Bath and North East Somerset
Clinical Commissioning Group

NHS Bath & North East Somerset

Seizing Opportunities – A Five Year Strategy

April 2014

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 needs to change over the 5 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 5 years as opposed to 1 or 2 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 than the model inherited at its outset in 1948.

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, to agree a Joint Health and Wellbeing Strategy, as produced by the Health and Wellbeing Board. This being based on a much wider base than purely health issues, underpins 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 had an initial meeting with the public and more will take place in the coming weeks.

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 have 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

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Chapter 1 Seizing Opportunities – Seizing Opportunities – An 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 5 year strategic plan is a key milestone in the development of the BaNES 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 will be increasingly focused around our practice clusters based in Bath City, Keynsham and the Chew Valley area, and Norton Radstock in the future.

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) tells us that we perform well on the majority of outcome measures applied to CCGs and are in the top 10% for many. We serve a generally healthy and 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 and despite overall good clinical outcomes, and 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 ageing population should be seen as a burden but that we need to ensure that we can support older people to have happy healthy B&NES, 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 £60m, 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 5 year vision has at its centre patients who are supported to manage their long term conditions more effectively and experience high quality care in safe environments with care delivered closer to home where it is appropriate to do so.

We will achieve this by continuing to focus on urgent care, further development of community teams 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.

Central to the delivery of our five year vision is our commitment to quality and a continued focus on the quality of local services, being alert to the needs of all of our populations, particularly the most vulnerable,

Over the next 5 years, we will see delivered an ambitious programme of priorities 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

Through our stakeholder engagement events, we have prioritised what we see as 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 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.

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:

Service Performance Management:

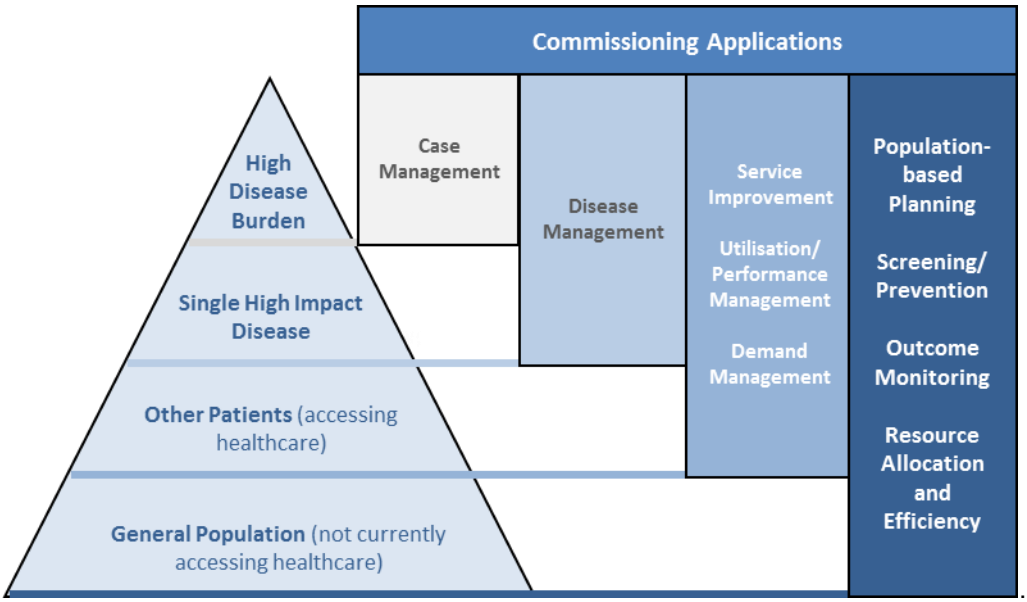
We will use service performance management to drive greater benefit from the healthcare services we have already commissioned. We will adopt and evidence-based approach to evaluation and performance management and this may require us to collect new sources of information that provide clues about the 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) 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 deliberately create indicators that can only be achieved through co-operative working, collaboration and integration.

Investment and dis-investment:

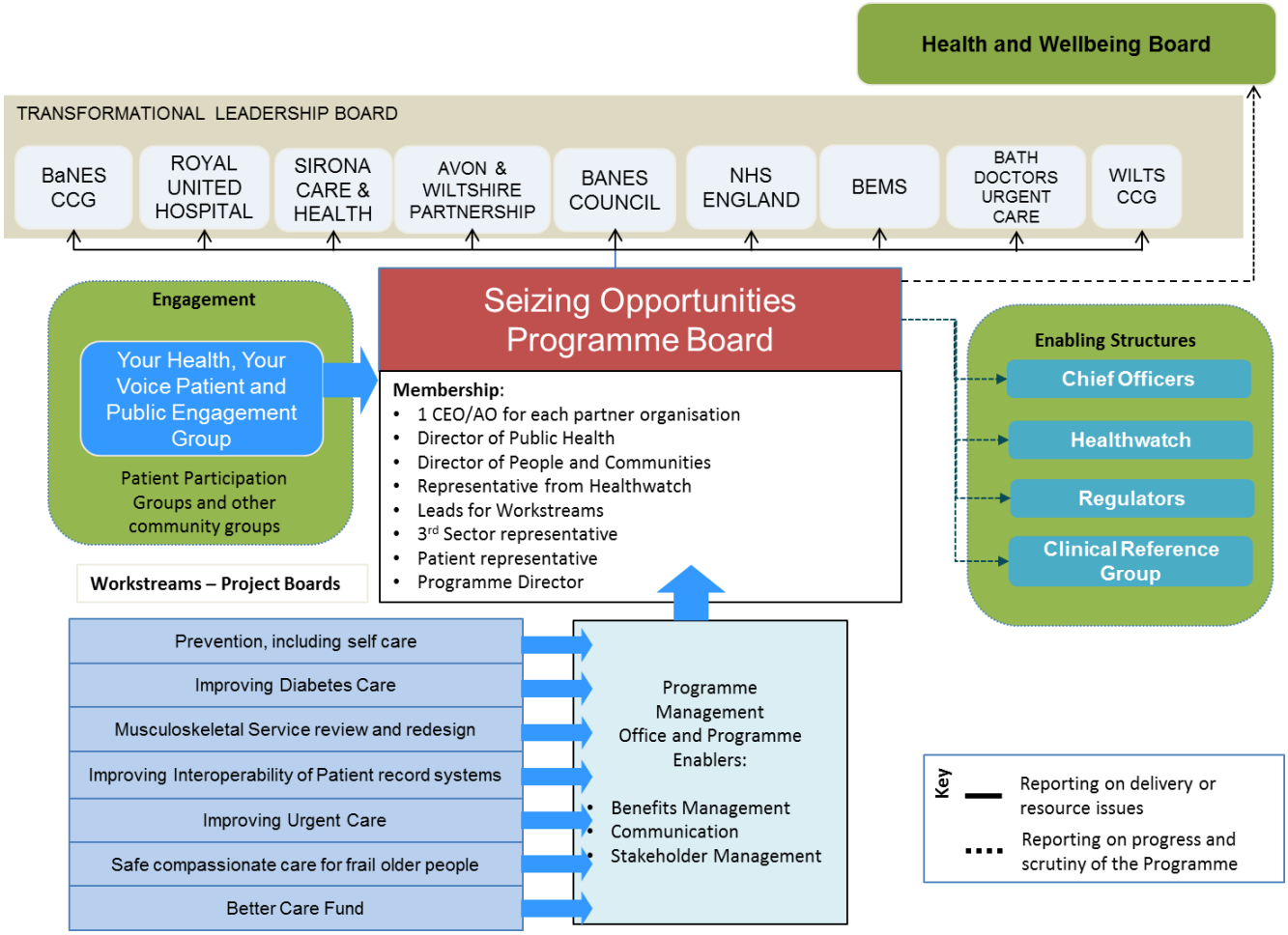
We will seek to invest in new pathways and services where they deliver improved outcomes and experiences at lower unit cost. We will work with providers and patients to establish new models of care that carry the confidence of both and test the case for change through evidence, analysis and consultation. 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.



Making It Happen

We acknowledge the very positive response of our stakeholders to the development of our 5 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).



Our 5year Transformational Leadership Board (TLB) will oversee the different work streams within the scope of the 5-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 principal 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 5 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.

Simon Douglass
Clinical Accountable Officer

Chapter 2 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	• 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	• Empowering & encouraging people to take personal responsibility for their mental and physical health and wellbeing	• Reducing inequalities and social exclusion & supporting our most vulnerable groups.

Our Approach	• We will lead a reconfigured system that
	  • Meets the current and future needs of our population,
	  • Targets 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 individual 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 (Years 1&2)	• Improve step down care • Embed the Community Cluster model • Increase Case Management	• Re-design MSK & Pain services • Review of Ophthalmology Pathways	• Embed risk stratification • Build opportunities around Better Care Fund • Integrated pathway for frail elderly and falls • Diabetes	• Embed the new Urgent Care Centre model • Mental health (incl. young people's mental health) • SEND reform • Develop a Self Care strategy and action plan	
Our Enablers	• Longer-term contracts • Develop Incentives for innovation, improvement and integration • Develop the role and sustainability of primary care services	• Develop Referral Management Support	• Develop our approaches to integrated care, e.g., House of Care • Improve integration of information systems	• Develop our approach to Citizen Participation and Empowerment • Role out Personal Health Budgets	
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 Introduction to Our CCG

In this chapter we set out:

Our vision for Healthcare in BaNES in 2018/19

- Our values
- Our commitment to quality
- Our approach to leadership and culture

The Overarching Vision for Healthcare in BaNES in 2018/19

Our vision is to provide care and support to the people of Bath & North East Somerset (B&NES), in their homes and in their communities, with services that support people to take control of their lives and reach their potential and are characterised by:

- 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 working 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

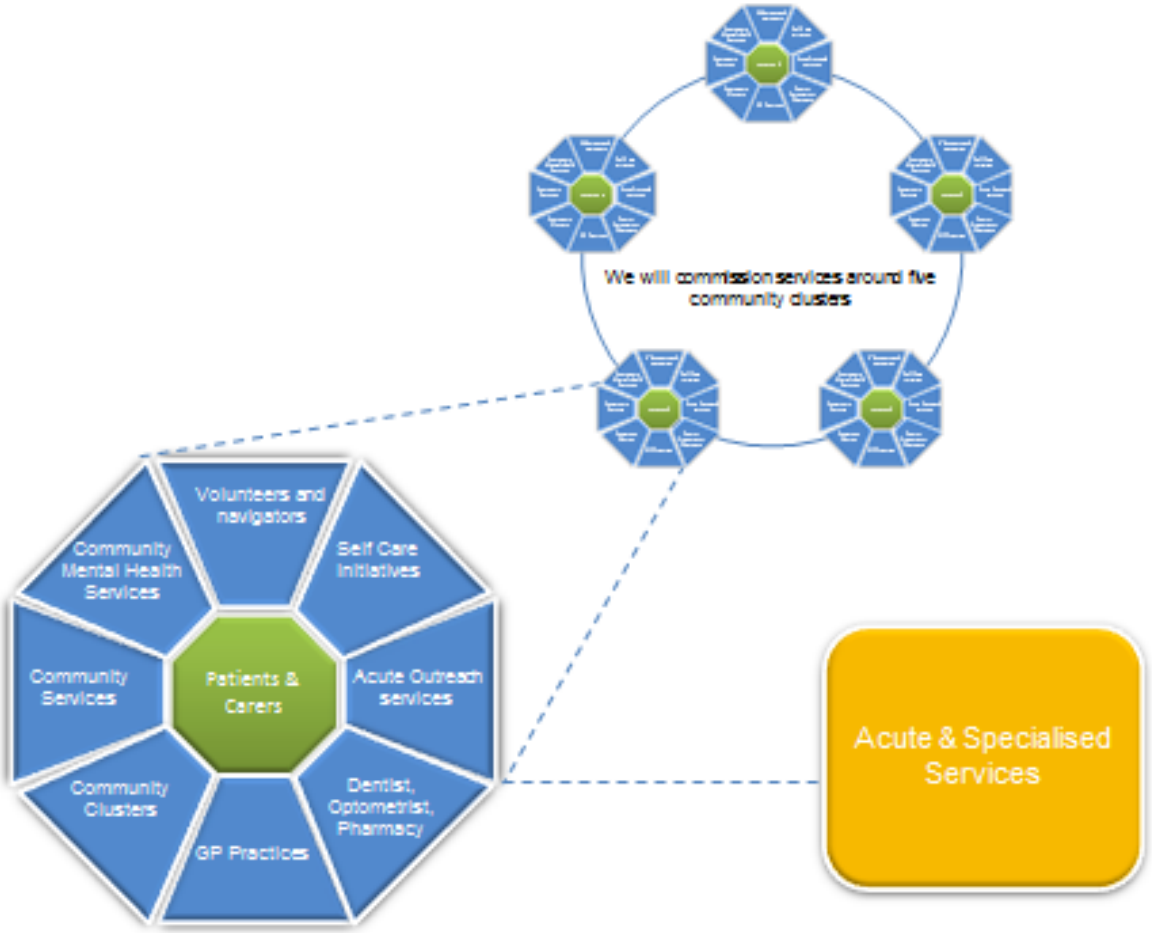
- Innovative and widely integrated and utilised pathways of care understood for each long term condition and including self-management, transition, urgent and contingency planning elements as routine

- A focus on the most vulnerable, at risk, frail or excluded citizens as a matter of priority regardless of age

- Local people of all ages who have worked with clinicians and practitioners to design, inform and then have access to information that enables them to be confident in the quality and safety of services 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, measure by quality and effectiveness of outcomes as experienced by the people who use them.



In Chapter 7 we set out the specific interventions that we have planned and explain how we intend to implement the shift in resources.

Our Values

We believe that it is important to be transparent about the way in which we make decisions, and to continue the 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 it can play in achieving our collective vision for care services by 2018/19 and we will create a receptive environment in which providers can thrive and become more efficient.

Patients 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 central 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. It is essential that, in order for key result areas to be achieved that all stakeholders including our patients, their families and carers are consulted, allowed to prioritise and to set a pace of change that is comfortable and achievable by all.

We expand on our commitment to quality later in this document.

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 attempting 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 its 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 the delivery of our 5 year vision 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 need that alter over time.

Examples of this include heart failure management which has moved from a silo based approach with episodic care at its heart, 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 involvement of patients to ensure it meets their needs in its design.

It has led onto it being used as a pilot for 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 practice elsewhere as evidenced by using heart failure and use of this model as a basis for a CQUIN both for us and neighbouring CCGs.

With the influence that clinician led commissioning has brought, this sort of change to clinical practice with better quality at its centre has become achievable, and it is our vision that we will build on this successful collaboration coupled with a focus on patient engagement and participation to reap the maximum benefits of clinical led leadership.

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. This will require a different approach.

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 5 year plan enables us to seize the opportunities of strong historic performance to make a step improvement in the care delivered to local people.

Chapter 4 The Population We Serve and the Services We Commission

In this section we set out:

- Our understanding of our population and the significant characteristics of their health and wellbeing
- Our current provider landscape
- How we currently use our financial resources
- Our stakeholders' view of challenges in the system

Our Population

Latest population estimates indicate that BaNES has a resident population of 177,643; a small increase from census estimates of 176,000. This slight increase is partly due to an increase in the number of births and in life expectancy. In addition, the area has seen an increase in migration from both international and national sources. The resident population is lower than the GP registered population of 197,040.[1]

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. Notable changes are expected in the following age ranges:[1]

- 19% increase (to 10,379) in the 5-9 population
- 17% and 15% reductions in the 35-39 and 45-49 populations
- A significant aging population
  - 32% increase (to 9,425) in the 70-74 age range
  - 27% increase (to 7,590) in the 75-79 age range
  - 39% increase (to 2,335) in the 90+ age range

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.

At a small area level there are differences in deprivation within BaNES (Table 1).

Table 1: Deprivation levels in BaNES by LSOA and percentage population

National quintiles of deprivation	No. of LSOAs in BaNES	% local population living in these areas
1 (least deprived)	48	41.7
2	33	28.7
3	20	17.4
4	9	7.8
5 (most deprived)	5	4.4

Five geographical areas are within the most notable 20% of the country across a range of data: Twerton West, Whiteway, Twerton, Fox Hill North and Whiteway West.[1]

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/personal responsibility for health.

Infant, children and young people's health

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.[2]

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.[3]

Adult health and wellbeing

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%.[2] 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.

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.[4]

Self-reported levels of wellbeing show that a smaller proportion of the BANES population report that they have low levels of happiness and low levels of satisfaction compared with national levels. Locally BANES has similar levels of high anxiety compared with national rates – 22.2% compared with 21%.[2]

Disease and poor health

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. Rates for England have risen only slightly in that time from 198.3/100,000 to 207.9/100,000.[5] 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 registered with diabetes mellitus on GP registers.[2]

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.[7]

Cause of death and life expectancy

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.[2]

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.[1] Life expectancy in BaNES is higher for men (80 years) and women (84 years) than regional and national averages.[5]

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. For men, life expectancy is significantly lower than the BaNES average in Twerton. As this is the only ward where life expectancy for men is statistically significantly lower, much of the inequalities in 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.[2]

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, particularly lung cancer (24% of additional deaths); circulatory diseases (20%); digestive diseases, particularly chronic liver disease including cirrhosis (19%); and respiratory diseases, particularly COPD (16%).

- Amongst women the difference in life expectancy can be largely attributed to cancer (23%), circulatory (15%), digestive diseases (12%) and COPD (11%).[6]

Table 2: Breakdown of the life expectancy gap between the most deprived quintile in Bath and North East Somerset and the least deprived quintile in Bath and North East Somerset, by cause of death, 2009-2011[6]

	Male			Female		
Broad cause of death	**Number of deaths in most deprived quintile**	**Number of excess deaths in most deprived quintile**	**Contribution to the gap**	**Number of deaths in most deprived quintile**	**Number of excess deaths in most deprived quintile**	**Contribution to the gap**
Circulatory diseases	137	34	19.5%	135	9	14.8%
Cancer	154	44	24.1%	130	24	22.6%
Respiratory diseases	68	26	16.2%	65	11	11.2%
Digestive diseases	37	30	18.5%	37	14	11.6%
External causes	35	20	12.8%	15	9	4.4%
Other causes	80	3	9%	144	26	27.2%
<28 days	0		…	2	2	8.2%

BaNES has a premature death rate of 290.5/100,000. Comparing the under 75 mortality rates of BaNES with England 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 (Table 3)[7]

Table 3: Under 75 mortality rate/100,000 (DSR), 2012[7]

	BANES	England
CVD	44.15	65.47
Respiratory disease	15.49	27.44
Cancer	100.56	123.26
Liver disease	10.84	15.4

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.[8]

Current Provider Landscape

We have engaged providers in early strategy discussions and received support for our vision and ambition. We believe that our providers have a readiness to change and are prepared to work in partnership with us to achieve our vision. However, we understand that the sequencing of change programmes and the change levers that we wish to employ will determine the success we have as an economy.

We have a complex provider landscape in and surrounding B&NES. 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. The RNHRD, the smallest FT in the country has been financially challenged since 2008 and is subject to formal intervention from Monitor. 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.

The majority of our patients access urgent and elective care services from the RUH, although for many of our patients in Keynsham and Chew Valley, UHB and NBT will be their nearest local acute provider. Specialist tertiary services are primarily provided by University Hospitals Bristol and North Bristol NHS Trust.

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).

Primary Care Provision

General Practice

There are 27 GP practices within the CCG area; all lists are open, signifying that supply is at least matching demand. Provision is evidenced as being high quality through annual QUOF scores and by low exception reporting rates. There is a narrow range between highest and lowest QUOF scores compared to the national average: 10% (which reduces to 4% if the bespoke University practice is excluded), compared to 22% nationally. This indicates that performance is reliably high. There are a high number of training practices and recruitment is not considered a problem locally.

The CCG Quality Profiles (July 2012), indicates that B&NES CCG performance for the ability to see a GP fairly quickly indicator is worse than the national picture by a degree that is unlikely to be explained by random chance. However, the ability to book ahead for an appointment indicator is better than the national picture.

All 27 practices are aligned to a commissioning cluster within the CCG with the following population distribution by cluster.

Cluster	List Size[1]
BANES CCG	**199274**
Norton/Radstock	49451
Bath West	40150
Bath Central	39323
Chew/Keynsham	38762
Bath East	31588
[1] ***as at January 2014***	

Dental Services

There are a high number of dental practices for our population size: 36 practices including 2 corporate groups and a range of independents. There is no overall market domination by any single group.

Pharmacists

We have 38 local pharmacies spread across our local communities. There is aspiration and capacity to increase the role of the community pharmacist in health promotion and early intervention in minor illness.

Opticians

We have 32 optometry providers, a relatively high number for our population size.

Urgent & Elective Secondary Healthcare Provision

Royal United Hospital, Bath NHS Trust (RUHB) is the main provider of local secondary acute hospital care and held in high affection by local people. From the 1st June 2014 the RUH will be the main maternity provider for our local population providing both acute and community maternity services. The RUH also provides more specialist tertiary services in certain specialties. The Trust is currently progressing through its Foundation Trust application with Monitor for the 2nd time. It is anticipated that the Trust will achieve Foundation Trust status by the Summer of 2014.

Although we commission the majority of our secondary care activity from Royal United Hospital Bath NHS Trust, BaNES patients represent only 33% of the trust's total activity. Wiltshire CCG, Somerset CCG and NHS England, as Specialist Commissioners, hold associate interests. Wiltshire CCG commissions 36% of the trust's activity and from 1st April 2014 will commission services through a separate contractual arrangement with the RUH. It is important to note this arrangement given the potential impact of any redesign projects on neighbouring CCGs. Cross CCG collaboration will be required on any major service changes.

Performance against certain key targets has been historically challenging particularly for A&E and waiting time targets although performance has improved significantly during 2013/14. The RUH and wider Bath health community was identified as a "challenged health community" in terms of A&E performance and received £4.4m of winter pressure monies in 2013/14.

The quality of services delivered by RUH has been the subject of attention from the Care Quality Commission and the CCG alike. The RUH was identified as a medium risk organisation for new style of CQC reviews and was one of? 18 pilot sites in December 2018. The most recent inspection and report (March, 2014) determined that services delivered by the Trust are safe and effective. Key areas for improvement have been highlighted and an improvement plan with input from commissioners has been put in place. We continue to work in partnership with the Trust to ensure that services delivered for our population are of the highest quality.

Royal National Hospital for Rheumatic Diseases provides Secondary care rheumatology services, Chronic Fatigue Services, Specialist Pain Management and a number of diagnostic services. The Min, as it is locally known, has a national reputation and was early Foundation Trust. The Trust has been struggling with financial viability for a number of years and its future of the Trust is currently under discussion with Monitor and Commissioners.

North Bristol NHS Trust and University Hospitals Bristol NHS Foundation Trust (UHB) provide for patient choice in secondary care and for more specialised tertiary services.

Significant service moves between the two North Bristol Trust sites; Frenchay and Southmead are planned to take place from May 2014. This is expected to have an impact on the RUH, with some and BaNES and South Gloucestershire CCG patients who may have previously chosen Frenchay Hospital, choosing the RUH rather than Southmead. North Bristol is also seeking FT status with an aspiration to complete its application during 2014.

Bath Doctors Urgent Care

Out of Hours GP Services, an Urgent Care Centre at the front door of the RUH and provision for the Homeless will be provided by Bath Doctors Urgent Care from the 1st April 2014. This is a new provider to the area who successfully bid for this new model of integrated services in 2013. They are part of Vocare Group, a leading care provider in the North East providing GP Out of hours, 111 Services, a GP practice and Urgent Care Centre and Walk in Centres.

Independent Sector Providers

Emerson's Green and Shepton Mallet Treatment Centres

The Independent Sector Treatment Centres (ISTCs) at Shepton Mallet and Emersons Green (EGTC) provide choice in elective surgery. EGTC is currently operating under a nationally commissioned contract which is due to expire in September 2015. The CCG is working with the local CSU supporting these contracts, on plans for service provision post September 2015.

BMI Bath Clinic and Circle Bath Private Hospitals

BMI Bath Clinic and Circle Bath private hospitals in and around Bath also provide additional choice for provision of elective care in certain specialties. Recent years have seen growth in the market share of these two providers and a significant variance of forecast outturn activity against plan is expected for 2013/14. The top three specialties responsible for this shift are general surgery, ophthalmology and orthopaedic elective care. Their services are well liked by patients and enjoy positive patient feedback.

Mental Health Provision

Avon and Wiltshire Mental Health Partnership NHS Trust for specialist mental health services

Is the main provider of specialist in patient and community mental health services? The Trust has been challenged both financially and in service terms but has a new management team and following investment from commissioners is now providing care which demonstrates fidelity to the DH model. The Trust is currently reviewing its timescale to progress into the Foundation Trust pipeline.

Services for adults with Learning Disabilities

The CCG and local authority operate joint commissioning arrangements with a pooled fund for commissioning local health and social care services which are delivered by a wide range of providers. Specialist community health services are provided by Sirona Care and Health who also support primary and secondary care, and AWP mental health services when necessary. Future demand for services is predicted to increase as people with profound and multiple learning disabilities live longer, and the population of older adults with learning disabilities rises.

The focus of services is primarily to promote individual support that enables people to live as independently as possible, whatever their level of learning disability or complexity of need, and to reduce health inequalities through access to all local health services with appropriate support.

South West Ambulance Service NHS Foundation Trust (SWASFT)

Ambulance provision is provide by South West Ambulance foundation Trust who assumed responsibility for the ambulance services for our patients and formerly provided by Great Western Ambulance Services on the 1st February 2013. The Trust provides ambulance services to a wide geographical areas covering, Bristol, B&NES, Gloucestershire, North Somerset, South Gloucestershire, Swindon, Wiltshire and Scilly Isles, Cornwall, Devon and Somerset and Dorset. Whilst performance targets are achieved at aggregate Trust level, local performance against key national standards has been poor in 2013/14.

Community Health and Social Care Provision

Sirona Care & Health Community Interest Company (CIC)

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

The PCT agreed a 5-year contract with Sirona, which runs until March 2016. The contract is a tri-partite agreement between the PCT, local authority and the provider and delivers a range of integrated services. In January, the CCG and Local Authority agreed to the re-tendering of these local services.

Housing Provision

Curo Housing

Formed following the transfer of council housing stock, Curo are the largest social housing landlord in the area. The organisation is highly entrepreneurial and has a strong reputation locally. Among other services, they provide the independent living programme which is commissioned by the local authority.

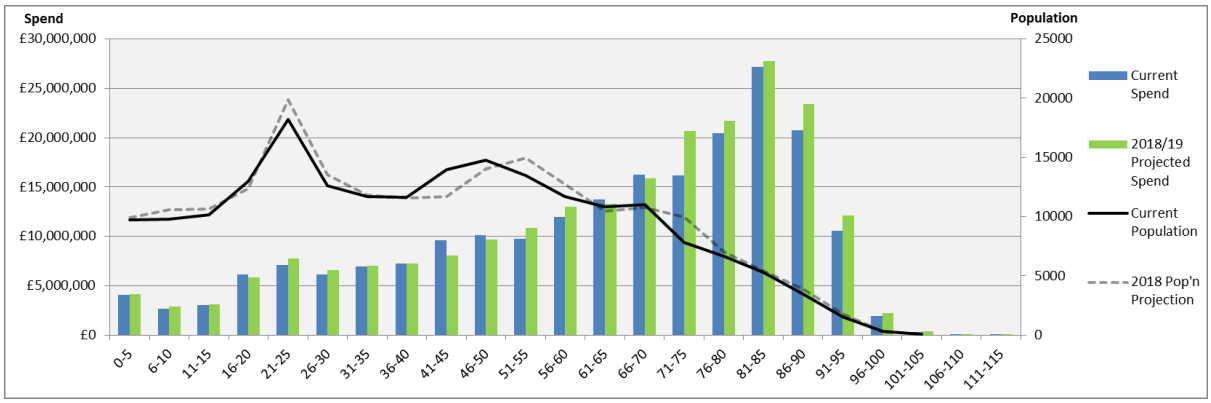
How We Use Our Resources

A key component of the CCG's financial strategy is to maximise the use of resource by ensuring costs incurred are those which deliver the safest and most effective care for patients at the best obtainable value. We expect the financial challenge for the health community to be in the region of £60m 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 over view of how we use our resources for our population.

We have used analysis contained in the Commissioning for Value packs, CCG and Local Authority Outcomes packs, Levels of Ambition Atlas, and local analysis of activity and spend to identify areas which present the opportunity for both quality improvements and financial or productivity benefits. spend more on people over 65 years old than any other age group.

The chart below shows the breakdown of our total 13/14 commissioned spend into estimated age bands, and the models the impact of population change in future years on spend.

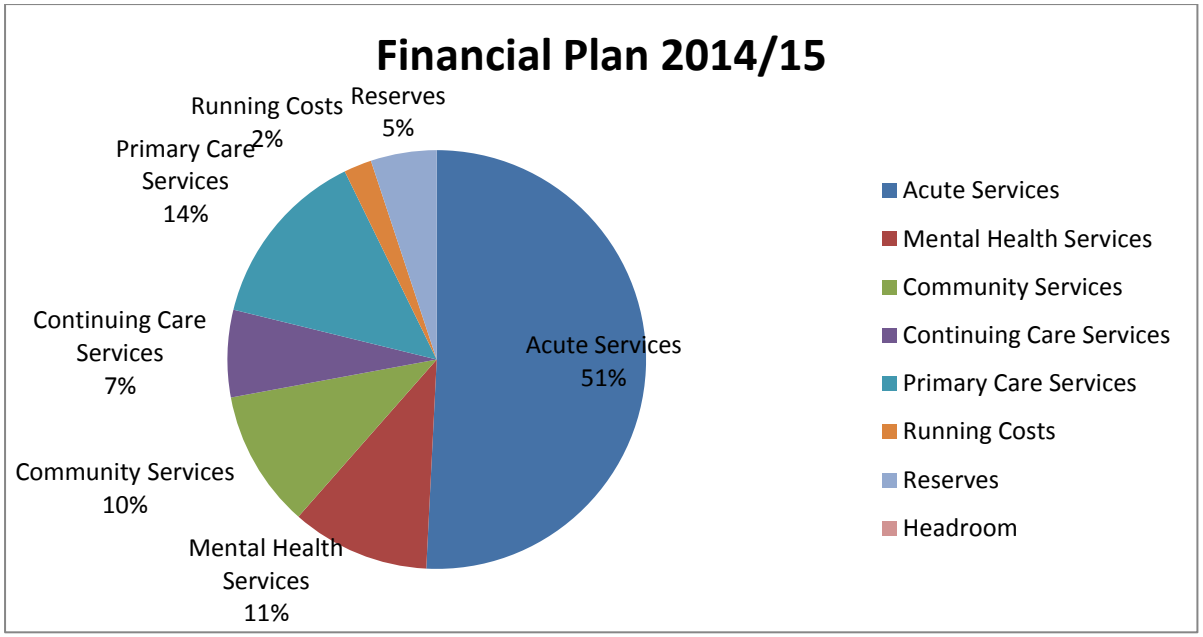
Spend against population by five year age band



Despite accounting for just 18% of the population, over 65s 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 impact of population growth overall on spent to be 5.3% and contribute to our anticipated financial gap by 2018.

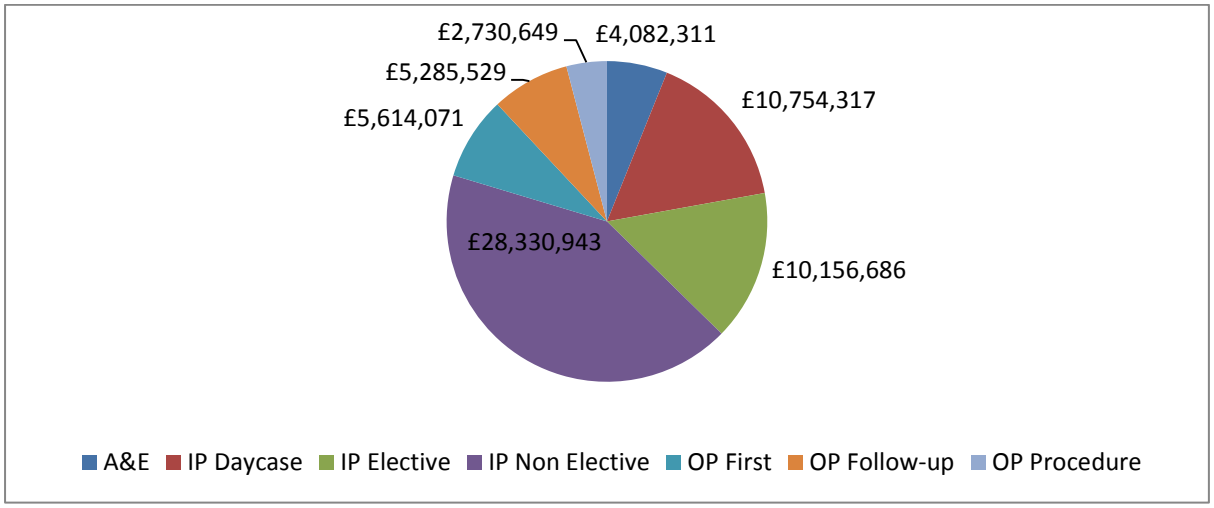
We spend more on acute and maternity services than any other type of care

The chart below shows our expenditure across all types of care. Over half of our commissioned spend is allocated to acute and maternity services that have traditionally been provided in hospitals, with 11% of funding allocated to community services.



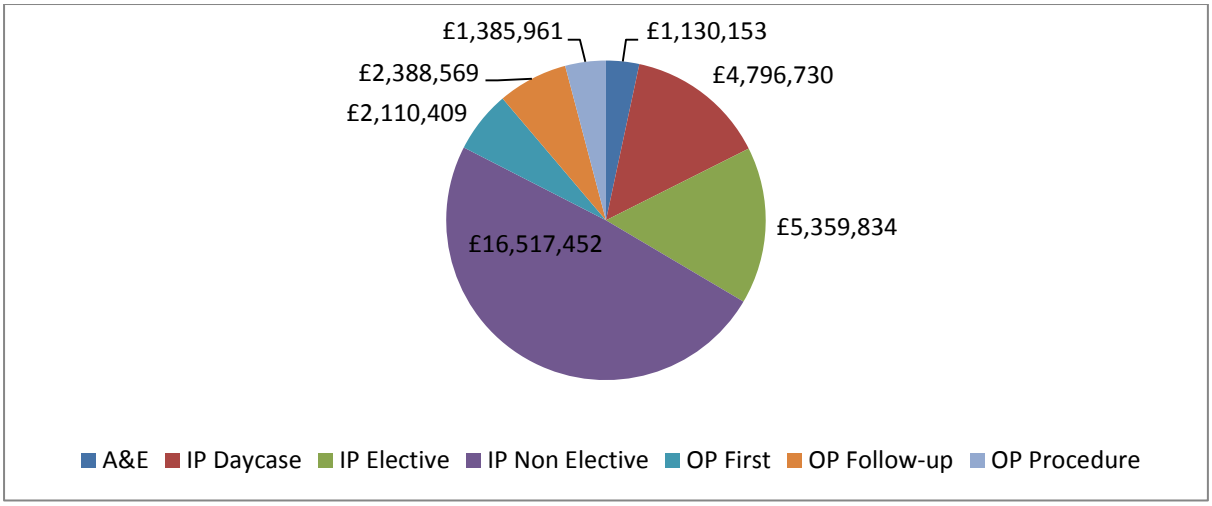
The chart below shows the breakdown, by type of care or POD (Point of Delivery), of resources allocated to acute services. The majority of this spend, 42% is on Non Elective care, or unplanned admissions and accounts for £28m across all providers.

BaNES CCG All Age Spend, All Providers by POD (April 2013 - Jan 2014)



This pattern of spend is broadly repeated in the over 65 years age group, for whom Non Elective admissions account for 49% of total acute spend across all providers. As this section of our population is forecast to increase, we must start work now to sure up the sustainability, capacity and responsiveness of our urgent care systems. We must also seek to ensure that we have systems and pathways in place to prevent the deterioration of older people's health and accidents such as falls to prevent significant numbers of older people being admitted for avoidable reasons.

BaNES CCG Over 65 Spend, All Providers by POD (April 2013 - Jan 2014)



Non Elective Care

The table below shows the most common specialties for Non Elective admissions across both demographic groups, over 65s and All Age.

Top Ten Specialties for Non Elective Admissions over 65 years

Description	**PBR Cost**
General Medicine	£6,708,610
Rehabilitation	£1,840,817
Trauma + Orthopaedics	£1,628,286
General Surgery	£1,164,946
Geriatric Medicine	£865,497
Cardiology	£830,328
Stroke Medicine	£625,942
Accident + Emergency	£612,839
Gastroenterology	£433,014
Respiratory Medicine	£275,164

Top Ten Specialties for Non Elective Admissions All Age

Description	**PBR Cost**
General Medicine	£8,734,693
Trauma + Orthopaedics	£2,764,347
General Surgery	£2,698,615
Obstetrics	£2,376,237
Rehabilitation	£1,932,271
Paediatrics	£1,439,958
Accident + Emergency	£1,319,823
Cardiology	£1,058,860
Geriatric Medicine	£903,705
Stroke Medicine	£703,277

Across both demographic groups the spend is highest in the General Medicine Specialty, with Trauma and Orthopaedics and General Surgery also areas of high spend.

For our over 65 population, the table below shows the most common reason for admission by HRG. It is likely that a number of these admissions will be preventable. *(Note: the next iteration of this* document will summarise the evidence base for this in more detail).

Atlas of Variation and Commissioning and Value

The NHS Atlas of Variation in Healthcare[1] aims to reduce unwarranted variation, increase value and improve quality through the use of benchmarking.

The Atlas is a set of methods and tools that can be used to plan and implement changes that will improve the quality and/or reduce costs across a range of conditions.

The Commissioning for Value Pack[2] identifies where to look for opportunities in both quality and spending through the use of benchmarking. The approach taken is to look at the evidence from the AoV with a view to increasing quality and/or savings.

The CfV states:

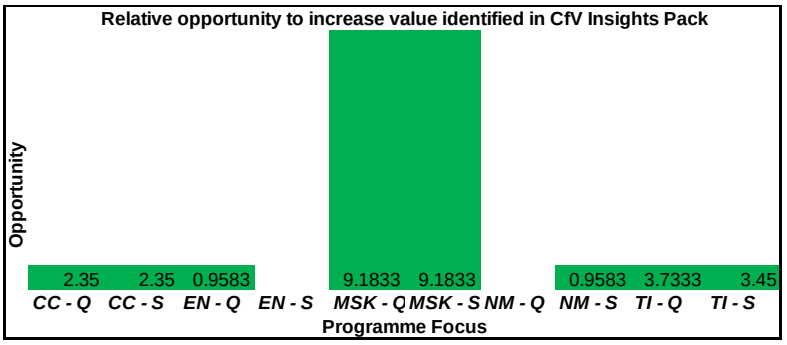
The programme areas that appear to offer the greatest opportunity in terms of both quality and spending are: Cardio Vascular Circulation Problems Endocrine, Musculoskeletal System Problems, Nutritional and Metabolic Problems, Trauma and Injuries.
The programme areas that appear to offer the greatest opportunity for quality improvements are: Musculoskeletal System and Cardio Vascular Circulation Problems.

The programme areas that appear to offer the greatest opportunity for spending are: Musculoskeletal System Problems and Cardio Vascular Circulation Problems.

[1] www.rightcare.nhs.uk (November 2011)
[2] Commissioning for Value: NHS England Gateway ref: 00525 (NHS England, Public Health England and NHS Right Care)

Opportunity Key

CC - Q	Cardio Circulation - Quality
CC - S	Cardio Circulation - Savings
EN - Q	Endocrine - Quality
EN - S	Endocrine - Savings
MSK - Q	Musculoskeletal System - Quality
MSK - S	Musculoskeletal System - Savings
NM - Q	Nutritional and Metabolic - Quality
NM - S	Nutritional and Metabolic - Savings
TI -Q	Trauma and Injuries - Q
TI - S	Trauma and Injuries - S



The Atlas of Variation's methods and tools and the Commissioning for Value Pack have been instrumental in the development of the CCG's Five Year Strategy and Two Year Operational Plan. The CCG has also taken into account evidence provided by local providers and stakeholders.

Chapter 5 The Case for Change

In this section we set out:

- The national context for change, including Everyone Counts planning guidance
- The case for change in BaNES

National Context

This is 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 Staffs and 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.

Everyone Counts

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, in to work as a Unit of Planning and ensure that there is a system wide approach to plans. The guidance also marks the shift away from short term annual planning cycles and gives CCGs the freedom to take a longer term five year approach to strategic planning.

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

1. Preventing people from dying prematurely, with an increase in life expectancy for all sections of society

2. Making sure that those people with long-term conditions, including those with mental illnesses, get the best possible quality of life

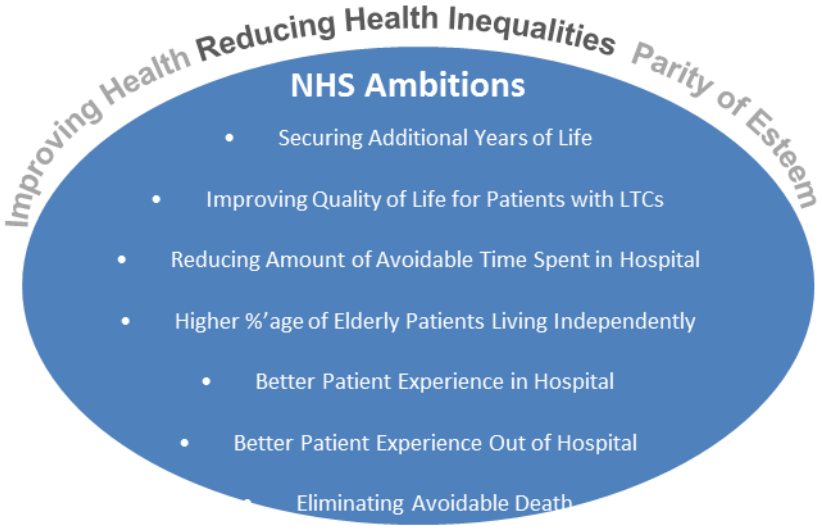
3. Ensuring that patients are able to recover quickly and successfully from episodes of ill-health or following an injury

4. Ensuring that patients have a great experience of their care

5. Ensuring that patients in our care are kept safe from harm and protected from all avoidable harm

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.



Our strategy is anchored in achieving change in six priority areas whilst maintaining high quality services and improving outcomes across the board:

- 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

The interventions that we have developed for each of these areas are anchored in achieving the six aspirational characteristics of a health and care system in 2018/19.

- Citizen Participation and Empowerment
- Modern models of Integrated Care
- Wider Primary Care, provided at scale
- Access to the Highest Quality Urgent & Emergency Care
- Delivering a Step Change in the Productivity of Elective Care
- Specialised Services Concentrated in Centres of Excellence

We describe our proposed interventions in Chapter 6 of this document.

The Case for Change in Bath and North East Somerset

We do not have the same challenges locally that some other Health and Care economies have, but we recognise nonetheless that we need to prepare our economy for the challenges of future years.

We have inherited a strong financial position from the predecessor PCT. However, 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 £60m of efficiency savings need to be achieved from a health perspective from directly commissioned services and from Providers' Case Releasing Efficiency Plans by 2020/21. 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.

Our population is generally healthy and wealthy and our outcomes consistently strong. However, we know that there are pockets of poorer outcomes and inequity that correspond to areas of both rural and urban deprivation. We also know that over coming years we will face demographic changes locally that reflect some of the challenges facing the national health and care economy. For example, an increased proportion of the population will be over 75, and increasing numbers of patients with multiple long-term conditions including diabetes and dementia.

What this means for our strategy

In this chapter, we will set out our rationale for shifting resources from down stream, costly interventions in the acute care setting, including specialist care, to more affordable, high quality upstream services. This encompasses preventative care as well as effective community support for those with long term conditions and an increasing level of frailty.

Our values enshrine our commitment to working collaboratively: therefore we will ensure that we will support the local authority and public health to achieve improvements in the local economy, social care and individuals' lifestyle choices to ensure that we see a shift of investment into upstream services, shown in the diagram below.

Why we need to change

The impacts of comorbidity are significant:

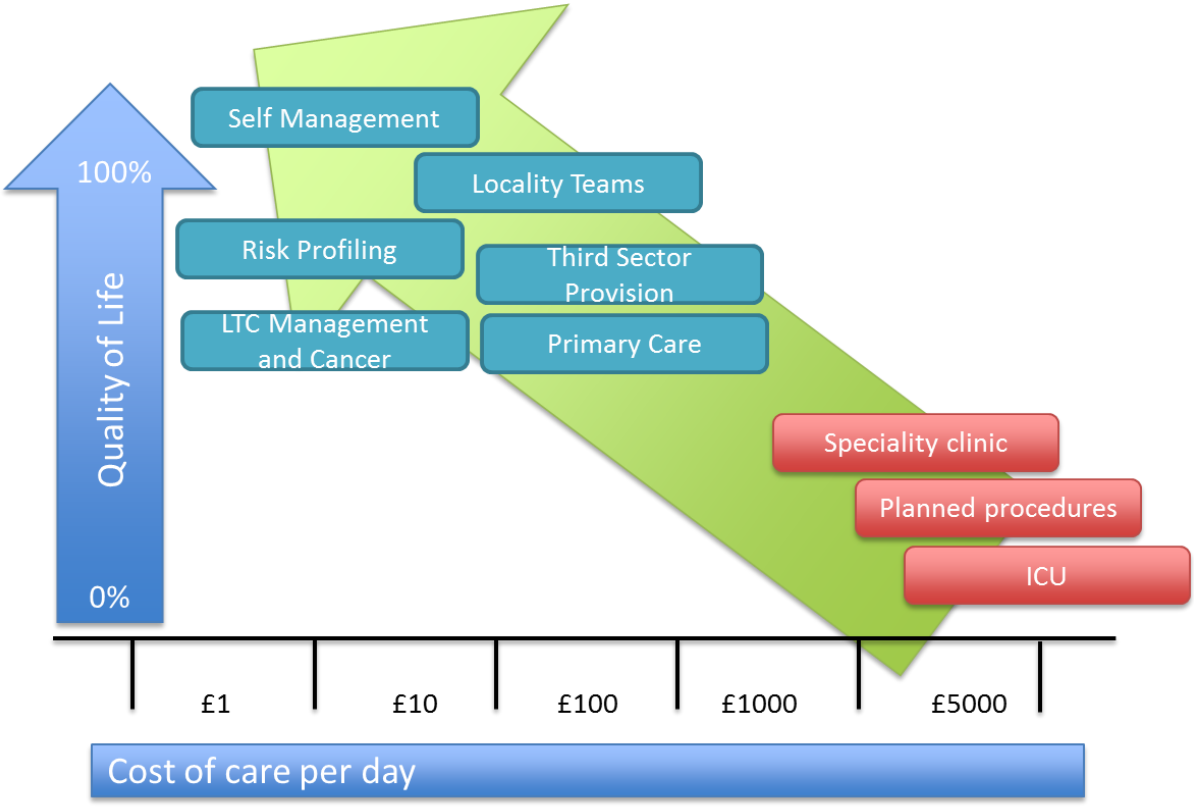
- Of those aged over 65, half have at least three chronic conditions and 1 in 5 have five or more chronic conditions
- In deprived areas, multimorbidity is more common and happens 10-15 years earlier and there are more people with mental as well as physical long term health problems
- In the over 65s, we believe that 17% of admissions are due to adverse drug events

The current paradigm for delivering care, both in secondary and primary care results in a siloing 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 multimorbidity.

The left shift of resources will therefore need to be supported by all our stakeholders if we are to successfully address the challenges of demographic change, multimorbidity and tighter resourcing of both health and social care.



Public Engagement Events :-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.

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

16th October 2013	9am-1pm	British Royal Society for Literary …….
24th October 2013	6pm-9pm	Centurion Hotel, Midsomer Norton
30th October 2013	1pm-4pm	Fry's Centre, Keynsham

The events were well attended with approximately 80 people attending from a variety of organisations.

The meetings provided an update regarding achievements in the first 6 months since the CCG was established, a high level description of future plans and priorities and 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 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 elderly. 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 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.

On-going consultation with the public

The first wave of 'Call to Action' events were held in the autumn. A further event was held on 13th March to engage the public with our developing strategy. We intend to continue to hold a series of further events during April and May 2014 with the public and our stakeholders so that they continue to be involved, providing them with the opportunity to hear and see our plans through traditional events, meetings and focus groups.

Digital Engagement

We will upload initial content which describes our 2 and 5 year plans and we will seek online feedback from people for a period of 30 days. Following that period, we will report on the consolidated feedback and our responses in our final 5 year plan. As our plans develop we will continue to report on progress via our online engagement tool, maintaining interactive communication with people who have signed up to its membership.

Engaging with Other Stakeholders - Providers and other Commissioners

Three engagement workshops were held with all key local providers, the Local Authority, NHS England, 3rd Sector representatives and Health watch. The purpose of the sessions was to discuss and test our plans to lead the local health care system to a place of sustainability, improved outcomes and providing high quality health care against a background of constrained resources over the next five years.

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 B&NES, developing our focus on urgent care and long term condition management and to tailor our commissioning plans based on evidence based approaches. The day resulted in clear support for our emerging strategy and the discussion groups very effectively helped to develop our focus.

During the second session on 27th February we considered 6 potential priority work streams for a focused health and system wide approach over the next 3 to 5 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 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 and we now have a clear sense of our priorities that, if delivered effectively will 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.

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.

This approach will build community interest and ensure we're 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. The approach will allow for a continuous dialogue which flows both ways – either on an individual level, or direct to community interest groups.

Chapter 6 Improving Care for the People of BaNES

In this section we set out our plans to improve six priority areas:

- 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

In preceding chapters we have set out:

- The local demography and the most significant needs for the population of BaNES
- The current demand and capacity pressures
- How we use our resources
- What benchmarking data tells us about our resource utilisation
- An overview of the likely financial pressures facing BaNES CCG and the wider health and social care community over the next 5 years.

This analysis underpins our reasoning for choosing the six priority areas that we have selected, on the basis that:

- 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 5-year period
- 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
- We need to continue to focus on long-term conditions and find ways to manage future demand pressures that will be experienced in these areas
- We need to find new ways to manage the demands associated with an ageing population and treat and care for patients in non-acute settings
- We need to develop our approaches to self-care and prevention to further improve outcomes on conditions that are amenable to health care
- We will need to develop our approaches to commissioning to consider how we continue to reduce inequalities within BaNES
- We will need to 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 need to dis-invest in acute services over time
- We will need to increase our investment in primary and community provision
- We will want to encourage further integration of primary, community and mental health services
- We will promote self-care, personal responsibility
- We will encourage the role of volunteers, navigators

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

High level description of the scheme:

Commissioning for prevention is one potentially transformative change that CCGs can make, together with Health and Wellbeing Boards and other local partners. Implemented systematically, the evidence suggests prevention programmes can be important enablers for reducing acute activity and capacity over the medium term.

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:

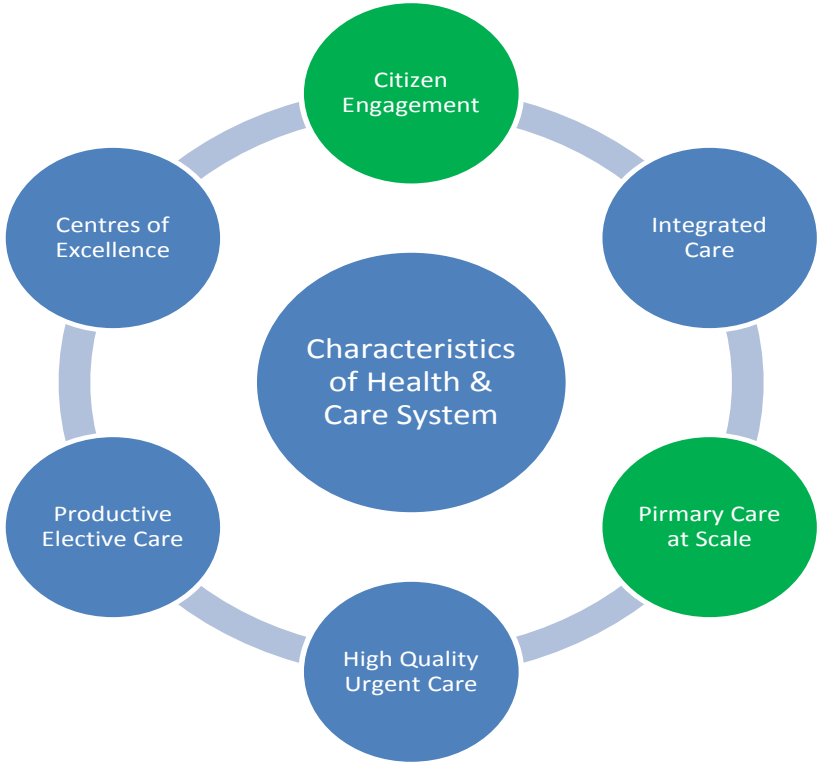
This section will include data that demonstrates :

- *Local prevalence of LTCs*
- *Life Expectancy and inequalities gap*
- *Local data re NEL admissions for existing LTC, benchmarked against other areas if possible*

Our Approach:

This section will contain narrative that details our approach to the priority area and will bridge the gap between the two year operational and five year strategic plan.

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



Anticipated Impact On The Seven Outcome Ambitions:

Expected Impact	Measure of Success
• Reduction in avoidable deaths particularly impacting people in deprived areas, reducing the inequalities gap	• *TBA*
• Improvements in the impact of chronic disability on wellbeing	• *TBA*
• Earlier diagnosis and treatment and delaying the progression of disease	• *TBA*
• Annual return on investment achieve by investing in interventions early in life is estimated to be 6-10%	• *TBA*
• Empowered patients, taking joint responsibility for their health and wellbeing	• *TBA*
• People able to live autonomous and active lives	• *TBA*

Timeline:

2014/15
- Analyse key health problems
- Create health inequalities framework
- Develop self-care strategy
- Prioritise and set goals with partners
- Identify high impact programmes (current and new)
- Plan resources

2015/16
- Identify appropriate outcome and process metrics
- Commission agreed priority programmes – mix of primary and secondary prevention
- Deliver agreed support to existing programmes

2016/17
- Measure, experiment and evaluate – examples could include improving outcomes in: self-harm; smoking cessation; weight management; management of atrial fibrillation, diabetes and hypertension; alcohol misuse prevention

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

High level description of the scheme:

Redesigning 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

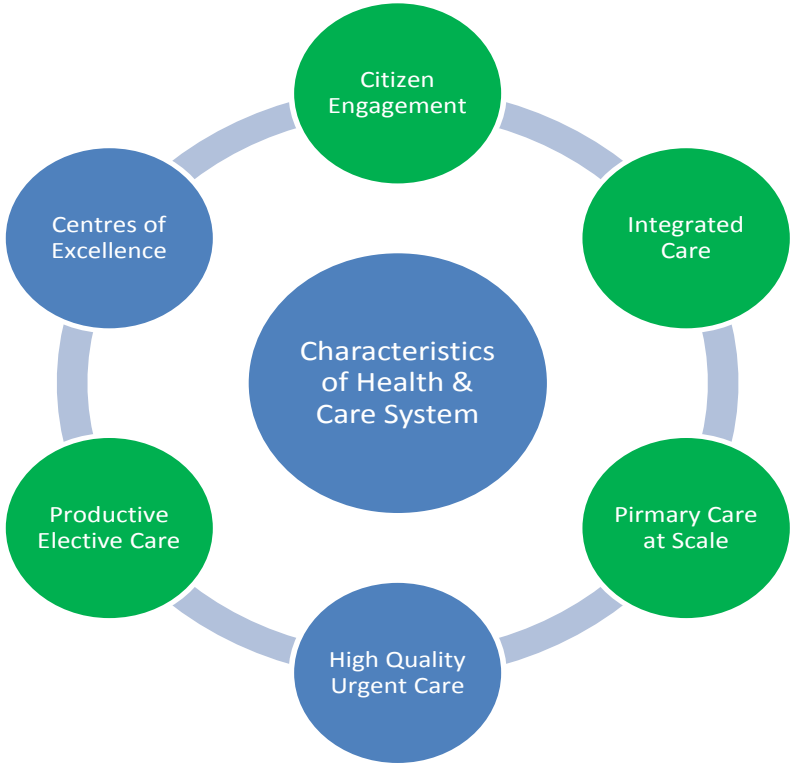
The Local Case for Change:

- 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
- BaNES has a significantly higher rate of major amputations than the England average

This section will also include costed activity for the management of LTCs, e.g. NEL admissions with a primary diagnosis of LTC.

Our Approach:

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



Anticipated Impact On The Seven Outcome Ambitions:

Expected Impact	Measure of Success
• Improved patient experience by ensuring patients receive high quality and timely care close to home	• *TBA*
• Halt the rise in type 2 diabetes and slow the progression of the disease in people who are already diagnosed by promoting self-management	• *TBA*
• Mitigation of some of the inevitable growth in spending on diabetes over the 5 year period	• *TBA*
• Sufficient capacity within diabetes services to meet the needs of rising numbers of people with diabetes across different care settings	• *TBA*

Timeline:

2014/15
- Establish diabetes task force group which includes patients and 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 evidence based model and appraise funding mechanisms
- Pilot current proposal for cluster based virtual wards in primary care with consultant input

2015/16
- 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

2016/17
- Review education for both patients and health care professionals

2017/18
- Implementation of remodelled services.
- Evaluation and Review

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

High level description of the scheme:

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 increasing demand on urgent care services due to an ageing population and increasing number of people with LTCs
- The minor injury unit sees patients with injury and illness which needs to be reviewed in light of the new model at the front door and NHS 111
- We need to consider the whole urgent care pathway in view of this model, including care provided by the MIU and 111
- 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 peaks

Local Case for Change:

This section will include data that demonstrates :

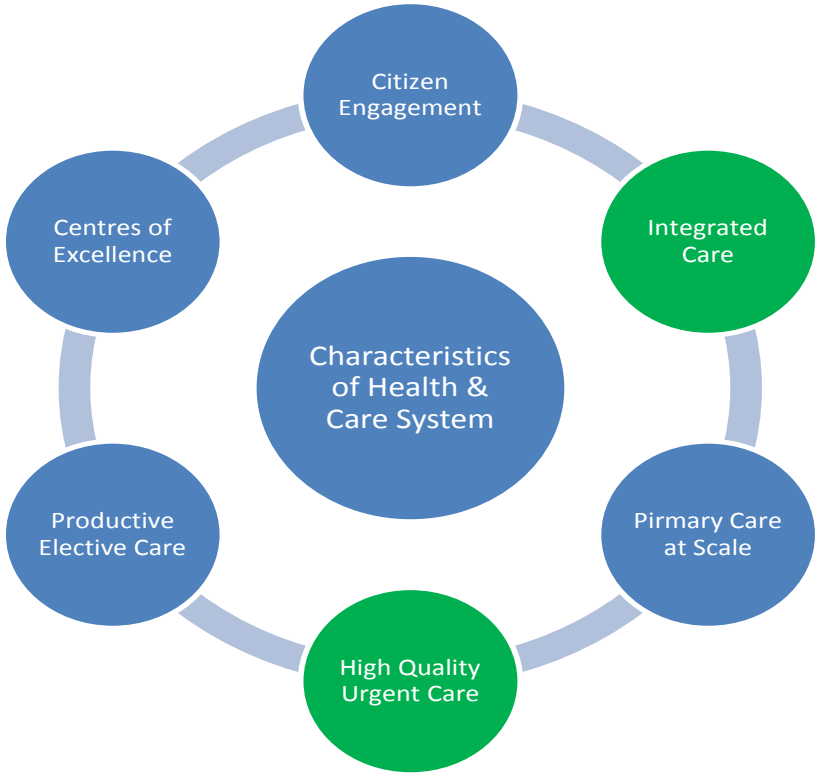
- *Utilisation of current services – A&E attendances year on year, benchmarked where possible against statistical neighbours*
- *Utilisation of Out of Hours, Urgent Care Centre etc. including trends where possible*
- *NEL admissions , particularly zero LOS*

Our Approach:

This section will contain narrative that details our approach to the priority area and will bridge the gap between the two year operational and five year strategic plan.

There is limited evidence to demonstrate the effectiveness of schemes that place primary care professionals at the front door of A&E so we will collate our own evidence base to assess.

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



Anticipated Impact On The Seven Outcome Ambitions:

Expected Impact	Measure of Success
• Reduced patient hand offs minimising clinical risk and incidents of avoidable harm	• *TBA*
• Reduced ED attendances to be quantified	• *TBA*
• Reduced NEL admissions to be quantified	• *TBA*
• Sustained delivery of the four-hour standard	• *TBA*
• Reduced dependency on bed based services with increased investment in community based services to support care at home	• *TBA*
• Improved patient experience through the reduction of repeating the same information to different professionals	• *TBA*

Timeline:

2014/15
- 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

2015/16
- 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

2016/17
- Embed new MIU arrangements

2017/18
- Review potential to make further changes to urgent care pathways
- Prepare for re-commissioning of 111 services

Redesigning Musculo-skeletal pathways to achieve clinically effective services

High level description of the scheme:

A whole system review and redesign of musculo-skeletal services with an aim to achieve co-ordinated and integrated care across the entire MSK pathway; potential inclusion of the following services: over a 5 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)
- With ageing population, demand for MSK related services is set to increase significantly

Local Case for Change:

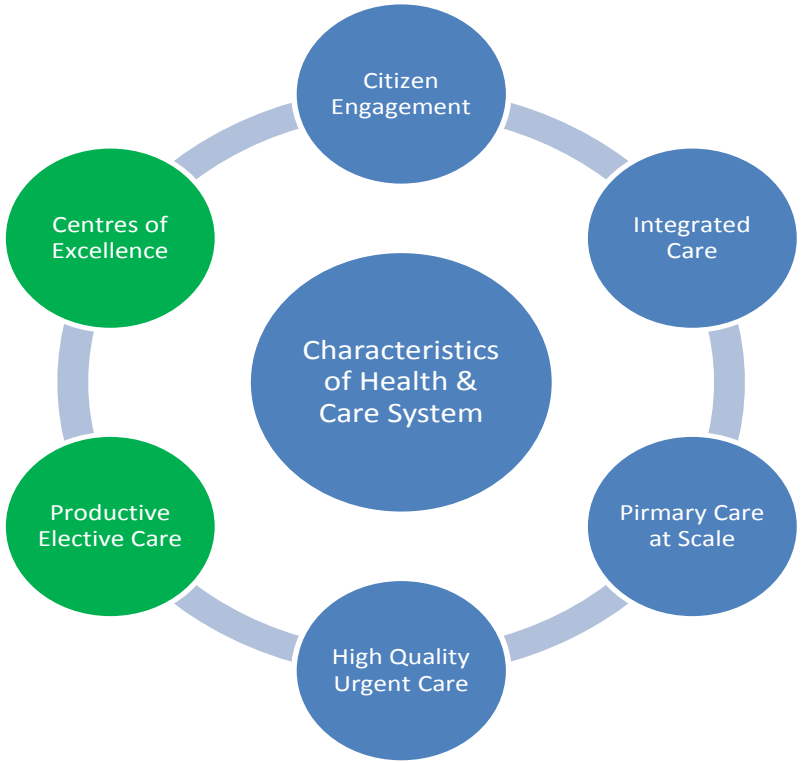
This section will include data that demonstrates :

- *Local data on utilisation of MSK services, including:*
    - *Use of Orthopaedic, Pain, Rheumatology and Physiotherapy services (EL, DC, OPPROC, OPFA, OPFU), benchmarked against statistical neighbours*

Our Approach:

This section will contain narrative that details our approach to the priority area and will bridge the gap between the two year operational and five year strategic plan.

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



Anticipated Impact On The Seven Outcome Ambitions:

Expected Impact	Measure of Success
• Improved clinical & patient-reported outcomes	• *TBA*
• Earlier diagnosis and appropriate treatment; reducing surgery rates and disability	• *TBA*
• Better skill mix and increased system capacity	• *TBA*
• More care delivered in community setting and reduction in acute	• *TBA*
• Efficiency savings & financial sustainability from integrated service	• *TBA*
• Increasing patient choice and improving partnership working, patient experience and engagement	• *TBA*

Timeline:

2014/15
- 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

2015/16
- 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

2016/17
- 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

2017/18
- Review a range of Orthopaedics pathways in line with best practice.

Commissioning integrated safe, compassionate pathways for frail older people

High level description of the scheme:

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

Local Case for Change:

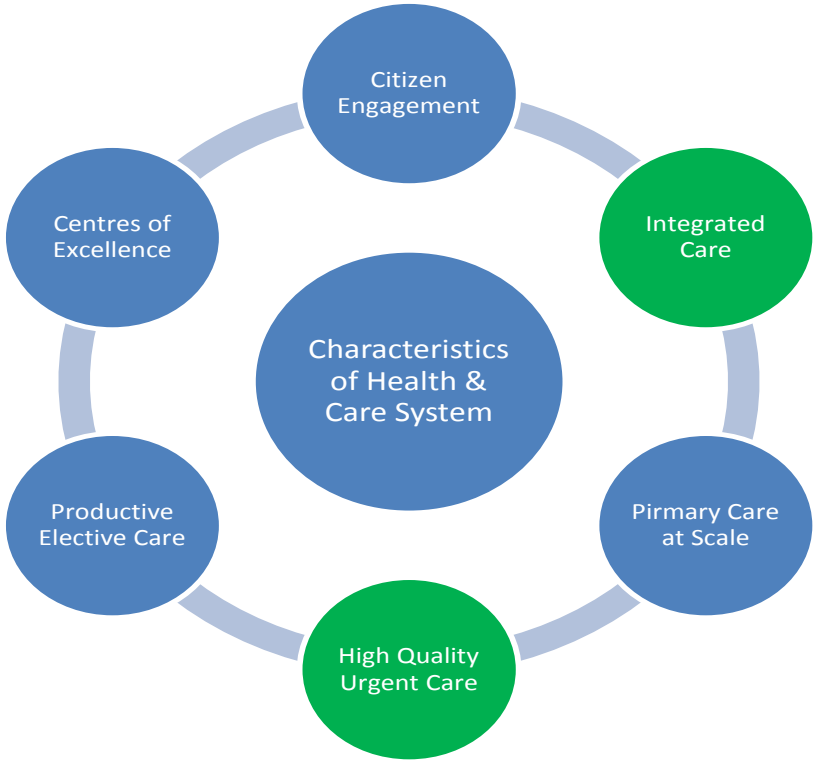
This section will include data that demonstrates :

- *Use of services by older people (e.g. NEL admissions over 65s, zero LOS, A&E attendances)*
- *Falls rate and use of services associated with falls (where falls is primary diagnosis etc.)*
- *Data on avoidable harmful incidents (polypharmacy, pressure ulcers etc.)*

Our Approach:

This section will contain narrative that details our approach to the priority area and will bridge the gap between the two year operational and five year strategic plan.

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



Anticipated Impact On The Seven Outcome Ambitions:

Expected Impact	Measure of Success
Care and support is built around the patient not the services	• *TBA*
Health and social care professionals are freed up through improved systems and processes which enable them to spend more time with patients with the greatest needs	• *TBA*
Patients receive a seamless and integrated response appropriate to their assessed health and social care needs	• *TBA*
Patients are efficiently prioritised, directed and seen by the right health and social care professional and receive the right care and support	• *TBA*
People experience reduced loneliness and isolation through timely and targeted intervention	
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	• *TBA*

Timeline:

2014/15

- 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

2015/16

- 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

2016/17

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

2017/18

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

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

High level description of the scheme:

Improve 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

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

Local Case for Change:

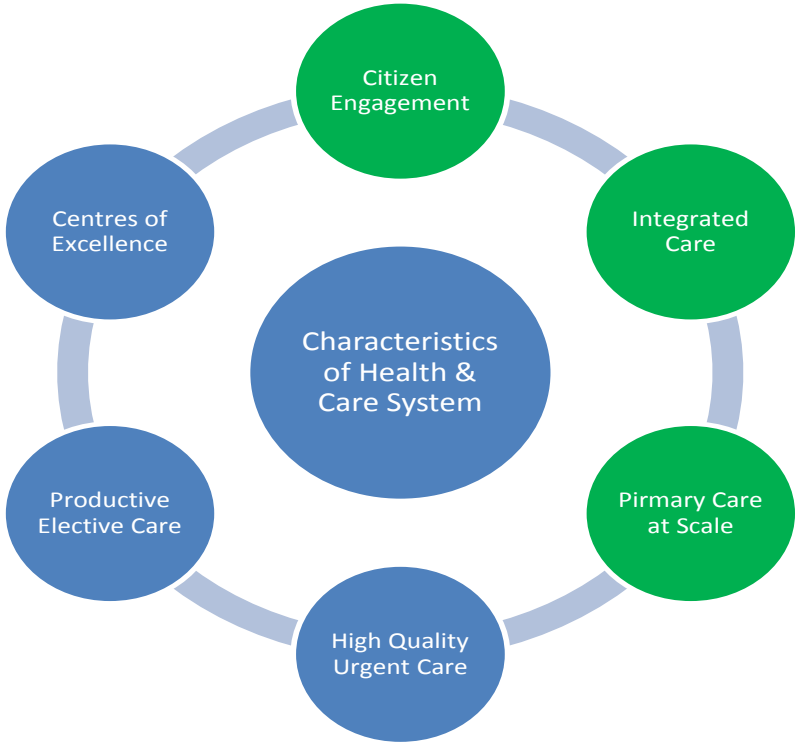
This section will include data that demonstrates :

- *Current IT infrastructure and an over view of the interoperability issues facing the health and care system*

Our Approach:

This section will contain narrative that details our approach to the priority area and will bridge the gap between the two year operational and five year strategic plan.

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



Anticipated Impact On The Seven Outcome Ambitions:

Expected Impact	Measure 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	• *TBA*
• Improve patient experience through the avoidance of repeating the same information to different professionals caring for the same patient	• *TBA*
• Reducing repetition across health and social care professionals can be seen to improve the efficiency of the workforce. A further financial impact could be reducing future need for IT Systems by making better use of existing ones	• *TBA*
• Increasing the secondary use of shared data would enable more informed commissioning decisions based on knowledge across care pathways	• *TBA*
• Reduced unplanned hospital admissions to be quantified	• *TBA*

Timeline:

- 2014/15
  - Establish Governance & Project Team
  - Appraise technical options & existing solutions
- 2015/16
  - Develop a shared vision for the health system and the IM&T strategy to support it
  - Identify resource requirements and potential funding sources
- 2016/17
  - Establish scope of systems to support integrated care planning
  - Develop consent model
  - Development of Business Cases
- 2017/18
  - Procurement of IT solution
  - Develop new ways of working supported by IT solution
  - Implementation of first wave
- 2018/19
  - Complete roll out of interoperability solutions
  - Review of implementation

Chapter 7 Our Commitment to Quality

Quality in Everything we do

Our commitment to quality is central to the CCG's 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 seek to 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.

What is quality?

Quality may be defined as the continuous improvement in effectiveness, experience and safety of health and social care services for the people of Bath & North East Somerset (BaNES) provided within available resources.

The three subdomains of quality are:

1. Patient safety

The first dimension of quality must be we do no harm to patients. This means ensuring within the services we commission the environment is safe, clean and avoidable harm such as excessive drug errors or rates of healthcare associated infections are reduced. To achieve this aim we will work, in partnership, and listen to our patients and staff to ensure that commissioned services are provided by the right people with the right skills that are in the right place at the right time.

Consideration is given to several indicators including:

- Serious incidents
- Reported safety incidents and 'whistleblowing' concerns
- Management of safety alerts
- Outcomes of Coroners Inquests
- Updates on Provider's safety strategies
- Healthcare associated infections
- Safeguarding Serious Case Reviews

2. Effectiveness of care (encompassing cost effectiveness, equality and diversity),

This means understanding success rates from different treatments for different conditions including.

- Hospital readmissions
- National Institute of Clinical Effectiveness (NICE) compliance
- Appraisals
- Clinical Audit and effectiveness outcomes
- Outcome measures
- Pathway development

- Research and Development
- Innovation and initiatives
- Policy updates
- Seven day service measures
- Just as important is the effectiveness of care from the patient's own perspective which may be measured through patient-reported outcomes measures and patient reported experience measures (PROMs and PREMs). Examples include improvement in pain-free movement after a joint replacement, or returning to work after treatment for depression. Clinical effectiveness may also extend to people's well-being and ability to live independent lives.

3. Patient/ service user/ carer experience (accessibility, acceptability and appropriateness)

Quality of care includes the compassion, dignity and respect with which patients are treated. It can only be improved by understanding patient satisfaction with their experience and to achieve this, consideration is given to a wide range of information including;

- Complaints, Concerns and Compliments
- Ombudsman reports
- Care Quality Commission (CQC) reviews
- Claims and Litigation
- Patient experience group updates- Your Health Your Voice'
- Innovation
- Patient and public engagement feedback
- Equality and diversity requirements
- Patient related outcomes
- Compassion in Practice outcomes
- Patient and staff satisfaction information including the NHS Friends and Family Test

The Current System

Quality structures in Bath and North East Somerset CCG will 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 centred 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 it serves
- Ensures 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 the 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 will 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 this is 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 will allow members of the public, patients and carers to communicate directly with the CCG's Board.

Patients, their families and carers want to be safe, listened to and involved in decisions about their care. We seek to meet these needs and make a difference as this provides us with the necessary drive to improve care and identify improved outcome, for example;

- local ownership of improvement initiatives,
- willingness to learn from situations where there have been unexpected incidents,
- complaints,
- listening to the users of services and other colleagues

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. It works closely with the other CCG Board level Committees to ensure there is alignment of activity and 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 to the Committee. This ensures that the Quality Committee has oversight of the following areas on behalf of the CCG Board and information both qualitative and quantitative is triangulated: to achieve a more rounded picture of a service. Benchmarking data is also considered.

- 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

The Committee functions are aligned with the 'Your Health Your Voice' Public and Patient Involvement Group and with the other Board level-committees. The CCG will continue to work in partnership with the Council, with NHS England, with neighbouring CCGs, the public and other key stakeholders to continually improve the quality of services for residents in BaNES

Quality in Commissioning:

BaNES CCG takes very seriously the need to provide equitable services across BaNES which meet the needs of the population and we are striving to secure improved outcomes and high quality care through our activities in all three stages of the commissioning cycle – planning; securing and monitoring. The challenge is to ensure that its residents have equitable access to health care which is effective and of a proven quality by involving people, including children, young people, their families and carers in the planning stage, identifying where outcomes could be improved, and understanding what changes are needed to maximise improvements.

In the securing phase we will contract with our providers for improved outcomes and consistently high quality services for every patient. It is through the monitoring of these contracted services that we will seek to understand whether improved outcomes and high quality care are being delivered or not, and we will take appropriate action in the interests of the communities we serve. The CCG must also ensure that patients and their carers are involved in decisions about their own health and have the information available to enable them to make an informed choice.

It is essential that a balance is achieved between locally identified priorities and centrally determined targets. The process of planning and commissioning will ensure that all stakeholders and special interest groups are involved and that there is a local focus on the implementation and achievement of national standards and performance targets. This systematic approach to commissioning services clearly offers the opportunity to build stronger quality arrangements into the process.

Although many health outcomes in BaNES are on average better than national outcomes, there are often wide differences between different parts of the area, with the poorest health frequently experienced by vulnerable groups and people living in more deprived areas. Therefore, when implementing changes to local services and looking at new ways of working, the CCG will work closely with its partners to consider the needs of different communities.

In order to achieve the CCGs strategic objectives and to ensure plans are made appropriately and in a co-ordinated way to change, reconfigure, invest in and disinvest in services, a planning and commissioning process is required. This process needs to be inclusive to involve the planning, commissioning and monitoring of all services provided to the population of BaNES

Many of the health services provided to the population of BaNES are delivered in partnership with the Council and the third sector organisations. It is also important therefore that the planning of services involves a multi agency approach and so the process must not only involve the various organisations but also users and carers to plan services in a way that reflects the needs of the local population.

Quality of care in provider services and in primary care

- The CCG commissions services from a number of providers and is associate commissioner, working in partnership with the lead CCG for others. 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.
- From April 1st. NHS England became responsible for planning, securing and monitoring an agreed set of primary care services. The CCG has a statutory responsibility to support NHS England improve the quality of primary medical care and a number of initiatives are in place to support the improvement of quality of primary care
- Through their Quality Account our key providers of secondary, community and mental health and learning disabilities health care have demonstrated a commitment to improving outcomes for BaNES patients, in relation to improving patient experience, reducing admissions and

further reducing deaths. The CCG will work closely with its providers of health care to ensure that they achieve this commitment to our population.

- Each major provider contract has a clinical quality and outcomes group (CQOG) that meets on a regular basis and reviews a range of quality indicators that are included within the quality schedules and CQUIN indicators for each contract. These include patient safety issues, safeguarding, complaints, serious and untoward incidents, indicators of quality improvement and service quality.
- These indicators and CQUINs reflect national, regional and local priorities that arise from provider performance issues, local quality improvement priorities and priorities set annually within the NHS Operating Framework- 'Everyone Counts'. Some of these metrics are measured across all our providers such as the way we measure compliance with infection control, NICE guidance, CQC essential standards and Equality and Diversity monitoring and some are far more specific to the type of treatment and care that is provided.
- The CCG wishes to continue work in partnership with its providers and other commissioners. To prepare for the 2014-2015 CQUINs, a successful CQUIN multi-agency planning event took place in October 2013 and future events will be planned
- The quality schedules into which we will build increasingly SMART Quality and Outcome measures and the CQUIN indicators allow for early identification of failing services and specialities and the mechanisms for early identification is via the contractual mechanism in the first instance and then on to the CCG Quality Committee and Commissioning College and the CCG Board
- The CCG also liaises with others in the system such as Care Quality Commission (CQC) and where there are significant concerns about the quality of services, these may be shared. In certain circumstances it may be necessary to decommission services that do not provide a high quality service and to reinvest in services that do meet the requirements

Improving Outcomes

It is essential when reviewing services and then deciding priorities that the CCG draws upon data from a variety of sources, both hard (quantitative) and soft (qualitative) data, and to *triangulate* this data to obtain a rounded view of quality. This analysis will also include identifying where there is unwarranted variation in quality within the BaNES area compared to comparator areas elsewhere. Data sources that are available to us and that we will use 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 be unable to hold services to account for the

quality of care they receive. In such cases, we have particular responsibilities to ensure that those patients receive high quality care and that their rights are upheld, including their right to be safe.

We are working with our partners including local police, social care, education, care homes and other local statutory and voluntary organisations and with our GP practices and other health care organisations 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 B&NES 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 for 2014-2016

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

Clinical Supervision policy: This will be developed in collaboration between adult and children safeguarding teams, alongside a programme of supervisory visits for provider safeguarding leads.

Prevent: is one of the four elements of 'Contest', the government's anti-terrorist strategy. The Adult Safeguarding Lead has been working with Providers to ensure they all recruit named Prevent leads. Prevent is now included in the National NHS Contract for 2014/15 and has accordingly been added to the Adult Safeguarding strategy.

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 and Development

Research and Development activity is one of the essential elements that applies to all of the characteristics of every successful and sustainable health economy to improve quality, access, innovation and value for money

The 2005 research governance framework for health and social care and the governance arrangements for research ethics committees, updated in 2012, set out standards for carrying out research in the NHS and the NHS England Research and Development Strategy (Draft) 2013-2018 *Research is everybody's business is currently at consultation stage*

The Health and Social Care Act (2012) places a clear duty on the Secretary of State, the NHS Commissioning Board (now NHS England) and Clinical Commissioning Groups to promote research on matters relevant to the health service, and the use in the health service of evidence obtained from research. Particularly relevant for CCGs are provisions of the sections 6, 17 (para.13) and 26 (para.14Y) of The Act, referring to research matters relevant to the health service and the use in the health service of evidence obtained from research.

When procuring services, and monitoring and renewing contracts, the CCG must ensure providers have processes in place to facilitate recruitment of patients into research studies. There is also a need for commissioners to have in place a process to meet the treatment costs of research for patients who are taking part in research funded by Government and research charity partner organisations. As part of this requirement the CCG must ensure there is appropriate engagement with the National Institute of Health Research Clinical Research Network and the Academic Health Science Network

Ensuring that Research and Development across the whole patient pathway, including with partners in local government and Public Health England is essential for the CCG as this, will contribute to improving outcomes and spreading innovation and economic growth.

As part of the NHS National Institute of Health Research (NHIR), the Western Comprehensive Local Research Network (WCLRN) provides quarterly performance reports to the CCG summarising the research activity within the CCG and local NHS R&D approval times

The CCG commissions a research and development service from the University of Bath. The University of Bath actively pursues research bids in conjunction with academic partners and ensures that its research practices are in accordance with research governance principles and guidance. Forty two projects are currently registered with the University and the annual report is awaited. This will include information on research key performance indicators to include patient recruitment rate and level of Research and Development activity. However, the service has advised the CCG that it is above target in recruiting patients to research studies in the BANES area in 12/13.

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 elderly
- 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.

Chapter 8 Our Financial Plan

In this chapter we:

- Summarise the financial strategy of NHS BaNES CCG over the forecast period 2014/15 to 2018/19
- Detail the assumptions within and outputs of the 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 Council 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 though 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.

Revenue Resource Limit

£ 000	13/14	14/15	15/16	16/17	17/18	18/19
Recurrent	212,204	216,640	223,112	226,981	230,697	234,477
Non-Recurrent	7,778	3,062	3,197	2,264	2,293	2,331
Total	**219,982**	**219,702**	**226,309**	**229,245**	**232,989**	**236,808**

Income and Expenditure

Acute	118,455	109,980	106,368	105,371	103,127	100,935
Mental Health	22,100	23,148	23,031	22,768	22,908	22,985
Community	22,043	22,952	22,574	22,495	22,408	22,375
Continuing Care	13,560	14,581	21,814	22,115	22,213	22,199
Primary Care	28,104	30,166	31,244	32,292	33,441	34,698
Other Programme	8,215	9,925	12,575	15,454	20,083	24,743
Total Programme Costs	**212,477**	**210,752**	**217,606**	**220,273**	**224,179**	**227,935**

Running Costs	4,440	4,654	4,176	4,164	4,149	4,135
Contingency	-	1,099	2,263	2,292	2,330	2,368
Total Costs	**216,917**	**216,505**	**224,045**	**226,952**	**230,658**	**234,438**

£ 000	**13/14**	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**
Surplus/(Deficit) Cumulative	3,065	3,197	2,264	2,293	2,331	2,370
Surplus/(Deficit) %	1.39%	1.46%	1.00%	1.00%	1.00%	1.00%

Net Risk/Headroom		1,836	1,913	592	630	668
Risk Adjusted Surplus/(Deficit) Cumulative		5,033	4,177	2,885	2,961	3,038
Risk Adjusted Surplus/(Deficit) %		2.29%	1.85%	1.26%	1.27%	1.28%

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

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 £19.1m 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.

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			
Other programme services	67	-			
Mental Health	-	260	250	150	150
Run costs	-	478	-	-	-
Primary Care Services	**-**	**-**	400	350	350
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	6,192	6,109	6,002	5,945	5,884

Total Health Community Savings	**10,159**	**10,228**	**10,275**	**9,499**	**9,362**

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.

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	-	650	492	142	100
Other programme services	114	349	249	449	450
Better Care Fund	-	7.845	-	-	-
Sub Total	**1,767**	**10,135**	**1,200**	**975**	**900**
Held for in year priorities	**473**	**200**	**200**	**200**	**200**
Investment to be identified	**-**	**-**	**830**	**1,095**	**1,210**
Total Recurrent Investment	**2,240**	**10,335**	**2,230**	**2,270**	**2,310**

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	824	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	**5,098**	**1,984**	**2,028**	**1,217**	**700**
Held for in year priorities	**202**	**205**	**200**	**200**	**200**
Investment to be identified	**-**	**-**	**-**	**848**	**1,403**
Total Non-Recurrent Investment	**5,300**	**2,189**	**2,228**	**2,265**	**2,303**

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 Council 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. 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

Chapter 9 Better Care Fund

In this section we set out:

- Key implications for main providers in delivering the system vision are understood and articulated, such that it is clear how the changes required by each, over the period work in concert to achieve the end state.
- That there is a robust and specific plan to allocate the Better Care Fund to improve integration of health and social care in accordance with the national guidance. The plan clearly supports delivery of the strategic plan and contributes to the delivery system transformation
- Enabling Plans grouped into five areas:

OD

Workforce

IT infrastructure

Estates

R&D

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. 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. The Health & Wellbeing Board provides strong local leadership, holding the whole system to account for improving health and wellbeing outcomes, with a particular focus on prevention and early intervention. For BaNES the Better Care Fund acts as a further enabler and structure to build on and expand existing joint commissioning and provision. Our focus for the future is on further alignment of resources that influence the wider determinants of health and wellbeing.

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 B&NES; the Royal United Hospital Bath; Dorothy House Hospice; Sirona Care & Health CIC; Curo Housing Group; Age UK B&NES; Avon & Wiltshire Mental Health Partnership NHS Trust; B&NES Council and BaNES Clinical Commissioning Group.

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:

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

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 Impact on the Health Economy and Assessing Our Progress

This section is under development. It will set out:

- Key implications for main providers in delivering the system vision are understood and articulated, such that it is clear how the changes required by each work in concert to achieve the end state

  Activity

  Financial Resources

  Workforce

  What will feel different for patients and the public

- The framework for how we will monitor our progress and assess our success in achieving an improvement in outcomes

The Impact of the 5 Year Strategy on the Health and Care Economy

We continue to develop detailed plans for our six priority areas and to strengthen the synergies between the Two Year Operational Plan and this Five Year Strategy to ensure continuity of our story. 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 develop iteratively before the 4th April and 20th June submission dates.

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' 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. Given this we will develop this section on impact under the following headings:

1. Activity
2. Financial Resources
3. Workforce
4. What will feel different for patients and the public

We will develop a framework for assessing our progress against our ambitions that allows us to measure success.

Chapter 11 Enablers

In this section we set out Enabling Plans grouped into five areas:

OD

Workforce

IT infrastructure

Estates

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:

- OD
- Workforce
- IT infrastructure
- Estates

Organisational Development

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 5 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 5 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 5 areas are still relevant and applicable to the CCG's and wider health and social care community's effective delivery of our 5 year plan. The following table summarises some of the mechanisms we will use ensure that delivery is supported through effective organisational development processes.

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

We recognise that we have a number of key strategic workforce issues to address if we are successfully to implement our 5 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 and Organisation

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 delivery

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 5 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 £4.6m (check 14/15 fig) 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 5 year strategy.

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

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 5 year plan and a joint impact analysis will be carried out by June 2014 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.

IT 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.

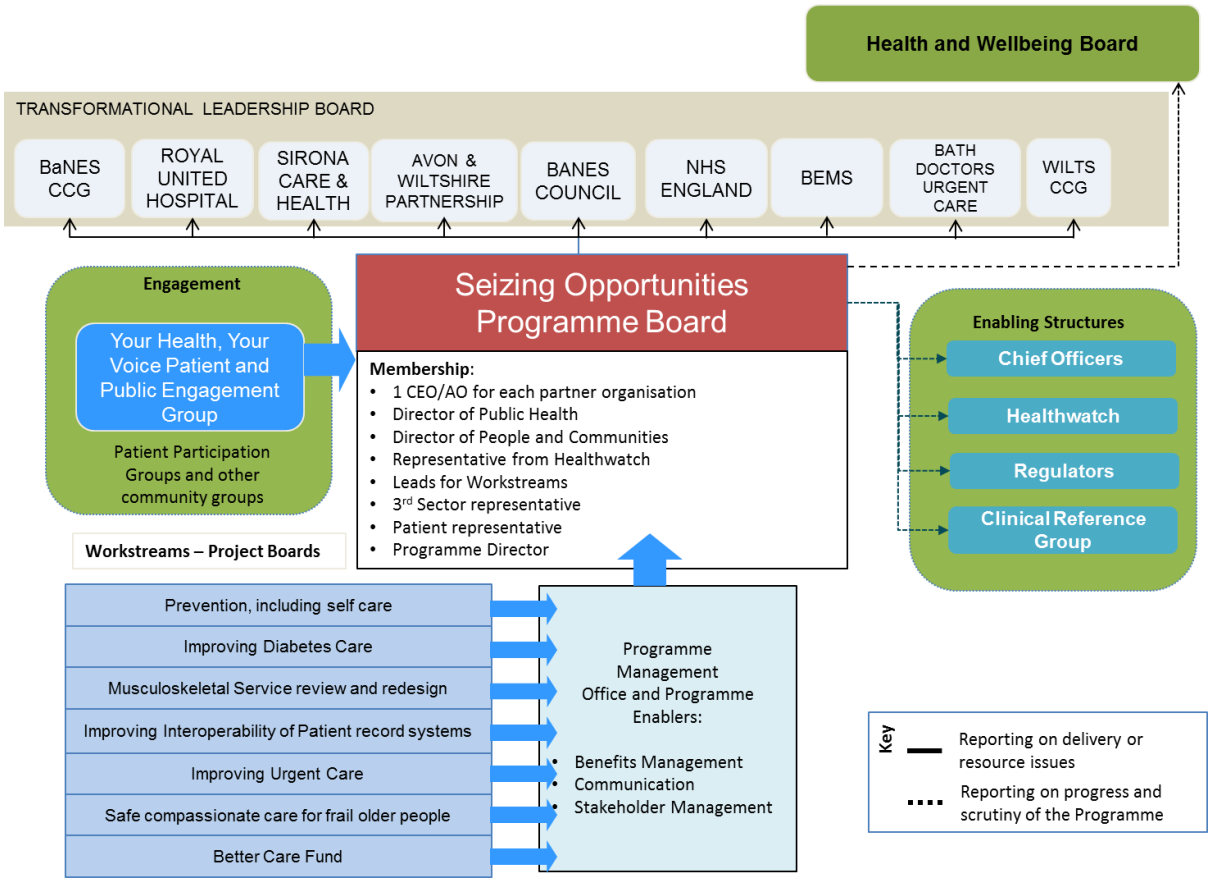
Governance of the IMT programme will adapt to ensure IMT is embedded in all commissioning developments. Potential benefits from technology and an awareness of the need for strong information governance will become part of how services are commissioned. We will use data as part of the commissioning process 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 12 Delivery and Governance Arrangements

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.



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 Transitional 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 5 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 Transformational 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.

Chapter 13 Implementation Plans

We do this last…

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

We are committed to maximising the strengths of collaborative working between health and social care system partners, and recognise the crucial contribution of provider stakeholders in delivering our plans in an effective and timely manner. We will engage with key stakeholders to create, sign off and progress our implementation plans.

We will ensure implementation plans for each priority area recognise, where relevant, the need to develop key enablers and supporting functions, and will ensure that multiple requirements relating to enablers and supporting functions are managed in a coherent manner.

We will develop our detailed implementation plans using structured project management approaches which are relevant and proportionate to the scale of each project, in accordance with accepted change management principles and using good practice techniques and tools such as the NHS Change Model. 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 roles and responsibilities
- Description of which stakeholders are engaged with the 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 any transitional impact of implementation and the resource required to manage it
- An operationalisation or handover plan to ensure smooth transition to a live service

Chapter 14 Communications and Engagement Plan

In this section we set out:-

- How we have engaged on the development of our five year strategy
- What were the key messages we have heard from the Public and Stakeholders and how these have informed the development of our strategy
- Our Plans for further on-going engagement during April and May.

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 through:-
- Personal Health Budgets
- Patient Choice & Decision Making

Our Approach to Encouraging Citizen Participation

The findings from our engagement activities described in Chapter X 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 and our engagement activity through the establishment of a Patient and Public Involvement Group , "Your Health, Your Voice " and our online patient communication which supports B&NES CCG to:

- Build a community of interest through membership

- Engages with people on their chosen topic of interest
- Tracks relationships and member activity
- 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
- Share outcomes; enabling continuous and flowing dialogue
- Capability to track, connect, record and analyses 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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References (Note these currently only relate to the Population At A Glance section and will need to be tied in properly at the end)

1. BaNES JSNA http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki

2. Public Health Outcomes Framework Data Tool http://www.phoutcomes.info/

3. Local Alcohol Profiles for England http://www.lape.org.uk/data.html

4. NHS Health Checks http://www.healthcheck.nhs.uk/interactive_map/

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

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

7. Health and Social Care Information Centre https://indicators.ic.nhs.uk/webview/

8. PHE Longer Lives http://longerlives.phe.org.uk/#are//par/E92000001

Glossary and Abbreviations

This section attempts to clarify some of the terminology and common abbreviations that may be used in the document

Abbreviation *Description*

Acute 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 cab 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 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 Major local provider of mental health service.

CQC Care Quality Commission 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.

Coronary Heart Disease CHD

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

CMT Community Mental Health Team

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.

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

CQUIN Commissioning for Quality and Innovation

CSI Commission for Social Care Inspection Former inspection/registration body for social care, now incorporated in CQC

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

DH Department of Health Government department responsible for health and social care.

EoLC End of Life Care

EPP Expert Patient Programme.

Established 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.

FOQ Act 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.

GDS General Dental Services Mainstream dentists

GPLHC GP Led Health Centre

GPwSI GP with Specialist Interest

HCAI Health Care Associated Infections

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

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.

Incidence The number of new cases of a disease within a given time period

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

ISTC Independent Sector Treatment Centre Private centres that have a contract with the NHS to perform certain treatments

IT Information Technology Computers and associated technology

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.

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

LA Local Authority

LAA Local Area Agreement. A document which sets out the priorities agreed between central government and a local authority and other key partners

LES Local Enhanced Service A primary care service contract that has been designed to meet a local need and is negotiated and offered to all local GPs in addition to their core contract.

Length of Stay Period that a person is in hospital

LSP Local Strategic Partnership formed between the council and its key partners, including the NHS, POLICE, Voluntary Sector and local business sector to agree and deliver the Sustainable Communities Strategy

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.

MH Mental Health

MOU A Memorandum of Understanding is a document describing a bilateral or multilateral agreement between parties.

MIU Minor Injuries Unit

Monitor Currently 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 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.

NHSCB The NHS Commissioning Board is to be created under the Health & Social Care Act 2012 to be responsible for arranging for the provision of health services in England.

NHSCBA the NHS Commissioning Board Authority is a special health authority set up in October 2010 with the purpose preparing for the creation of the NHSCB

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 Continuing Healthcare NHS Continuing Healthcare is a package of care that is arranged and funded solely by the NHS, where an individual is assessed as having a primary health need. The National Framework for NHS Continuing Healthcare sets out the process for establishing eligibility for NHS Continuing Healthcare, the principles of care planning and dispute resolution relevant to the process. NHS bodies and local authorities have a responsibility to ensure that the assessment of eligibility for the NHs Continuing Healthcare and its provision take place in a timely and consistent manner.

NRLS National Reporting and Learning System. The system enables patient safety incident reports to be submitted to a national database. Most incidents are submitted to the NRLS electronically from local risk management systems. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care.

NSF National Service Framework A set of NHS guidelines indicating best practice in a given service.

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

Non Elective Medicine Treatment for illnesses that is not planned, including severe pneumonia, flare-ups of inflammatory bowel disease, severe asthma attacks and worsening of COPD, needing admission to hospital.

Non Elective Surgery Surgery that is not planned and which is needed for urgent conditions

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

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.

OOH Out Of Hours Services operating outside of normal working hours

Overview & Scrutiny Committee (O&S or OSC Local Authority Committee with the power to scrutinise performance and changes in health and care services.

ONS for National Statistics.

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.

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.

Patient Care Trust Administrative body responsible for commissioning primary, community and secondary health services from providers until March 2013

PCT Cluster Bath & North East Somerset and Wiltshire PCTs working with a shared Board – the accountable NHS organisation for 2014/2015

PBC Practice Based Commissioning An initiative to directly engage GPs and other clinicians in the commissioning work of the PCT

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

PCT Primary Care Trusts PCTS commission primary, community and secondary care from providers. To be replaced by CCGs in April 2013

Programme Budgeting A way of assessing investment in health of the population.

PROMS Patient Reported Outcome Measures

Public Health The science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society (Acheson 1988)

QUIPP Quality, Innovation Productivity and Prevention Over 2011-12 to 2014-15, the NHS will face significant additional demand for services arising from the age and lifestyle of the population, as well as the need to fund new technologies and drugs. To meet this challenge, the NHS needs to deliver recurrent efficiency savings of up to £20 billion by 2014 2014-15 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

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

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.)

Registered Population Is the population registered with a general practice constituent practice of a PCT

RNHRD Royal National Hospital for Rheumatic Diseases Specialist NHS Hospital (Foundation Trust)

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 B&NES 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

SEND Special Educational Needs. Any learning difficulties which calls for Special Educational provision to be made.

Senior Commissioning Managers SCMs

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.

UCC Urgent Care Centre A centre that is open 24 hours a day, seven days a week these centres will treat most illnesses and injuries that people have which are not likely to need treatment in a hospital. This includes chest infections, asthma attacks, simple fractures, abdominal pain and infections of the ear, nose and throat.

VFM Value for money

Appendix A [TBU]