

Bath & North East Somerset Council

NHS  
Bath and North East Somerset  
Clinical Commissioning Group

## Seizing Opportunities -

### NHS Bath and North East Somerset CCG 5 year Strategic plan 2014-19 2 year Operational plan 2014-16

March 26<sup>th</sup> 2014

*Healthier, Stronger, Together*

## Patient

### Bath and North East Somerset CCG

#### A real life case study

- History and Symptoms
- Diagnosis
- Treatment plan
- Prescription
- Prognosis

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## History

### What we already know about this patient

- One of 211 clinical commissioning groups
- 27 GP practices form BaNES CCG
- BaNES CCG is in the top 25% of CCGs
- Stable financial history – 2014/15 relatively secure, but challenges coming 2015/16
- Healthy, wealthy, happy people

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## Symptoms

### If our population was 20 people

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## The uncomfortable truth

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## Diagnosis

### Demographic changes

Life expectancy ↑

75+ population

Deaths ↓

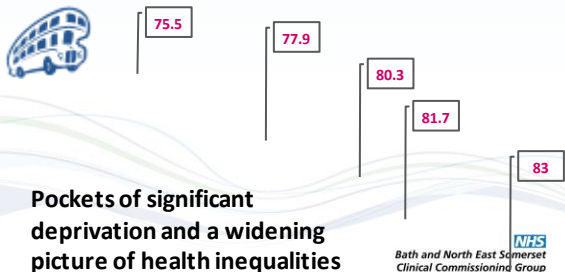
2014

to increase by 20%

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## Diagnosis

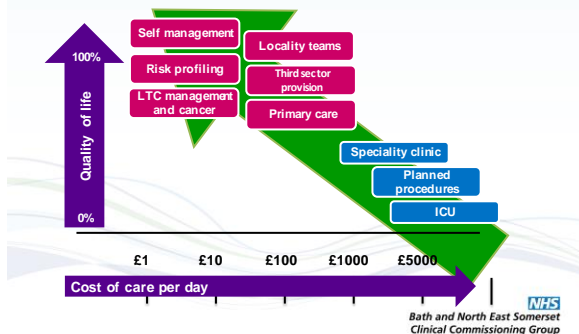
The number 20 bus route



Pockets of significant deprivation and a widening picture of health inequalities

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## Treatment plan



## Treatment plan

Our vision

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.

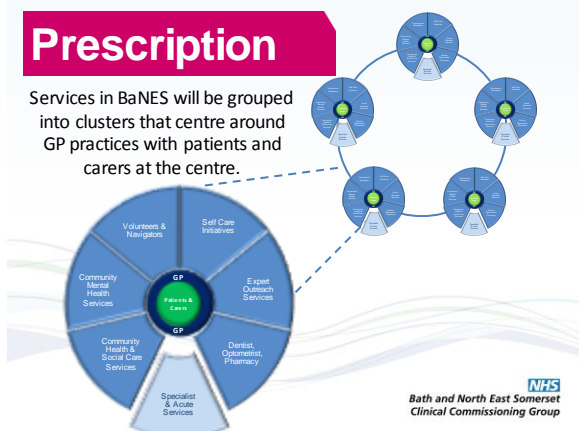
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Stronger

Together

## Prescription

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



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Community Mental Health Services: Talking therapies, Liaison services, Wellbeing College

Volunteers & Navigators: Signposting Services for Carers, Community schemes

Self Care Initiatives: LTC support, e.g. Desmond services, Expert Patient Programmes

Community Health & Social Care Services: MDT approach with Practices, Focus on greatest risk



Expert Outreach Services: Diabetes, heart failure and COPD, Supporting complexity

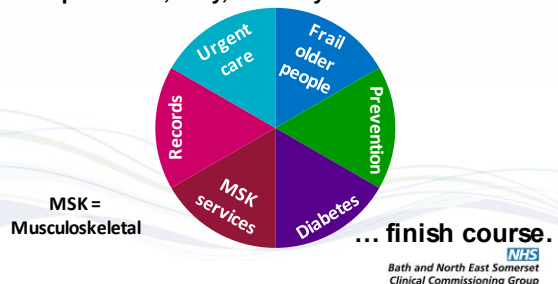
Specialist Services: Vascular surgery, Dialysis, Transplant services, Neurosurgery

Dentist, Optometrist, Pharmacist: Minor illness, Supporting Polypharmacy

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## Prescription

Six priorities, daily, for five years...



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## Prescription



### Care for frail older people

**WHAT** Safe and compassionate care from every service - through a new community cluster team.

**WHY** Care centred around each individual in our increasing longer-living population.

**SO?** By working together health and social care teams spend more time with patients than currently.

**1 RESULT** Reduced unnecessary hospital admissions, loneliness and isolation. Increased wellbeing and positive mental health.

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## Prescription



### Prevention and self care

**WHAT** Commissioning services to prevent illness, rather than focusing on treating illness.

**WHY** Evidence shows prevention programmes can reduce avoidable health problems.

**SO?** So this makes for healthier people and allows the health system to focus on those people whose health problems are unavoidable.

**1 RESULT** Earlier diagnosis and treatment, and delay progression of disease.

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## Prescription



### Diabetes care

**WHAT** Redesigning the diabetes care pathway.

**WHY** We want patients to get the right level of care in the most appropriate place.

**SO?** So that we're able to support the growing number of people living with diabetes, which is increasing by 5% every year.

**1 RESULT** A better experience for patients from high quality timely care close to home.

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## Prescription




### Musculoskeletal services

**WHAT** Head to toe review and redesign of the service - with your experiences at its heart.

**WHY** It makes the biggest impact on improving the quality of the service while reducing spend.

**SO?** So if we ignore this we won't be able to care for the growing needs of our ageing population.

**1 RESULT** A better experience for patients: high quality timely care close to home.

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## Prescription



### Patient record systems

**WHAT** Health professionals seeing info when they need it.

**WHY** For patients: less repetition, less frustration, more confidence in your consultation and treatments.  
For your health professionals: more efficient, more effective and safer decision.

**SO?** So it's a better experience for everyone.

**1 RESULT** Joined up working between health and social care services.

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## Prescription



### Urgent care

**WHAT** A streamlined urgent care system.

**WHY** To make sure patients are assessed and treated by the right clinician first time. And to help them choose the right service when they need it.

**SO?** So that our local health system can manage increasing demands.

**1 RESULT** Reduced the number of times a patient is passed from clinician-to-clinician which in reduces clinical risk.

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## Prescription

- Plan delivers all nationally mandated items including surplus, contingency, non-recurrent investment (headroom) and contribution to Better Care Fund
- Resource releasing (QIPP) target between 1.4-1.8% of income pa
- Recurrent investment created at 1% of income pa
- Running costs reduction target of 10% in 15/16

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## Prognosis

- A sustainable health economy where resources are used to deliver the safest & most effective care at best value
- Realistic, balanced plans which support delivery of our priorities and our statutory obligations
- Clever use of funding to drive beneficial and innovative change through collaborative approaches
- Effective use of Better Care Fund

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## Prognosis

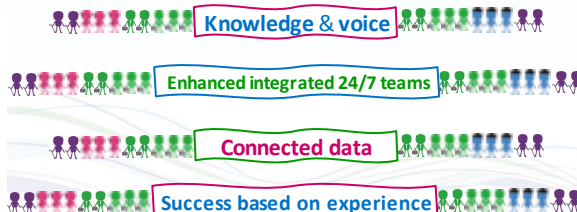
In five years time...



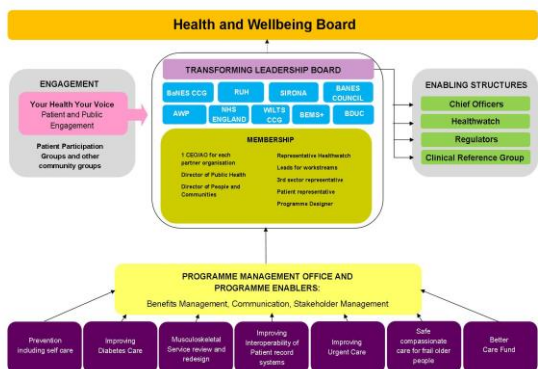
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## Prognosis

In five years time...



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## Operational Plan for 2014-16

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## Urgent Care

- New integrated Urgent Care and Out of Hours services model
- Ambulatory care pathways that work across primary and secondary care
- Review impact of the 2013-14 winter pressures initiatives
  - with a view to commissioning on a substantive basis to create additional capacity in the system

## Primary Care

- Review of local enhanced services to ensure they are 'fit for purpose'
- Develop a local Primary Care Strategy
- Bed in new relationships with LMC and provider organisations

## Long Term Conditions and Frail Older People

- Cluster Model, active ageing service and redesigned adult social care pathway
- Review Dementia challenge fund initiatives – view to commission long term
- Establish diabetes working group & design new pathways

## Planned Care

- Develop proposals for an integrated Musculoskeletal (MSK) Service
- Review Ophthalmology services with the RUH
- Review the provision of physiotherapy services

## Quality Objectives

- Culture of continuous improvement and innovation
- Work collaboratively with our local providers to ensure staff are delivering high quality
- Ensure consistent access to effective treatments

## Enablers

- Citizen participation
- Interoperability
- Integrated Care
- Personal Health Budgets
- Primary Care Development

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**Thank you!**  
**Any questions?**



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