely with them and the CCGs to ensure that future estates strategies align with and enable the delivery of our Primary Care Commissioning strategy. Key considerations will be the development of facilities that promote and enable integrated working across organisational boundaries and the delivery of diagnostics and specialist care in out of hospital settings. We will work closely with our partners to ensure any urban development proposals consider the implications of out of hospital service developments. As members of the Spatial Planning groups we are able to make best use of the opportunities that exist through Section 106 and gifted land as both have a positive financial impact on NHS England.

4.37. In doing this, we recognise that there is very limited scope in NHS England's primary care budget to meet the revenue costs associated with expanding general practice premises. The revenue consequences of developing practice facilities have a recurring impact on the primary care budget, and BGSW have a defined process through which to prioritise this funding over many other competing demands on the primary care allocation.

4.38. To this end we are currently reviewing the current level of premises usage and reimbursement and working with the Local Authorities to identify any shared public sector body opportunities for improving value for money and promoting more innovative use of estates.

4.39. NHS England is committed to a comprehensive review of PMS contracts to ensure these offer value for money and deliver services that are aligned to patient need, as well as CCG and NHS England strategies. A local review of PMS contracts was undertaken throughout 2012/13 by the former Cluster PCTs. This resulted in the vast majority of PMS contracts being successfully reviewed. A further review of PMS contracts across BGSW will be undertaken in three phases:

- Phase 1 will be to facilitate any further transfer back to a GMS contract that PMS contractors wish to make.
- Phase 2 will be to comprehensively review those contracts where the previous review was not concluded to the satisfactions of the NHS England.

- Phase 3, which will be undertaken in 2015/16, will be to review the objectives of existing PMS contracts to ensure they reflect the needs of their population, are delivering value for money and are aligned to CCG and NHS England priorities.

4.40. Other local priorities for 2014/15 include:

- Reviewing the minor surgery Directed Enhanced Service, which covers specific types of procedures carried out by GPs.
- Working with local authorities to support them to develop more healthy living pharmacies to provide local people with health and wellbeing advice, thus helping to promote healthy lifestyles and to reduce health inequalities.
- Reviewing access to NHS dentistry and improving this for local patients where necessary.

Next steps

4.41. The plan include specific actions to support development of general practice services in ways that reflect the six characteristics of high quality care as we have described in our vision. We intend to work with the 4 provider groups within Primary Care to improve current services and to further identify the contribution each can make to the implementation of the overall vision of Wider Primary Care.

Primary care financial context

4.42. In 2013/14, a surplus of £3.4m is forecast. This surplus is carried forward into 2014/15, as are future surpluses and deficits.

4.43. Expenditure on GP IT is currently excluded from the primary care financial plan. NHS England is reviewing options for future funding of GP IT.

4.44. QOF and the public health element of the global sum payments to practices is included in full within primary care however 15% of QOF and 7.2% of the global sum is nominally attributed to the reporting of S7a public health allocation.

4.45. Primary care services are most directly affected by changes in population. GPs' income is largely based on list sizes, and demands for pharmacy, dental and ophthalmic services also change as the population changes. Overall population demographic growth is forecast to cost £2.4m in 2014/15 (0.9%).

4.46. There are also a number of cost pressures arising out of national directives. For example, an Enhanced Service is proposed for a named GP for those aged 75 and over, and there is to be greater choice of GP practice with Area Teams responsible for any in-hours urgent medical care. There are also

expected to be additional costs for QOF as services are improved and practices increase their level of achievement.

4.47. Primary care services are subject to annual pay and price increases. The Doctors and Dentists Review Body has not yet announced the pay increases for 2014/15, and a 1.3% increase has been assumed in the plans for primary care and 1.5% for dental, costing £3.0m.

4.48. The price increase associated with pharmacy costs is assumed to be 2% at a cost of £1.1m. The price increase associated with ophthalmic is assumed to be 1.5% at a cost of £0.2m.

4.49. As outlined above, demographic growth of £2.4m is included within the plan (0.9%). In 2013/14 the demographic growth for pharmacy was 3.5% and for ophthalmic 2.5%. If this growth is repeated in 2014/15 this would be a cost pressure of £2.2m across these two areas. The Area Team's plan is that the demographic growth for both pharmacy and ophthalmic will be in line with the longer term historic average of 1.5% reducing the cost pressure to £1.0m.

4.50. Premises reimbursements are assumed to increase by 2.75% or £0.5m.

4.51. QIPP has been included within the financial plan at £3.0m in 2014/15 and £2.3m in 2015/16. To date ideas for QIPP are currently being developed. QIPP delivery is a risk until robust plans to deliver the full value are developed and implemented.

4.52. The allocation has been increased in 2014/15 by £5.7m or 1.98% growth.

4.53. The summary financial position is shown below:

Primary Care	£'000	£'000
	2014/15	**2015/16**
Previous year outturn	273,530	276,432
Adjustment for non recurrent spend	-1,980	0
Inflation uplifts	4,409	4,487
Growth	2,443	2,499
Provider Efficiency	0	0
Service Investments	1,030	1,020
QIPP	-3,000	-2,325
Sub total	276,432	282,113
Contingency	1,418	1,441
Headroom	2,063	1,838
Total	**279,913**	**285,392**
Notified Allocation	280,434	284,864
Surplus / (Deficit) carried forward	3,190	3,711
Total Resources	**283,624**	**288,575**
Submitted plan surplus / (deficit)	**3,711**	**3,183**
Planned allocation changes	-300	
Reduction in surplus carried forward		-300
BGSW plan surplus / (deficit)	**3,411**	**2,883**

4.54. The plan delivers a surplus in line with the 2013/14 forecast outturn surplus position.

Secondary and community dental financial context

4.55. This service has financially over spent in 2014/15, with the year end forecast over spend of £1.1m. The area team is working with NHS South West CSU, which provides business intelligence support, and primary care to better understand the reasons for the over spend. Where there is evidence that the area team inherited incorrect financial baseline budgets these will be corrected via allocation transfers with CCGs. The area team is currently estimating that there will be £300k of funding allocation adjustments in 2014/15.

4.56. A review of the total dental pathway will be undertaken during 2014/15 to ensure appropriate activity is treated at each setting of care across secondary, community and primary care. This is expected to generate QIPP savings of £700k in 2014/15 and £800k in 2015/16.

4.57. The financial position is shown below:

Secondary / Community Dental	£'000	£'000
	2014/15	**2015/16**
Previous year outturn	21,161	20,344
Inflation uplifts	518	479
Growth	212	305
Provider Efficiency	-846	-814
Service Investments	0	0
QIPP	-700	-800
Sub total	20,344	19,514
Contingency	97	99
Total	**20,441**	**19,613**
Notified Allocation	20,180	20,500
Surplus / (Deficit) carried forward	-1,084	-1,345
Total Resources	**19,096**	**19,155**
Submitted plan surplus / (deficit)	**-1,345**	**-459**
Planned allocation changes		
Growth		5
Allocation adj with CCG	300	300
Reduction in deficit carried forward		300
BGSW plan surplus / (deficit)	**-1,045**	**146**

4.58. Although the 'headline' allocation has increased over 2013/14 levels, the need to absorb the previous year's deficit creates additional cost pressure moving into future years.

4.59. The 2014/15 plan is a deficit of £1m which is in line with the 2013/14 forecast outturn deficit of £1.1m despite the impact of the 2013/14 deficit reducing the 2014/15 allocation.

SECTION 5: PUBLIC HEALTH SERVICES (e.g. national screening and immunisation programmes, public health services 0-5 years)

Introduction

5.1. Responsibility for the commissioning of public health services is split between Public Health England (PHE), local authorities and NHS England.

5.2. It is NHS England's responsibility to commission a number of public health services as agreed with the Department of Health and built into the Government's Mandate to the NHS and the NHS Outcomes Framework. An agreement between the Secretary of State for Health and NHS England, made under Section 7a of the National Health Service Act 2006, details the public health commissioning functions that are carried out by NHS England. Known as the '7A agreement', these services sit within a number of programmes:

a) Immunisation programmes
b) Cancer screening programmes
c) Non-cancer screening programmes
d) Children's public health programmes (The Healthy Child programme from pregnancy to age 5)
e) Child health information systems
f) Public health services for people in prison and other places of detention including those held in the young people's secure estate
g) Sexual assault services

5.3. These programmes are nationally mandated supported by thirty-two national service specifications.

5.4. It is the responsibility of Public Health Teams within the Area Team (made up of NHS England and Public Health England staff) to commission safe and effective programmes as listed above in order to achieve positive health outcomes; reduce inequalities; and to ensure value for money sand increased productivity within allocated resources.

Public health strategic intent

5.5. NHS England's ambition is that everyone has greater control of their health and their wellbeing. We want everyone to be supported to live longer, healthier lives by high quality health and care services that are compassionate, inclusive and continually improving.

5.6. The summary plan for public health is included as Appendix 2 (Public Health Plan on a Page). The public health services commissioned by NHS England

directly support the achievement of the NHS outcomes framework domains and ambitions, in particular:

Domain 1 - Prevent premature deaths and increase life expectancy	The preventative immunisation and screening programmes enable interventions to stop people from dying prematurely, securing additional years of life for people with treatable conditions (outcome ambition 1).
Domain 2 - People with LTCs get the best possible quality of life	Screening programmes support the early identification of health conditions, enabling people to receive treatment and support much sooner, improving their quality of life (outcome ambition 2). Immunisations (such as the 'flu jab) can also improve the quality of life for those in particular at-risk groups. In addition, early diagnosis can ensure more planned and integrated care can be put in place, reducing avoidable hospital stays (outcome ambition 3).
Domain 4 - Patients have a great experience of their care	Continual performance management, working with providers and other partners, ensures the highest standards of patient experience from the public health services we commission.
Domain 5 – Patients in our care are kept safe and protected from all avoidable harm	Keeping patients safe from avoidable harm is the core purpose of our public health services.

Roles and responsibilities

5.7. Responsibility for commissioning public health services is commissioned by a number of key bodies:

NHS England	Is accountable for letting contracts and ensuring that local providers of services deliver against the national service specifications and meet agreed population uptake and coverage levels. We are responsible for monitoring providers' performance and for supporting providers in delivering improvements in quality and changes in the programmes when required.
Public Health England(PHE)	Develops the national standards and operational guidance and provides expert leadership and advice to NHS England teams. They also play a leading role in collecting and sharing data and monitoring quality assurance.
Local authorities	In addition to leading the local public health system, they provide information, advice and oversight to the public health arrangements of NHS England, PHE and providers through local Health protection Boards and Health and Wellbeing Boards. They also commission sexual health services where cervical samples are taken and public health programmes for children and young people aged 5-19 years, including school nursing services which carry out school based immunisations for some areas. From October 2015 commissioning responsibility for public health programme covering pregnancy to five

	years old (ie. Health Visiting and the Family Nurse Partnership) will transfer to local authorities.
CCGs	Are responsible for quality improvement in services delivered by GP practices, such as immunisation and screening services. As commissioners of treatment services for patients who receive positive screens, they have a crucial role in commissioning pathways of care that effectively interface with screening services, have adequate capacity to treat screen-positive patients and meet quality standards. CCGs also hold the contracts and payment mechanism (MPP) for maternity services which provide antenatal and newborn screening.

Partnership working

5.8. The *Immunisation and Screening National Delivery Framework and Local Operating Model* sets out clear guidance for the commissioning of the 7A public health programmes. It also covers working arrangements between the embedded Public Health England Screening Immunisations Teams and NHS England. Alongside this guidance, there continues to be a need for continual close working between all the organisations responsible for public health at a local level. The implementation of the national service specifications needs to be carried out in collaboration with CCGs and local authorities to reflect local need.

5.9. The complex public health commissioning arrangements mean that effective partnerships and continual collaboration between all organisations responsible for public health at a local level, including CCGs, are essential in order to ensure that implementation of national service specifications reflects local need.

5.10. Joint working is between area teams, local authorities and CCGs to identify areas of inequalities and address variation in uptake and coverage across communities will be critical to success in increasing access, information and choice, in particular for disadvantaged communities.

5.11. While the commissioning of all national immunisation and screening programmes is undertaken by NHS England, certain elements (such as antenatal and newborn screening services) are included in contracts led by primary care contracting, CCGs, specialised commissioners and in some cases local authorities (e.g. sexual health service contracts). Strong links are needed between area teams and these contract leads to ensure the strategic commissioning requirements of immunisation and screening programmes are addressed through these contractual routes.

5.12. Joint working is also important with the commissioners of treatment pathways (e.g. paediatric services for children identified with congenital hip dysplasia or ophthalmology outpatients in the case of the diabetic eye screening

programme) to ensure that any changes through re-tendering of services do not adversely affect the referral pathway for screen-positive patients.

Priorities

5.13. Everyone Counts sets two overarching ambitions for public health commissioning:

- to improve quality and consistency by increasing the pace of change for the full implementation of the national service specifications; and
- to set performance 'floors' to address unacceptably low performance by local providers.

5.14. The guidance sets out the following priorities to achieve these ambitions:

- New trajectories for roll out of the family nurse partnership and the health visitor programmes
- A revised specification for pneumococcal vaccination
- The introduction of HPV testing in women with mild/borderline changes in their cervical screening
- Revised performance baselines for bowel and diabetic eye screening
- The extension of the bowel screening programme for men and women up to age 75
- A minor change to the service specification for seasonal flu
- A meningitis C catch up programme for university entrants
- The continuation of a time-limited MMR campaign for people over 16 and a catch-up campaign for teenagers
- The continuation of the temporary programme for pertussis for pregnant women
- The implementation of DNA testing for sickle cell and thalassemia screening
- A shingles catch up programme planned for 71-79 year olds, starting with 78 and 79 year olds
- The extension of the childhood flu programme (to 4 year olds initially).

5.15. The Public Health Plan on a Page included as Appendix 2 provides details of the local commissioning intentions that relate to these national requirements.

Public Health financial context

5.16. By commissioning effective screening and immunisation programmes with improved coverage and up-take, the public health programme will contribute to delivering financial efficiencies across the health economy by disease prevention, reduced incidence and early identification of cancers (breast,

bowel and cervical) and life threatening disease – e.g. Abdominal Aortic Aneurism.

5.17. The public health team will ensure that all commissioned programmes demonstrate value for money and that high quality, evidenced based cost effective services are delivered including:

- Introducing relevant public health CQUIN targets to new contracts and reviewing variation in performance and coverage across immunisation programmes to reduce incidence and impact of infectious disease.
- Identifying risk of disease and disability early through the commissioning of safe and effective Screening Programmes
- Work with providers to demonstrate the value of the universal Healthy Child Programme Improve life chances and access to services for children and families through the effective commissioning and safe transition of Health Visiting and Family Nurse Partnership Programmes
- Implement Health Visiting and Family Nurse Partnership workforce trajectories (including a new Family Nurse Partnership Service for Wiltshire) to increase the numbers of qualified health professionals locally and to ultimately improve outcomes for children and families.
- Work with Public Health England to implement new immunisation programmes as they arise (e.g. MenC for University entrants) and to expand existing programmes to new cohorts (e.g. Shingles and Childhood Flu).
- Ensure commissioned services represent best value for money and are evidence based
- Benchmarking the payment and contracting mechanisms of our commissioned services within our Area Team and beyond to ensure equity of provision.
- Reprocurement of services where regulations dictate or where driven by financial and performance necessity.
- Using revised data sets to ensure screening programmes (e.g. – New-born Blood spot first and second line testing) is costed on the basis of accurate birth data
- Assessment of school based immunisation provision against capacity and other competing Public Health targets and implement local solutions for BGSW.
- Develop robust commissioning plans to include armed forces personnel and their dependants in all Public Health commissioned services.

5.18. In 2013/14, a surplus of £0.526m is forecast. The surplus from 2013/14 is not carried forward into 2014/15, although subsequent surplus / deficits are carried forward.

5.19. The public health financial plan in 2014/15 delivers a breakeven position and includes 0.5% contingency. The 2015/16 plan currently shows a deficit of £777k. This is due to the expected allocation growth in 2015/16 of £778k being currently excluded from the notified value. Once the expected growth is applied the financial plan in 2015/16 is breakeven.

5.20. The 2014/15 and 2015/16 plan both include 0.5% contingency of £185k and £189k respectively. This is in line with the planning guidance. No headroom or QIPP is included within the plan in line with the planning guidance.

5.21. There are a number of cost pressures arising out of national directives. The changes for Meningitis C, HPV and childhood influenza vaccinations add £2.1m. The full year costs of the increase in health visitors and the additional cohorts in 2014/15, and the expansion of Family Nurse Practitioners adds a further £1.3m.

5.22. The financial plan includes £1.8m for investment and £0.6m for activity growth in 2014/15. The total investment / activity growth funding of £2.4m is less than the £3.4m cost pressures outlined above as some of these cost pressures have been funded in 2013/14.

5.23. The allocation in 2014/15 includes £1.3m for health visitor uplifts and £0.1m for meningitis C. Costs pressures above this level are to be funded locally.

5.24. NHS England is required to report nationally public health spend against the section 7a allocation. However some of the costs associated with S7a such as public health QOF and the public health element of GP global sum (7.2%) are within primary care allocations. As a result the area team is required to report against both the public health position and the S7a position.

5.25. The summary financial position is shown below:

Public Health	£'000	£'000
	2014/15	**2015/16**
Previous year outturn	34,574	36,842
Inflation uplifts	813	838
Growth	636	679
Provider Efficiency	-962	-1,163
Service Investments	1,782	420
QIPP	0	0
Sub total	36,842	37,617
Contingency	185	189
Total	**37,028**	**37,806**
Notified Allocation	37,028	37,028
Surplus / (Deficit) carried forward	0	0
Total Resources	**37,028**	**37,028**
Submitted plan surplus / (deficit)	**0**	**-777**
Planned allocation changes		
Growth		778
BGSW plan surplus / (deficit)	**0**	**0**

SECTION 6: ARMED FORCES

6.1. NHS England (BGSW) commission armed forces health services (for serving personnel and their families) on behalf of all areas in the South of England including London.

6.2. NHS England have a statutory responsibility to ;

- To ensure equitable access to effective treatments for patients in England in line with service specifications and clinical policies
- To ensure that armed forces patients 'suffer no disadvantage' as laid out in the Armed Forces Covenant on-going
- To continue to embed the single operating model contained within Securing Excellence for the armed force and their families. To review the model by October 2014
- Working collaboratively with the Defence Medical Services to deliver the priorities contained within the Armed Forces National Partnership Agreement. To review and refresh the agreement. Summer 2014.
- To establish Armed Forces networks, through collaboration with CCGs to ensure that services are locally integrated by March 2015
- A common service specification for the improvement of veterans mental health services is developed and implemented by December 2014
- To implement a programme of data quality improvement including the development and publication of a performance and quality dashboard Summer 2014

To ensure that all objectives are;

- Underpinned by an exemplary approach to patient and public engagement
- A comprehensive performance management framework
- Full implementation of the direct commissioning assurance framework

6.3. NHS England has agreed capacity plans, detailing anticipated demand for services, for armed forces healthcare activity for 2013/14. NHS England (BGSW) has agreed capacity plans with providers in the south of England and more contracts will be placed in 2014/15 in order to increase the availability of services for armed forces and their families.

6.4. There are some challenges in terms of the availability and accuracy of data to support commissioning decisions. This is partly due to providers not always identifying patients as serving armed forces personnel or their families NHS

England (BaNES, Gloucestershire, Swindon and Wiltshire) is working with national NHS England leads for information and finance to resolve these issues.

6.5. A review of current commissioning for quality and innovation payments (CQUINs) across existing contracts is identifying the CQUINs which most support the armed forces population. These will be adapted and promoted as part of contract negotiations.

6.6. A detailed 5 year plan for Armed Forces Commissioning is being developed in parallel to this plan and should be read in conjunction.

What this means for Wiltshire and Swindon

The Army Regular Basing Plan

6.7. "The Army Regular Basing Plan sets out the future lay down of the British Army as it moves back to the UK from Germany and restructures to deliver its future operating model", *Army 2020.*

6.8. The plan honours the policy commitment made in Strategic Defence and security Review (SDSR) to bring UK forces back from Germany by 2020. The Army is on track to bring 50% of its forces back by 2015 and the remainder in 2020.

6.9. The Defence Infrastructure Organisation will deliver service family homes and new single living accommodation for Armed Forces personnel.

6.10. The plan also forms a part of a wider commitment to give service personnel greater stability allowing their families to integrate better into local communities, their spouses to find long term jobs and their children to have continuity in education.

6.11. It is envisaged that by 2020 an additional 4000 Armed Forces personnel will be stationed in Wiltshire. It is anticipated that there will be 2000 additional personnel at Larkhill, 900 at Bulford, and 1100 in Tidworth.

6.12. The Lyneham base will be re-established as a training facility and will provide capacity for up to 5000 armed forces personnel. Work is underway with the MOD to understand the full impact of this development and when this will take place.

6.13. In Swindon healthcare is provided by GWH to those who are based at the Military College should they need the services of secondary care.

6.14. In preparation for the increase in Armed Forces personnel and their families it will be crucial for partner organisations, both those commissioning and providing services, to work together to ensure that the incoming armed Forces personnel and families have full access to all services including;

- Maternity
- Primary and secondary care
- Public Health services
- Education
- Housing
- Transport
- Crime and Justice

6.15. The Commissioning organisations that will need to work together to ensure a full range of services are available to the incoming Armed Forces personnel and their families include:

- NHS England as the commissioner of Primary Care Services and elements of Public Health services along with secondary care service for Armed Forces personnel.
- Wiltshire Council as the commissioner and provider of education; housing; social care; transport; environmental services and/leisure.
- Wiltshire and Swindon Clinical Commissioning Groups as the commissioners of secondary care services for reservists and armed forces personnel dependants not registered with DMS.
- Wiltshire Police as commissioners and providers of community policing and the wider crime and justice services.

6.16. In order to ensure that the planning and onward delivery of these services for the incoming Armed forces and their families is as comprehensive as possible the suggestion put to Wiltshire Health and Well Being Board (HWB) was to set up a working group with representatives of the commissioning organisations (listed above) and the MoD in order to develop a joint commissioning plan for this specific population and their families.

6.17. Wiltshire HWB agreed that the joint commissioning of services be discussed at the Military Civilian Integration Partnership hosted by Wiltshire Council with the objective of developing and agreeing a joint commissioning plan for Armed

Forces personnel and their families who are currently or will be residing in Wiltshire.

Armed forces financial context

6.18. NHS England (Bath, Gloucestershire, Swindon and Wiltshire) commission armed forces health services (for serving personnel and their families) on behalf of all areas in the South of England and London.

6.19. In 2013/14 a deficit of £1.2m is forecast. The deficit from 2013/14 is not carried forward into 2014/15, although subsequent surplus / deficits are carried forward.

6.20. The 2013/14 deficit has in part been created by former PCT's not being able to fully identify armed forces activity within financial baseline returns. The area team has been unable to complete a full review of financial baselines in order to agree adjustments with CCG's during 2013/14 due to national activity and financial reporting limitations. These limitations are currently being addressed via the national activity reporting subgroup. Once robust armed forces activity reporting information becomes available the area team will review historic baselines and transact funding adjustments with CCGs during 2014/15. The 2014/15 plan includes £300k as an estimate of baseline funding adjustments.

6.21. The area team have received the full reserve of 910k held nationally. This has been used to reduce the rollover over spend moving into 2014/15.

6.22. Troop repatriation from Germany will commence during 2014/15 with a significant number of serving members of the armed forces and their dependants being based in Wiltshire. In line with national advice the Area Team's 2014/15 plan does not include demographic or non-demographic growth at present as the financial impact has not been agreed. The national advice is movements within England will offset each other and the repatriation from Germany will be considered once the financial impact is agreed. The Area Team has however identified the likely cost pressure within the risks and mitigations section of the plan rather than within the base case plan. The risk is circa £0.5m in 2014/15. It is unlikely that the MOD will agree to passing over funding to the NHS once the repatriation takes place as they have already allocated the savings within the MOD.

6.23. There is no QIPP within the 2014/15 financial plan. However QIPP has been included within the plan for 2015/16 at a value of £0.6m. This represents 2% of allocations. It is expected that there would be a requirement to deliver QIPP within armed forces in line with other areas of direct commissioning.

6.24. The summary financial position is shown below:

Armed Forces	£'000	£'000
	2014/15	**2015/16**
Previous year outturn	28,536	27,601
Veteran MH adj as not prog cost	-600	
Inflation uplifts	782	745
Growth	0	1,730
Provider Efficiency	-1,117	-1,104
Service Investments	0	0
QIPP	0	-565
Sub total	27,601	28,407
Contingency	45	141
Headroom	0	0
Total	**27,646**	**28,548**
Notified Allocation	27,646	27,646
Surplus / (Deficit) carried forward	0	0
Total Resources	**27,646**	**27,646**
Submitted plan surplus / (deficit)	**0**	**-902**
Planned allocation changes		
Veterans mental health	0	0
2013/14 allocation to be corrected	0	0
2014/15 allocations adjustments	0	0
Growth	0	581
Reduction in deficit carried forward		0
BGSW plan surplus / (deficit)	**0**	**-321**

SECTION 7: SPECIALISED COMMISSIONING

Aims and vision

7.1. NHS England's ambition is to achieve equity and excellence in the provision of specialised care and treatment. We will achieve this through excellent commissioning which:

- is patient centred and outcome based. The patient must be placed at the centre of planning and delivery and commissioners, working with providers, must deliver improved outcomes for them across each of the five domains of the NHS Outcomes Framework
- is fair, consistent throughout the country and ensures that patients have equal access to services regardless of their location
- improves productivity and efficiency.

7.2. The *Everyone Counts* five-year strategy planning guidance sets out the following strategic commissioning approach for specialised services:

- Ensuring consistent access to effective treatments for patients in line with evidence-based clinical policies, underpinned by clinical practice audit.
- A clinical sustainability programme with all providers, focused on quality and value.
- An associated financial sustainability programme with all providers, focused on better value through a two-year programme of productivity and efficiency improvement.
- A systematic market review for all services to ensure the right capacity is available, consolidating services where appropriate, to address clinical or financial sustainability issues.
- Adopting new approaches to commissioning care where it promotes integrated care and clinical oversight for patients, in particular services and care pathways to include a prime contractor model and co-commissioning with CCGs.
- A systematic rules-based approach to in-year management of contractual service delivery

Call to Action

7.3. NHS England is developing a national five-year strategy for specialised services as part of *A Call to Action*. It will strengthen our existing vision and approach.

7.4. Patients, the public, clinicians and NHS England staff are being engaged in its development. It is being developed alongside the implementation plan for the UK strategy for rare diseases. It is anticipated that the process will not only develop the strategy but will also clarify our understanding of our current starting point, the needs of our populations and the baseline from which we are developing our services.

7.5. The call to action will build upon the following values and principles for specialist commissioning, which emerged following the *Carter Review* in 2006:

- A stronger patient voice in specialised services
- More robust governance arrangements
- Proper costing of care pathways
- Better linkages between specialised and non-specialised services
- Uniform monitoring of patient activity
- Horizon scanning as a way of informing future commissioning plans
- Truly integrated care and a seamless patient pathway
- The involvement of clinicians in the development of service standards and outcome measures.

7.6. Engagement began in late 2013 and a draft strategy is being developed alongside a series of local engagement events within each area team. This draft strategy will go out for public consultation between March and May 2014 and the strategy will be finalised in July 2014.

7.7. Local five-year strategies and plans need to be developed alongside this call to action, taking account of the issues raised and the emerging national strategy.

Services concentrated in centres of excellence

7.8. A key priority of the NHS England planning guidance to 2019 is to continue to improve patient outcomes by concentrating relevant services in centres of excellence, where there is clinical evidence that this is effective.

7.9. Work is being undertaken at a national level to understand current service landscapes and patient flows, to identify opportunities for quality improvements and efficiencies and to set out a process for achieving improvements.

7.10. BNSSSG Area Team commission Specialised Service on behalf of BGSW and work in partnership through a collaborative approach.

Pathway integration

7.11. We need to continue working together with CCGs to integrate pathways of care for patients who need specialised treatments. While patients may attend a specialist service for some specific treatments or procedures, their on-going care will be managed by their GP in the community and the majority of any rehabilitation, therapies or other follow-up will be through CCG-commissioned services.

7.12. Close joint working is needed to ensure that these care packages are integrated and that there are no gaps. This is particularly important where CCG-commissioned tier 3 services or other interventions are required as a formal stepping-stone to specialised tier 4 services (for example in obesity services).

Financial sustainability

7.13. Improvements in the commissioning of specialised services need to be delivered against a backdrop of ensuring that patients and citizens get the best value from every pound spent on health services. Services need to be financially sustainable for the future. Our plans need to be explicit about how we will work with local and national partners to close the projected funding gap and deliver on the QIPP agenda.

7.14. In helping to deliver value for money for the taxpayer, commissioners and providers should support the implementation of *Better Procurement, Better Value, Better Care*. For specialised commissioning in particular, this means ensuing that supplies are purchased at the best price.

7.15. In addition, pathways of care should be commissioned to be as streamlined and efficient as possible, avoiding duplication and designing out inefficient steps and processes to deliver better value and better care for taxpayers and patients.

How we will deliver change

7.16. Close working with a wide range of stakeholders is essential to deliver the improvements we want to see in specialised commissioning. At a national level, NHS England works with a range of stakeholders to determine the service standards and outcomes expected through the development of clinical strategies set out within the five national Programmes of Care (PoC).

7.17. Clinical Reference Groups (CRGs) develop the PoCs with expert engagement including all healthcare professionals related to the particular service area. In addition, a strong patient focus is achieved via formal patient and public involvement processes and on-going engagement with patients and carers as part of the strategic planning and local delivery functions.

7.18. We work in partnership with CCGs and other local stakeholders to make commissioning decisions to ensure the whole patient pathway is as locally responsive as possible in meeting patients' needs and that we manage providers collaboratively.

7.19. Locally, we also work closely with academic health science networks (AHSNs), strategic clinical networks, local authorities, health and wellbeing boards, overview and scrutiny committees and commissioning support units. Each area team has dedicated public health support and this helps to ensure that we have a clear population view of health needs for specialised services.

SECTION 8: HEALTH AND JUSTICE

Aims and vision

"True justice for the most vulnerable is about pulling people into treatment, not pushing them away from the support they need. People should get the same quality of services in prison as they do in the community...we have to do more in early intervention, to support children and young people before they reach crisis point...we need diversion services to be a cornerstone of better care and support for offenders with mental health problems"

The Secretary of State for Health, speaking about health and justice commissioning at a joint event with the Ministry of Justice, March 2011

8.1. NHS England aim to commission services that offer care of the very highest standard and the best health outcomes for people in prisons and other justice settings. Ensuring that these people receive the same standards of care that they would in the community is a core principle that underpins our approach. In addition, we want to drive quality improvements in the care and outcomes delivered.

8.2. In the BGSW area there is one prison that is located in Erlestoke in Wiltshire. The prison is a category C prison for male sentenced offenders and provides 494 places.

8.3. The BNSSSG commission Health & Justice services on behalf of BGSW Area Team. Through the services they commission, we want to make progress towards the government's objectives of reducing violence - in particular by improving the way the NHS shares information about violent assaults and supports victims of crime - and developing better healthcare services for offenders and people in the criminal justice system which are integrated between custody and the community.

8.4. People in prison and other justice settings tend to have poorer health and worse health outcomes than the average population. We will work, together with partners, to commission services in ways that will help to tackle these inequalities. In addition, we will continue to develop our commissioning approach in response to the *Bradley Report*'s recommendations to address the over-representation of people with mental health problems in prisons.

Responsibilities

8.5. Through a single operating framework (developed jointly with the National Offender Management Service, Public Health England, Youth Justice Board, Home Office Immigration Enforcement and Police Custody Healthcare) we

are responsible for commissioning health services in the following places:

- Prisons
- Young offender institutes
- Secure children's homes
- Immigration and removal centres
- Police custody suites
- Court liaison services.

8.6. Responsibility for commissioning health and justice services is shared between the NHS England, CCGs and local authorities:

- **NHS England** – responsible for the direct commissioning of health services for people who are detained. Also responsible for some public health services (such as substance misuse services) for prisons. Area teams may devolve this responsibility to existing local joint commissioning arrangements in order to support more joined up services and continuity of care where they are satisfied that this will deliver their required outcomes.
- **CCGs** - responsible for commissioning health services for people engaged with the justice system but not in detention. Have a duty to co-operate in multi-agency youth offending teams. CCGs also responsible for commissioning emergency care services for "every person present in its area" including those in detention.
- **Local authorities** – responsible for commissioning many public health services for people in their area including those engaged with the justice system. Local authorities also commission sexual health services that may be used by victims of sexual assaults.

Priorities

8.7. The key priorities in commissioning for health and justice from 2014/15, set out in the *Everyone Counts* five-year strategy planning guidance, are:

- To ensure that commissioning is informed by an up-to-date health needs assessment, taking account of the reconfiguration of the custodial estate, including the creation of resettlement prisons.
- To support sustainable recovery from addiction to drugs and alcohol and improved mental health services.
- Promotion of continuity of care from custody to community and between establishments, working closely with probation services, local authorities and CCGs.
- Development of a full understanding of the healthcare needs of children

and young people accommodated in the secure estate and work collaboratively to commission services to meet these needs.

- Continued close collaboration with our partners in the successful implementation of the Liaison and Diversion Programme.
- To ensure timely and effective transition of commissioning responsibility for healthcare in immigration and removal centres.
- A number of developments for sexual assault referral centres to develop the service and make it more equitable (listed as a public health ambition in the *Everyone Counts* five-year strategy planning guidance).

8.8. Commissioning plans for the next five years need to address these priorities. They also need to be flexible, with contracts capable of being adapted to meet changing circumstances and any shifts in the policy directions of the various external bodies and agencies involved in health and justice.

For example, changes in the use of the custodial estate (for example from a prison to an immigration and removal centre) can happen at short notice, leading to a fundamental change in the health needs profile of the people who will be accommodated there.

8.9. Consideration needs to be given to the implications of an ageing prison population and commissioners need to be aware of the growing need for the delivery of a range of social care alongside healthcare in prisons.

8.10. Commissioners also need to consider the on-going development of the market for the provision of healthcare in justice settings, ensuring that there are sufficient providers able to offer quality, innovation and value for money.

Partnerships

8.11. Effective partnerships are crucial to enable us to achieve our aims of commissioning excellent, equitable, integrated health services that deliver the best outcomes for people engaged with the justice system.

8.12. Partnership working already exists through local prison partnership boards and health and criminal justice boards, bringing together NHS England, CCGs, prisons, the police, local authorities and NOMS. These partnerships are able to ensure the effective use of resources, support continuity of care during the transition from custody to the community and can monitor and support equity of access.

8.13. These partnership approaches need to be further developed and expanded to ensure they are able to reflect the increased focus on the integration of services and the inclusion of reducing re-offending rates and other related indicators in the public health outcomes framework.

8.14. The NHS England, CCGs and local authorities (public health, children's services and social services) need to work together to commission integrated pathways of equitable health and social care for people whose lives intersect with justice services and to develop outcomes aligned to local joint strategic needs assessments and health and wellbeing strategies.

8.15. For the majority of people in prisons and other justice settings, their engagement with these services is temporary. Most will transition back to the community, although some will go back and forth. To ensure the best, most equitable health and outcomes for them, it is essential that health and justice services are not commissioned in isolation, but are seen as part of a continuum with the services these individuals would receive in their local community.

SECTION 9: PATIENT AND PUBLIC VOICE AND ENGAGEMENT

Aims and vision

"We must put citizen and patient voice absolutely at the heart of every decision we take in purchasing, commissioning and providing Services."

Tim Kelsey: National Director of Patients and Information, NHS England

9.1. Through 'Putting Patients First: The NHS England Business Plan for 13/14 – 15/16' NHS England has an on-going commitment to transparency and increasing the patients' voice in improving patient care. The plan describes an 11 point scorecard which NHS England will introduce for measuring performance of key priorities, focused on receiving direct feedback from patients, their families and NHS staff. This plan supports 3 of the 11:

- Priority 6 – Outcomes Framework – Domain 4 'Ensuring that people have a positive experience of care
- Priority 9 – NHS Constitution rights and pledges, including delivery of key service standards
- Priority 10 – Becoming an excellent organisation

9.2. In primary care the BGSW Area Team will focus on working in partnership with local communities which includes patients their families and carers to improve the quality of primary care services which will in turn influence commissioning.

9.3. Providing the culture and opportunity for the patient, their family or carer to give feedback – positive and negative- and responding and learning from this is at the heart of the commissioning and delivery of high quality service. The establishment of Patient Participation Groups (PPGs) within GP Practices have been encouraged over a number of years to help promote patient voice and responsiveness. The development of these groups has been varied in a number of ways: these include- the number of groups established, their membership and function as well as their ability to influence. Therefore working with patients, carers and practitioners across boundaries and organisations our ambitious plan aims to:

- Improve the opportunity and culture that enables patients', their families and carers to give feedback – positive and negative – including raising complaints in relation to primary care services. This will include the promotion and understanding with the patient' rights, responsibilities and the pledges set out in the NHS Constitution 2013.

- Complete the development of a model of best practice that enables PPGs to use patient insight to influence service improvement and the commissioning of services.
- Scope the number and type of PPGs in existence including the level, quality and impact of PPG activity
- Work with local Healthwatch organisations to develop PPG networks / Forums with the purpose of 'peer' support, sharing of best practice and development/learning opportunities.
- Devise mechanisms to ensure patient engagement and participation is integrated into primary care assurance and commissioning cycle
- Service improvement and commissioning decisions are better supported when people are involved in identifying problems and in designing solutions together. Working to develop and strengthen our partnerships we will:
- Work with stakeholder groups to look at their sources of feedback and how we can ensure we maximise opportunities to learn from this rich source, as a catalyst, to proactively influence change and drive improvements for patients
- Give consideration to equality and diversity issues faced by those group of people who are seldom or less likely to be heard and develop a means of enabling their feedback and participation as far as reasonably possible

9.4. The development of the best practice model that enables PPGs to use patient insight to influence service improvement and the commissioning of services is being undertaken with Healthwatch Swindon. It is vital that this work is linked to other developments in this field. Therefore we will:

- Continue to liaise with the National Association of Patient Participation (NAPP) to ensure the model is integrated into the into the 'assurance framework' for 'healthy participation and PPGs' that is currently being developed by them and to seek the opportunity to collaborate with NAPP in the rollout of their work.
- Liaise with Devon, Cornwall and Isles of Scilly Area Team as they undertake the development of PPG wide assembly to ensure sharing of information and learning and the limitation of duplication.

Without knowing exactly what this model of the use of patient insight by PPGs will look like as this is in its early stages of development it is important that we consider certain 'tests' to check out success. Some will be more measurable than others. The tests include:

9.5. Range of knowledge and opportunity

- Roles and responsibly are defined and agreed by each PPG and their practice
- PPG members are aware of the information that should be available to them
- Opportunities for PPG to support the practice in the collection and review of data are established

A range of material and resources to support the model being rolled out will be described and where they are not immediately available to implement the model on wider scale (across BGSW) resource sought immediately. Within the 5 year plan is the intention to role facilitate the model being used across all PPGs across BGSW.

9.6. Influence

- Participating PPG members have access to a wide selection of information on the experience of patients relating to the Practice
- The PPG influence service change
- The PPG is valued by the Practice team
- Other patients in the practice will see the activity and influence of the PPG

9.7. A trusted process

- There is feeling of mutual respect and developing/development of understanding form the participating PPG members and practice staff
- Fears ,concerns and challenges by PPG members and staff are raised and addressed

9.8. No issue is left behind

- No question/issue raised in the processes to develop the model will be lost; each will be responded to.

9.9. The difference can be seen and felt

- PPGs are using the model and members report they see and feel they are making difference
- Participants will be in the constant loop of feedback
- The opportunities to give feedback are clear to those using the services
- “You said” – “ we did” will in the public domain
- There will be clear successes to celebrate and failures to genuinely be learned from

9.10. Cultural change is part of success

- It must galvanise people by reaching hearts and minds of staff, patients and the wider public

Each of these deliverables is capable of objective evaluation.

SECTION 10: SUMMARY OF BGSW AREA TEAM FINANCIAL POSITION

10.1. The following tables provide a summary of the projected financial position for 2014/15 and 2015/16:

2014/15						
	Prior Year Surplus / (Deficit) £'000	Notified Allocation £'000	Expenditure £'000	Submitted Surplus / (Deficit) £'000	AT Surplus / (Deficit) Net of Expected Allocation Adjustments £'000	Target Surplus £'000
Primary Care	3,381	283,624	279,913	3,711	3,411	2,836
Secondary / Community Dental	-1,085	19,096	20,441	-1,345	-1,045	191
Public Health	526	37,028	37,028	0	0	0
Armed Forces	-1,200	27,646	27,646	0	0	276
Total BGSW	**1,622**	**367,394**	**365,028**	**2,366**	**2,366**	**3,304**

2015/16						
	Prior Year Surplus / (Deficit) £'000	Notified Allocation £'000	Expenditure £'000	Surplus / (Deficit) £'000	AT Surplus / (Deficit) Net of Expected Allocation Adjustments £'000	Target Surplus £'000
Primary Care	3,411	288,575	285,392	3,183	2,883	2,886
Secondary / Community Dental	-1,045	19,155	19,613	-459	146	192
Public Health	0	37,028	37,806	-777	0	0
Armed Forces	0	27,646	28,548	-902	-321	276
Total BGSW	**2,366**	**372,404**	**371,359**	**1,045**	**2,708**	**3,354**

10.2. The Area Team surplus / (deficit) position is different to the plan submission surplus / (deficit) position due to anticipated allocation adjustments that have yet to be transacted. Current planning rules result in in year surplus / (deficit) values being carried forward into future years. Therefore in year deficits cumulatively increase within the submitted plan where allocations exclude growth in 2015/16. The current notified allocation for armed forces and public health exclude growth for 2015/16.

10.3. As mentioned there are a number of allocation adjustments assumed within the area teams plan but excluded from the notified allocations. These are summarised as follows:

- Public health growth in 2015/16 - £778k
- Secondary care dental allocation adjustments with CCGs in 2014/15 - £300k
- Armed forces growth in 2015/16 - £581k
- Armed forces veteran mental health allocation - £600k

10.4. GP IT is currently excluded from the area teams plan. NHS England is currently reviewing the funding arrangements for GP IT and future submissions of plans would take account of any future guidance.

10.5. The primary care financial position would deliver a surplus of £3,411k in 2014/15 and £2,883k in 2015/16, which would result in nil draw down of retained surplus and in line with the planning guidance to deliver at least 1% surplus margin.

10.6. The treatment of capital and deprecation remains unclear. There remains a likelihood that deprecation costs will need to be funded within current notified allocations. This would be an additional cost pressure to the current plan.

10.7. The plans include £3.7m QIPP to be delivered in 2014/15 and £3.1m in 2015/16. The 2014/15 value is split £0.7m secondary / community dental and £3.0m primary care. A detailed proposal to deliver savings across the whole dental pathway is currently being developed including detailed activity information. As primary care expenditure is predominately driven by registered population size the opportunity to deliver QIPP is restricted. There are however schemes that are currently being assessed for in year QIPP delivery including primary care dental claw back, list validations, premises reimbursements.

10.8. The planning guidance requires the area team to include 0.5% contingency across all programme areas, and 2.5% non-recurrent headroom in 2014/15 and 2% in 2015/16 across all programme areas apart from public health. The area team plans include the contingency requirement however the full headroom has only been included once a 1% surplus can be delivered.

10.9. Further iterations of the financial plan are expected to be required over the next few weeks into the new financial year addressing the total financial pressures across NHS England in total.

SECTION 11: SUMMARY

11.1. This paper details the commissioning a plans of NHS England (BGSW). Comments from stakeholders and partners are welcomed.

11.2. It is important that this plan is not read in isolation and should be read in conjunction with:

- NHS England's Armed Forces Commissioning Plan
- NHS England's Primary Care Delivery Plan
- NHS England Specialised Commissioning Strategy
- The 4 CCG 5 year plans

Appendix 1 – PRIMARY CARE PLAN ON A PAGE

NHS England

Values and Principles	Common core offer of high quality patient centred primary care	Continuous improvement in health outcomes across the domains	Patient experience and clinical leadership driving the commissioning agenda	Balance between standardisation and local empowerment	
Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care	Care delivered in a safe environment

Pre-existing Priorities 12/13	Strategic Context & Challenges	QIPP Improvements	Organisational Development
▪ *Deliver GMS /PMS core contract requirements* ▪ *Contribute to delivering the NHS Outcomes framework* ▪ *Contribute to delivery of the Public Health Outcomes Framework* ▪ *Deliver aspects of The Mandate relating to Primary Care* ▪ *Deliver Quality Premium programme in primary care* ▪ *Implement Electronic Prescription Service* ▪ *Implement Summary Care Record* ▪ *Appraisal and Revalidation of GPS* ▪ *Safeguarding arrangements in primary care*	▪ *Everyone Counts – Planning for patients* ▪ *Mandate emphasis on primary Care* ▪ *Equalisation agenda for all GMS /PMS* ▪ *Improvements of primary care services and reduction in variation* ▪ *Development of LPNs across independent provider groups* ▪ *New Dental Contract* ▪ *Commissioning Secondary Care Dental* ▪ *Implementation of Assurance Frameworks for Primary care contractor groups* ▪ *Patient Access to electronic records by 2015*	▪ *List validation of General Practice* ▪ *Validation of Optical Payments* ▪ *Validation of Dental claims* ▪ *Back office efficiencies* ▪ *Review of QOF payments* ▪ *Review of APMS contracts* ▪ *Better use of contractual levers including those for underperformance* ▪ *Redesign of Medicines use review system* ▪ *QP 6-14 Peer review of outpatient referrals ,emergency admissions and A&E attendances*	▪ *Agree work plans with CCGs to improve primary care performance and reduce variation in primary care* ▪ *Set up LPNS for Dental, Pharmacy and Optometry to develop pathways and carry out needs assessment* ▪ *Establish training programmes for staff in order to implement SOM effective*

	National Priorities 2013-15	Expected Outcomes of Implementing National Guidance Locally in 2013-2014	End State Ambition 2015-16
Assurance	Safe transfer of ; ▪ PCT contracts to NHSCB ▪ Business critical systems and processes ▪ Management of the performers list ▪ Home Oxygen service to CCG ▪ GP appraisal and revalidation system ▪ SCR programme to CSU to develop into patient accessible record	▪ Business systems checked for consistency ▪ National Performers list policy has been adopted ▪ Home Oxygen service transferred safely to CCG ▪ Appraisal and revalidation systems reviewed for consistency ▪ EPS transferred to CCG and continuation of roll out evident ▪ SCR programme transferred to CSU - further development of electronic patient record ▪ Transition plan for HCP 0-5 commissioning transfer to LA has been agreed	▪ Business systems and processes consistent across country ▪ Performer list policy adhered to nationally ▪ Home Oxygen service responsive to patient need ▪ Appraisal and revalidation system working with high uptake ▪ EPS roll out completed ▪ Electronic patient record accessible to all patients ▪ HCP 0-5 commissioning safely transferred to LA ▪ Control of Entry regulations in place and operating well
Quality	▪ Develop a strategy for quality improvement in primary care ▪ Develop web based database of GP quality indicators ▪ Adhere to national performance assessment frameworks for each provider group ▪ Develop further the reporting system for quality concerns, SUIs and never events in primary care ▪ Safeguarding arrangements in place across all primary care contractors ▪ Improve access to primary care services ▪ Improve patients satisfaction of primary care services	▪ Implementation of the quality improvement strategy for primary care has been achieved ▪ Implementation of the web based tool for GP quality indicators has been developed and adopted ▪ Robust reporting system is in place for reporting quality concerns SUIs, never events in primary care ▪ Safeguarding systems evident and operating across all independent contractor groups	▪ Quality improvements in primary care are visible ▪ GP quality indicators drive improvement in outcomes ▪ Robust Assurance systems are in place for primary care increasing safety and quality for patients ▪ Robust Safeguarding arrangements in place across all parts of the health and social care system
Single Operating Model	▪ Implement single operating model across all contract groups	▪ The single operating model is embedded in management of primary care provider groups	▪ Nationally consistent way of doing business in primary care
General Practice	▪ Implement online access to primary care medical record ▪ Implement the equalisation approach to GP contracts ▪ Implement on line patient appointments and repeat prescription service ▪ Develop e.consultation service	▪ Work underway with CCG and CSU to develop SCR into patient accessible electronic record ▪ Discussion underway with LMC and practices re equalisation of contracts ▪ Work progressing with online appointments and prescribing and e.consultation service	▪ Patients can access health records electronically ▪ Equalisation of GP contracts finalised ▪ Patients able to book appointments and order repeat prescriptions on line ▪ e.consultation services rolled out in general practice
Securing Excellence-Dentistry	▪ Introduction of new Dental Contract ▪ Establishment of Dental LPN ▪ Commission Secondary care dentistry ▪ Ensure that services are responsive to need ▪ Ensure robust OOH / 7 day service in place ▪ Promote access to dentistry ensuring rate of new patient relates to need	▪ Preparation for the new Dental Contract ▪ Fully operational LPNs in place ▪ Contracts in place with acute providers for secondary care dentistry ▪ Implement specialty pathways for dental as they are developed ▪ Implement the Assurance Management Framework for Primary care dentistry	▪ New Dental contract implemented ▪ LPNs driving improvement in commissioning ▪ Robust Assurance systems are in place for primary care increasing safety and quality for patients
Pharmacy & Optometry	▪ Revised policy /regulations for Control of Entry for Pharmacists ▪ EPS programme transferred to to CCG /CSU ▪ LPNS to be established for Pharmacy and Optometry (eye care)	▪ Revised Control of Entry regulations adopted by AT and operational ▪ EPS programme being developed through CCG /CSU ▪ Established LPN in place for Pharmacy and Optometry	▪ Control of Entry operating ▪ EPS rolled out across AT patch
FHS	▪ Monitoring of FHS performance to ensure delivery of service within financial envelope and quality measures	▪ Ensure FHS service meeting all quality, service and financial KPIs	▪ SBS providing effective and efficient FHS services

Appendix 2 - PUBLIC HEALTH PLAN ON A PAGE

NHS England

Values and Principles	Services are patient centred and outcome	Improved outcomes are delivered across each	Fairness and Consistency – patients have access to services regardless of			Productivity and efficiency
Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care		Care delivered in a safe

Pre-existing Priorities

The NHS Outcomes Framework identifies earlier diagnosis as one of four key contributors to address premature mortality and the need for better prevention. The National ambition is to improve and protect health and wellbeing. The aim is to improve not only how long we live but how well we live and to ensure that we support the whole community to live healthily, reducing health inequalities
BGSW will achieve this by working with our partners to:

- Deliver national Health Child Programme 0-5 years including Health Visiting and Family Nurse Partnership.To improve the health and life chances of families
- Deliver the national Immunisation Programmes and improve uptake to increase herd immunity and reduce the risk of infectious outbreaks
- Deliver the National Cancer Screening Programmes to help improve early diagnosis of breast, bowel and cervical cancer
- Deliver the National non-cancer Screening programme including Diabetic Eye Screening, AAA Screening, the Antenatal and Newborn Screening programmes to improve early diagnosis of disease and disability.

Strategic Context and Challenges

- Making every contact count
- Implementing the Public Health Outcomes Framework
- Embedding a single model of screening and immunisations for NHS England
- Safe transition of healthy child programme back to Local Authorities
- Implementation of new programmes, keeping abreast of the pace of change
- Improving uptake of section 7a commissioned services for marginalised and at-risk groups.

In order to achieve the above challenges BGSW will complete a local benchmarking and assurance process against the National Specifications and work with providers to develop timely action plans for compliance.
We will also work with NHS England and PHE data sources to assess not only coverage data but Public Health and demographic data to ensure that services are fair and equitable and to allow for the development of targeted approaches to improving uptake.

QIPP Improvements

The Public Health team will ensure that all commissioned programmes demonstrate value for money in line with QIPP principles, and that high quality, evidenced based cost effective services are delivered. This will include the systematic application of robust financial and contract performance monitoring and review processes.
We will also achieve QIPP by:

- Ensuring we are targeting the right people
- Identifying risk of disease and disability early through the commissioning of safe and effective Screening Programmes
- Reduce the impact of infectious disease outbreaks and ill-health by commissioning safe and effective Immunisation Programmes
- Improve life chances and access to services for children and families through our Health Visiting and Family Nurse Partnership Programmes
- Ensure commissioned services represent best value for money and are evidence based
- Benchmarking the payment and contracting mechanisms of our commissioned services within our Area Team and

Organisational Development

The focus of organisational development for BGSW is:

- Working closely with the PHE embedded Screening and Immunisation team to ensure an integrated approach to commissioning
- Working in partnership with other Area Team commissioning and contracting teams (Primary Care, Specialised Commissioning, Armed Forces, & Health and Justice) in order to maximise resources
- To continue to develop relationships with commissioners and providers in the local health economy
- To provide training and development opportunities to the Public Health team
- The continuation of the partnership approach developed with the local authority and Health & Well-being boards.

The above priorities will allow the BGSW Public Health team to commission the section 7a Services in an integrated and effective manner to benefit the health of the population of BGS&W.

	National Priorities 2014-15	Expected Outcomes of Implementing National Guidance locally in 2014-15	End State Ambition 2015-16	Additional Local Priorities 2014-2016
Immunisation	• Seasonal Flu Programme for children is to be further rolled out (including 4 years olds, and commencing delivery in secondary schools) • Extension of Men C to University entrants. • Continuation of MMR catch up, Pertussis in pregnant women, Shingles in 70/79 year olds • Minor changes to the seasonal flu specification • Implementation of the revised specification for pneumococcal vaccination	• Increased participation in the flu vaccination programme to reduce avoidable hospital admissions and severe complications in at-risk patients. • Completion of immunisation uptake improvement programmes particularly for at risk and marginalised groups. • Increased herd immunity and resultant improvements in Public Health as a result of the extension of the childhood flu programme	• Full participation in vaccination programmes with accurate and timely data available at general practice level • Sustained high uptake levels without local pockets of opt out risking overall population health	• Continue to develop governance process for assuring improvements in immunisation uptake • Evaluate performance and set local targets for improvement for all new and existing programmes • Review and revise all local contracts and contracting mechanisms to improve performance • Assess the school-age immunisation provision against capacity and other competing Public Health targets • Assess all contracts outside of primary care for possible re-tendering • Implement CQRS as a mechanism for data collection and payments for primary care
Screening Programmes (Cancer)	• Review existing services to identify areas of non-compliance to national specifications and risks to programme delivery. Develop action plans to ensure full delivery to national specifications by March 2015 • Age extension for existing Bowel Screening Programme (men and women 75years) • Introduction of HPV testing as part of the Cervical Cancer Screening Programme for women with mild and border line changes • Implementation of the new performance baselines for bowel screening.	• Full rollout of age extension Bowel and Breast Screening programme with sustained timely access to diagnostics and subsequent treatment where required • Increased participation in screening programmes with reduced variation between local populations • Benefits across the health system of early detection and diagnosis of cancer	• Full participation in screening programmes so that earlier detection leads to prevention of premature death, help to recover from ill health and an overall more positive experience from the health service	• Continue to develop governance process for assuring improvements in cancer screening uptake • Improve coverage of screening programmes particularly hard to reach groups • Assess existing contractual arrangements and review the need to retender as necessary and appropriate • Re-commission the cervical screening programme for armed forces personnel to represent a fair and equitable programme across the system. And potentially develop commissioning intentions for the other screening programmes in relation to armed forces and their dependants
Screening Programmes (Non-Cancer)	• Review existing services to identify areas of non-compliance to national specifications and risks to programme delivery. Develop action plans to ensure full delivery to national specifications by March 2015 • Introduction of the new performance baselines for Diabetic Eye Screening • Implementation of the DNA test as part of the Sickle Cell and Thalassaemia Screening Programme • Ensure that the payment for the antenatal and newborn screening and immunisation programmes are recognised within the Maternity Pathway Payment and that there is not a subsequent reduction in activity or quality	• Increased participation in screening programmes with reduced variation between local populations • Review of the participation in antenatal and new born screening services, analysis of the root causes of variation and the spreading of identified best practice • Benefits across the health system of early detection and diagnosis of disease and disability.	• Full participation in screening programmes so that earlier detection leads to prevention of premature death, help to recover from ill health and early detection of disability, and an overall more positive experience from the health service • Full participation in screening programmes to support goal of giving every child a healthy start in life	• Continue to develop governance process for assuring improvements in non-cancer screening uptake • Improve coverage of screening programmes particularly hard to reach groups • Assess existing contractual arrangements and review the need to retender as necessary and appropriate • Benchmark programmes across the region with a view to standardise payments and improve VFM
0-5 years Programme (including HV and FNP and Child Health Information System)	• Implement the 14/15 workforce trajectory for Health Visiting Call to Action, and continue to review and report performance on a monthly basis. • Continue to collect and monitor the quarterly data in relation to Health Visitor outcomes • To plan and work towards the transition of the Healthy Child Programme (0-5) to local authority. Transition Boards/Groups will provide regular updates to all stakeholders • Implement the new trajectory for Family Nurse Partnership expansion Wiltshire	• Increase in Health Visiting workforce and resultant improvements in service delivery • Expansion of Family Nurse Partnership to improve outcomes for young vulnerable first time mothers and their families.	• In 2015, commissioning responsibility for this aspect will transfer to Local Authority partner organisations and the ambition is for the expected service capacity and all national standards to be sustainably delivered prior to transfer.	• Ensure safeguarding and quality arrangements in place reported through Quality Surveillance • Ensure arrangements in place to ensure coordinated and integrated commissioning • Ensure the commissioning and implementation of the existing and planned new Family Nurse Partnership Programmes
NHS England and PHE agreements	• Develop common strategies to improve outcomes • Implement Every Contact Counts and develop public health advice service • Continue to strive for improved and more timely data collection and analysis to better commission the Section 7a Services.	• Close partnership working of all Public Health functions with coordinated and integrated commissioning intentions for 2014/15	• Full utilisation of Public Health Advice service by public to measurably improve domain outcomes for the local population	• Continue to develop governance arrangements • Ensure local prison services have appropriate access to Public Health services

Appendix 3 - ARMED FORCES COMMISSIONING PLAN ON A PAGE

Armed Forces Health Commissioning

Our vision is to provide high quality and safe care for Armed Forces personnel and their families, in accordance with the Armed Forces Covenant and the NHS Constitution.

System Values

- Ensure that Armed Forces personnel are not disadvantaged in their access to healthcare through the principles of:
- Equity of offer;
- Equity of access; and
- Equity of outcome.
- Ensure that special consideration is given to those injured as a proper return for their sacrifice

System Principles

- Prioritising patients in the decisions we take
- Listening and learning
- Making evidence based decisions
- Being opening and transparent
- Being inclusive
- Striving for improvement

System Objective One

Services for the armed forces are commissioned in line with the commitments of the Armed Forces Covenant

System Objective Two

We work in partnership with the MoD to commissioning healthcare in line with the partnership and in support of DMS's objective to promote, protect and restore the health of the Defence population in order to maximise fitness for role

System Objective Three

We will work with the MoD and CCGs to improve the model of integrated care that service leavers with mental health or complex physical health needs receive

System Objective Four

We will collaborate with CCGs and Health and Wellbeing Boards to develop and embed strong armed forces Networks to ensure that the armed forces community receives appropriate care regardless of commissioner

Delivering better care through the digital revolution

a) increase use of choose & book, including advice and guidance functionality, within DPHC
b) increase the use of telemedicine as an alternative to face to face care where appropriate;
c) increase access to national screening programmes
d) link DMS systems to Child Health Information Systems

Co-ordinated access to Musculoskeletal pathway

(a) Improved use of choose & book and its functionality within DPHC for access to secondary / tertiary referral for MSK conditions
(b) re-design MSK pathways to make best use of recognised good practice in rehabilitation

Improved access to mental health services

a) Improve care co-ordination on service discharge
b) Improve signposting to appropriate mental health services
c) Improve the use of recognised good practice services for veterans' mental health such as online counselling

WIS leavers to have an agreed health plan

Work with the MoD to ensure that all WIS service leavers leave with a personal health plan; designed to empower patients to take to take more control of their long term health and direct them to the most appropriate professional under the primary care team to manage their routine needs.

Overseen through following governance arrangements

- Area Team Corporate Management Group
- Area Team (AT) Strategy Steering Group
- Direct Commissioning Performance Group
- Joint Commissioning Group
- Armed Forces Oversight Group

Measurement

- Increased choose and book referrals
- Waiting times
- Co-produced workforce measures
- Access to screening programmes
- Number & % of agreed health plans
- Armed forces network metric

Sustainability

- We will consider sustainability and affordability in our approach to decision making.
- We will work with DMS to, where possible, standardise the approach to state funded items to help deliver affordability and sustainability

Appendix 4 - SPECIALISED COMMISSIONING VIA BNSSSG AREA TEAM

Vision

That everyone in England can access a range of high quality, good value specialised by working in collaboration with patients and partners to deliver

Specialised Objective One
To ensure patients can access specialised services are commissioned to national standard and specifications

Delivered through compliance

Assessment of all clinical services against specifications
Agreement of derogation plans to enable providers either to meet standards or to enable re-provision
Implement changes to vascular surgery to improve safety and save lives working through the Strategic Clinical Network and Clinical Senate functionality

Specialised Objective Two
To improve access and increase throughput to standard radiotherapy and IMRT

Delivered through expansion

Review of existing capital plans for expanded capacity
Agree future configuration of capacity
Adopt best techniques for fractionalisation, etc

Specialised Objective Three
To improve capacity and care pathways for patients requiring specialised mental health services (CAMHS, secure, etc)

Delivered through re-provision

Local capacity changes including strategic view of NHS provision
Implementation by CCG of enhanced tiered services and embedding of Case Managers

Specialised Objective Four
Development of ODN model to progress prime contracting and to support concentration of provision of specialised services from fewer centres

Delivered through strategic change

Build on local examples of good practice (such as TYA MDAT) to support access to specialised children's services across the South West

Overseen through the following governance arrangements

- Specialised Commissioning Oversight Group
- Area Team Executive
- Specialised Commissioning Delivery Group
- Specialised Commissioning Collaborative
- HWBB and HOSCs

Measured using the following success criteria

- NHS England operating a balanced and sustainable specialised commissioning budget
- Delivery of the mandate
- Local acceptance of changes in clinical delivery to facilitate concentration on fewer centres

System values and principles

- No-one tries harder for patients and the community
- We will maximise value by seeking the best outcomes for every pound invested
- We work cohesively with our colleagues to build tolerance, understanding and co-operation

Appendix 5 - HEALTH & JUSTICE PLAN ON A PAGE

5 Year Strategic Plan and Vision

Working together to achieve excellence in health outcomes and experience in justice settings for people in BaNES, Gloucestershire, Swindon and Wiltshire

Priority One

To reduce health inequalities and improve the health outcomes for people in contact with the justice system through provision of high quality services that are equivalent to community services

Performance Management framework

- Active management of contracts to a set of standardised quality criteria
- Consistent improvement in patient valued outcomes

Pathway Review

- Ensuring integration across pathways

Priority Two

Reducing reoffending

Multi agency working & planning to enable Transforming Rehabilitation

- Understanding workforce requirements
- Reducing duplication of work

Priority Three

Strengthen leadership and patient voice to inform and improve the efficiency and effectiveness of services delivered through increased joint planning, collaboration and commissioning with commissioning partners

Early intervention and prevention

- Understanding workforce requirements
- Reducing duplication of work

Commissioning improved health in justice outcomes

- Moving towards a single framework
- Embed patient voice and engagement in service developments and the commissioning cycle

Improving victim experience and outcomes

- Evidence of working with vulnerable people
- Listening to and understanding the support they need

System Objective Four

Value for money

Assure partners, patients and the public that resources are well targeted, adequate and offer the best outcomes for patients

- Increase available benchmarking tools.
- Evidence HNA's inform service design

Overseen through the following governance arrangements

- Bristol, North Somerset, Somerset & South Gloucestershire Criminal Justice Board.
- Informed by Strategic Clinical Network for Health in the Justice system and for Mental Health
- NHS England BaNES, Gloucestershire, Swindon & Wiltshire Executive Team (Direct Commissioning Assurance)
- NHS England Health and Justice Oversight Group
- Local Authority (Overview & Scrutiny Committee

Measured using the following success criteria

- Number of offenders going back through the system
- Sustained engagement with CRC and NPS – no offending within a 12 month period and no duplication of services offered.

High level risks to be mitigated

- Information governance – linking IT systems across different organisations involved in the pathway.
- Data collection – consistency; measuring agreed outcomes.
- Expertise available to support the patient voice and engagement in justice settings.
- Engagement with key stakeholders to ensure the success of the strategy and encourage joint commissioning where appropriate.

How we seek assurance

- Regular local finance meetings with Providers and AT finance.
- Ensure HNA's are current and public health information informs targeted spend
- Engage in regular benchmarking activity and where necessary testing the market to ensure Value for Money for services provided

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