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Seizing Opportunities – A Five Year Strategy

23rd of May 2014

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

Foreword

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

The NHS belongs to the people.

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

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

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

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

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

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

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

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

Dr Ian Orpen – Chair

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Executive Summary

Our Vision

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

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

Seizing Opportunities

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

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

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

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

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

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

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

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

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

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

Our Priorities

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

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

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

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

Delivering Change

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

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

Service Performance Management:

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

System Performance Management:

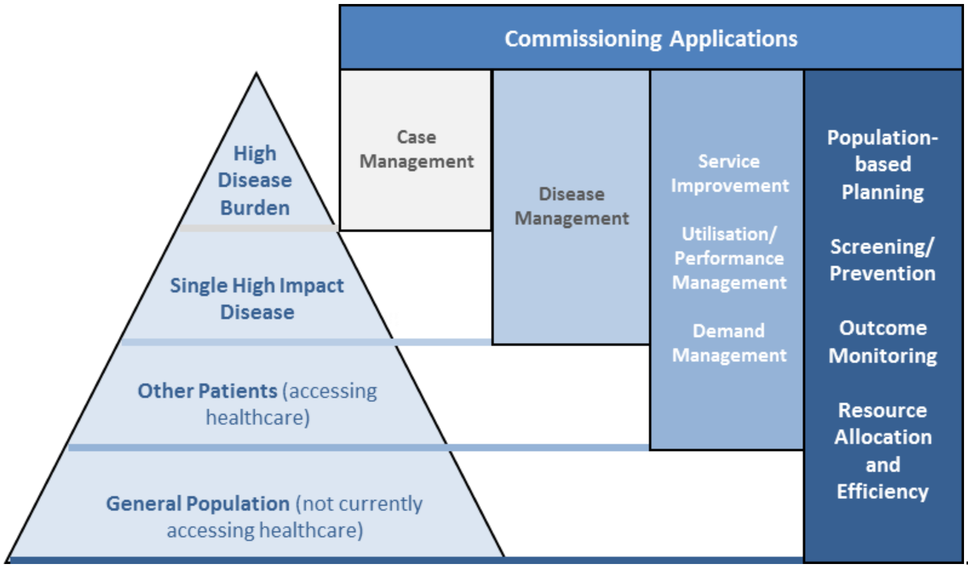
We will develop a locally agreed and clinically-derived set of Key Performance Indicators (KPIs) and outcomes that enable us to have a comprehensive perspective of the 'health' of our health system. We will want to measure success not by absolute benchmarks of these KPIs but by continuous improvement.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

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

Investment and dis-investment:

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

Figure 1: Commissioning Levers



Making It Happen

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

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

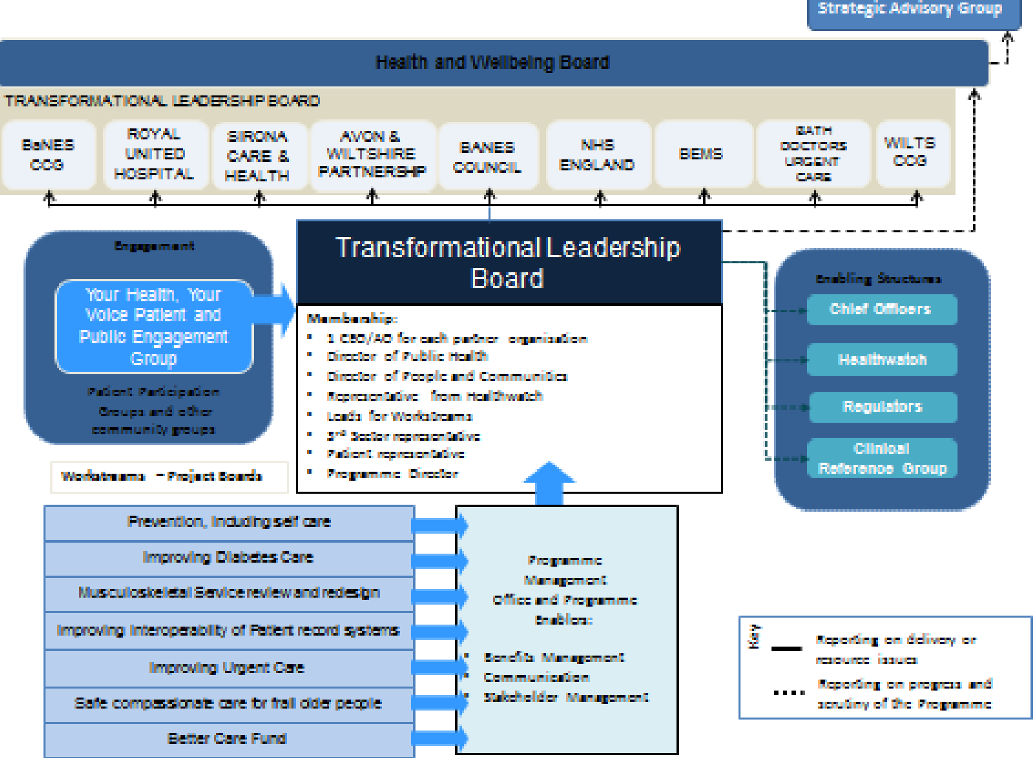


Figure 2: Governance Structure

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

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

Conclusion

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

Dr Simon Douglass
Clinical Accountable Officer

PART A

The Health and Care Economy in Banes

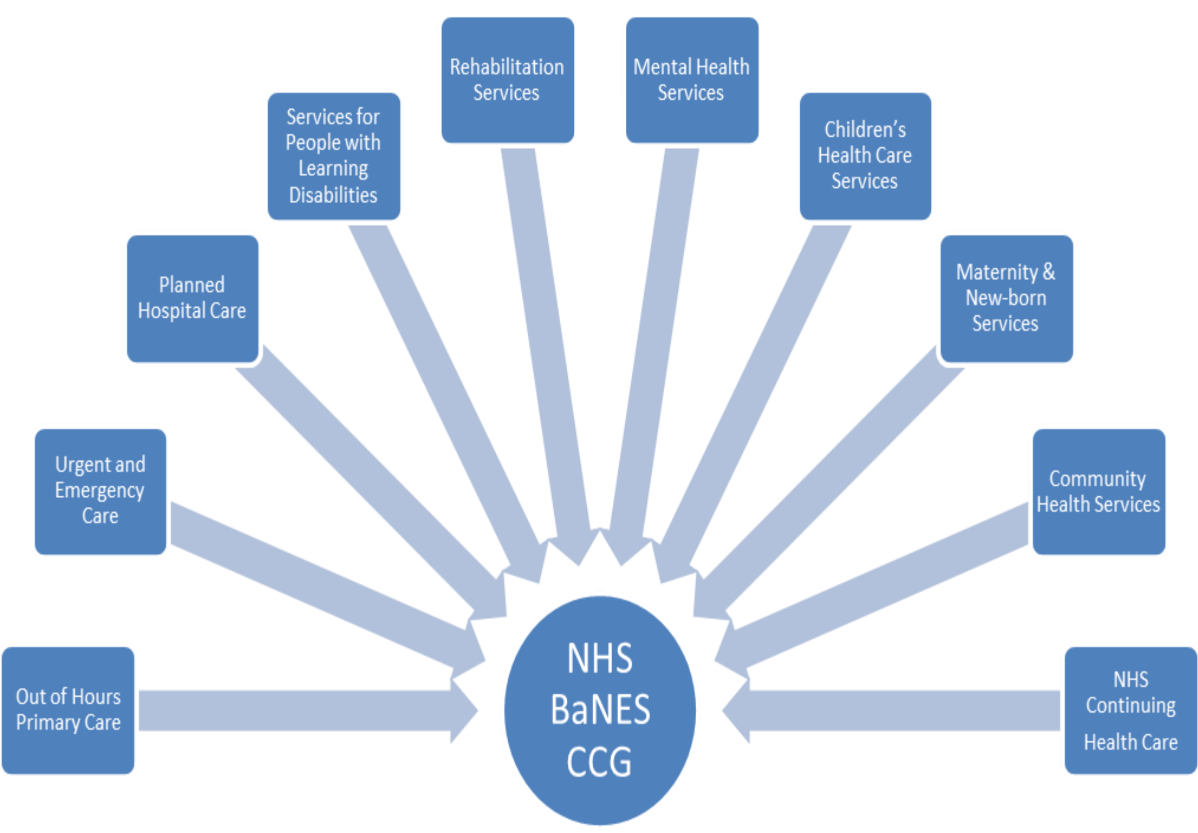
Chapter 1 – An Introduction to Our CCG and the local economy

Our Role

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

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

Figure 3: What is the CCG Responsible For?



Our Values

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

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

Our Values

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

Our Commitment to Quality

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

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

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

Leadership and Culture

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

Clinically Led Commissioning

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

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

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

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

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

The Provider Landscape

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

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

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

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

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

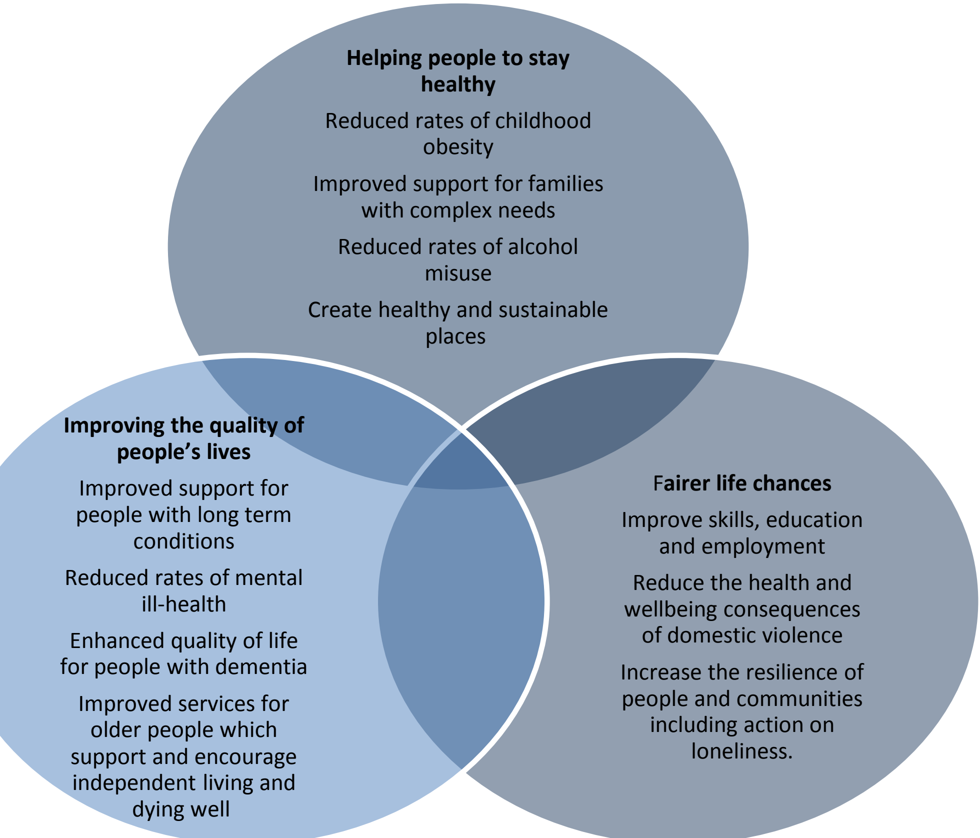
Regular assurance reports are made to the Quality Committee. This ensures that the Committee has oversight of areas of patient safety, patient experience and clinical effectiveness on behalf of the CCG Board. Information, both qualitative and quantitative, is triangulated: to achieve a more rounded picture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

Chapter 2 - Our Vision

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

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

The local H&WBB objectives and priorities are: -



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

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

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

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

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

Delivering Our Vision

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

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

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

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

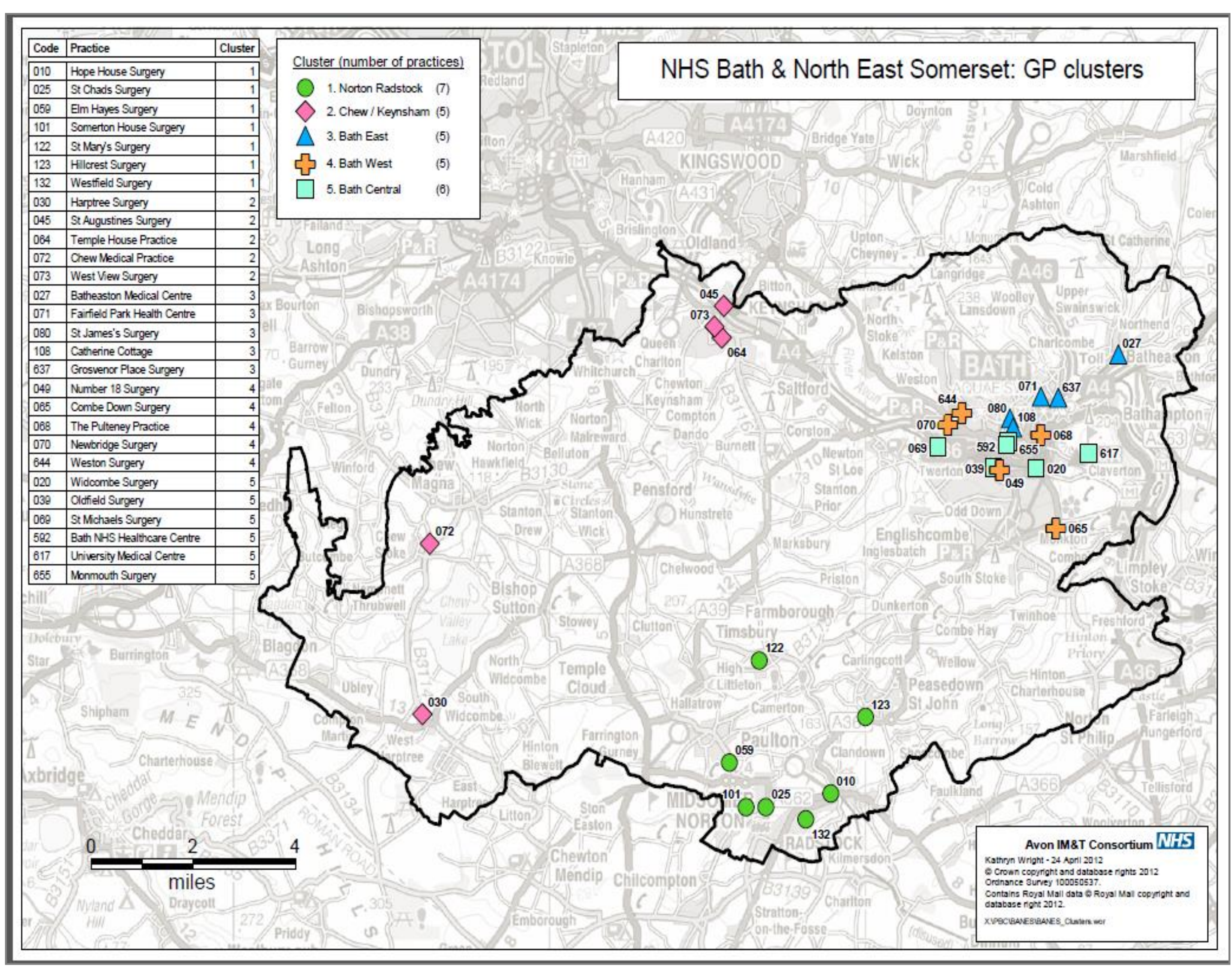
The overall impact of our 6 priority work programmes will vary within each individual priority strand as they are linked and support a common requirement to enhance integrated care in BaNES, with clinicians' part of the multidisciplinary teams with the needs of the patient at its heart.

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

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

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

Figure 4: Configuration of GP Clusters



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

Figure 5: Integrating Services in Clusters

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

Volunteers & Navigators
Self Care Initiatives
Expert Outreach Services
Dentist, Optometrist, Pharmacy
Specialist & Acute Services
Community Health & Social Care
Community Mental Health Services
GP
Patients & Carers
GP

Bath and North East Somerset
Clinical Commissioning Group

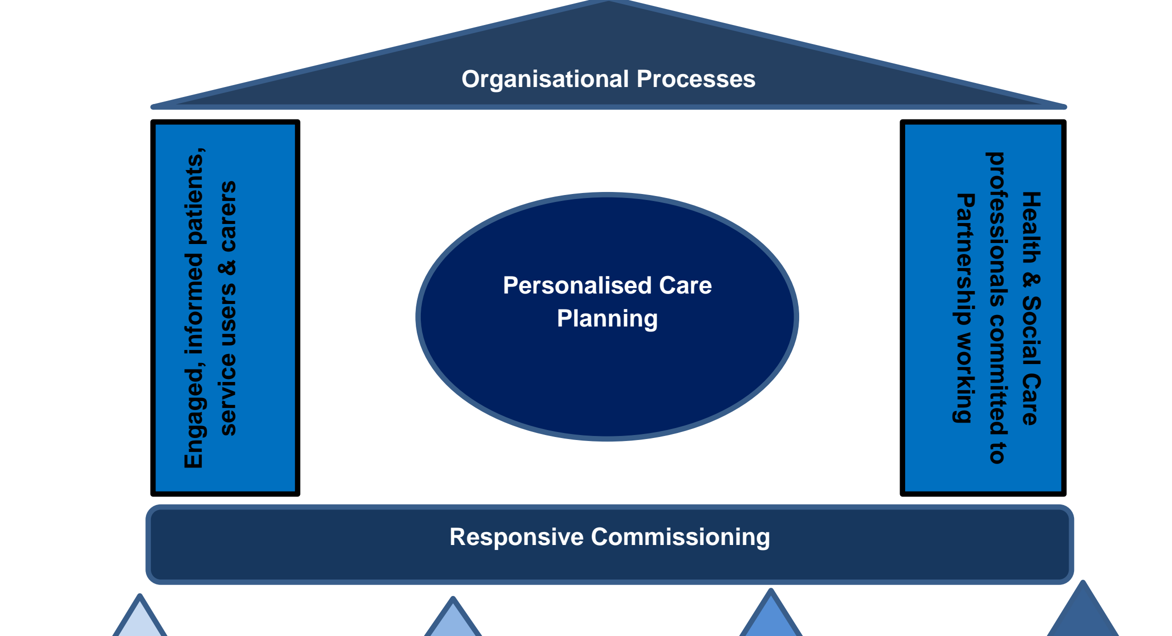
Building Integrated Care in BaNES

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

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

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

Figure 6: The House of Care Model in BaNES



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

Acute and Specialist Services

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

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

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

Developing Primary Care at Scale

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

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

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

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

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

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

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

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

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

Participation and Empowering Patients

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

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

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

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

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

Our Strategy on a Page

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

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

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

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

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

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

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

Our Mission

Healthier, Stronger, Together

"to lead our health and care system collaboratively through the commissioning of high quality, affordable, person centred care which harnesses the strength of clinician led commissioning and empowers and encourages individuals to improve their health and well being status".

Our Focus – high quality health and care system

▸ Improving quality, safety and individuals experience ▸ Improving consistency of care and reduce variability of outcomes and experiences	▸ Providing proactive care to help people to age well and proactively help people with complex care needs	▸ **Sustainable health system** within a wider health and social care partnership with resources directed to support commissioning priorities	▸ Empowering & encouraging people to take personal responsibility for their mental and physical health and wellbeing	▸ Reducing inequalities and social exclusion and supporting our most vulnerable groups

Our Approach

▸ We want to lead a reconfigured system that meets the current and future needs of our population, targeting deprived areas, is **financially sustainable** with care offered in the optimum setting	▸ We will **improve outcomes.** ▸ We will drive **improvements in the performance, productivity and individuals experience.**	▸ We will encourage Providers to collaborate, innovate and work in effective partnerships to deliver seamless and integrated care	▸ We will invest resources in areas and activities that support better prevention and early intervention	▸ We will focus on both the mental health and physical health needs of individuals.

Our Priorities

▸ Increasing the focus on prevention, self-care and personal responsibility ▸ Improving the co-ordination of holistic, multi-disciplinary Long Term Condition Management (focusing initially on diabetes)	▸ Creating a **sustainable Urgent Care system** that can respond to changes in demand ▸ Commissioning safe, compassionate care for frail older people	▸ Redesigning musculo-skeletal services to improve their efficiency (**productive elective care)** ▸ Ensuring the interoperability of IT systems across the health and care system	▸ Delivering the plans for the Better Care Fund to support our model of **integrated care** with a focus on: • 7 Day Working • Protection of Adult Social Care Services • Integrated reablement and hospital discharge • Admission avoidance • Early intervention and prevention

Our Enablers

▸ Develop contractual levers ▸ Develop Incentives for innovation, improvement and **integration** ▸ Enhanced primary, community and mental health services provided 7 days per week ▸ **Sustainable model of primary care**	▸ Develop Referral Management Support ▸ Develop interoperability to improve integration of information systems ▸ Develop commissioning support services	▸ Develop 'Our House of Care' model to improve integration of services for patients. ▸ Develop organisational capacity and competence.	▸ Develop our approach to **Citizen Participation and Empowerment** ▸ Improve quality and **outcomes** for patients ▸ System wide governance arrangements: ▸ Delivery overseen by Transformational Leadership Board ▸ Agreed high level measures of success

Our Vision for Patients

▸ Patients and carers will feel supported, confident and able to navigate their way around the health and care system, supported by local communities, navigators and volunteers ▸ Patients will work with clinicians to help design services and will be confident in the quality and safety of services	▸ Enhanced, seamless primary, community and mental health services will be provided 24/7 where required around clusters of populations: 'care closer to home' ▸ Specialist and hospital based services will be supporting community based services with their expertise and providing care for those of us with complex needs	▸ We will have evidenced based, efficient and innovative pathways of care that will evolve and develop as population needs change with self care and personalised care planning at their core ▸ Services will have an equal focus on the physical and mental health well-being of the people that use them	▸ There will be reduced inequalities & social exclusion of our most vulnerable groups and areas in Bath and North East Somerset ▸ We will be using integrated care records to share information where it counts with different organisations: 'tell our story only once' ▸ Patients will have the ability to and understand how to voice and raise concerns easily ▸ Patients will be cared for by staff who are caring, motivated, trained and supported to deliver effective clinical practice

Chapter 3 - Understanding the Case for Change

1. The National Drivers For Change

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

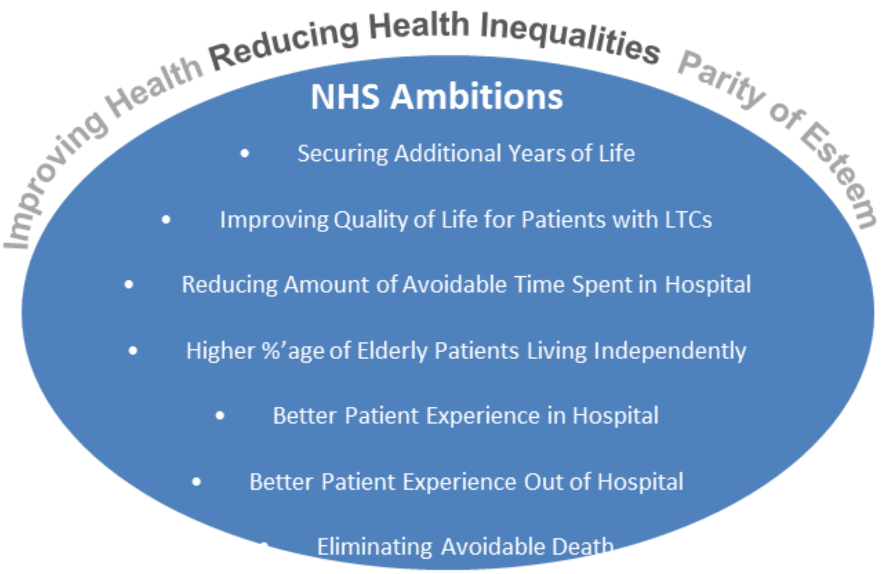
Nationally, the demands on health and care services are increasing as people live longer with more complex long term conditions. Patient expectations continue to rise, despite confidence in the NHS brand suffering as a result of high profile system failures such as Mid Staffordshire Trust NHS Foundation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

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

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

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

Figure 7: Everyone Counts



2. The Local Case for Change

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

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

Meeting the Needs of a Changing Population

Our Population

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

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

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

51% **49%**

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

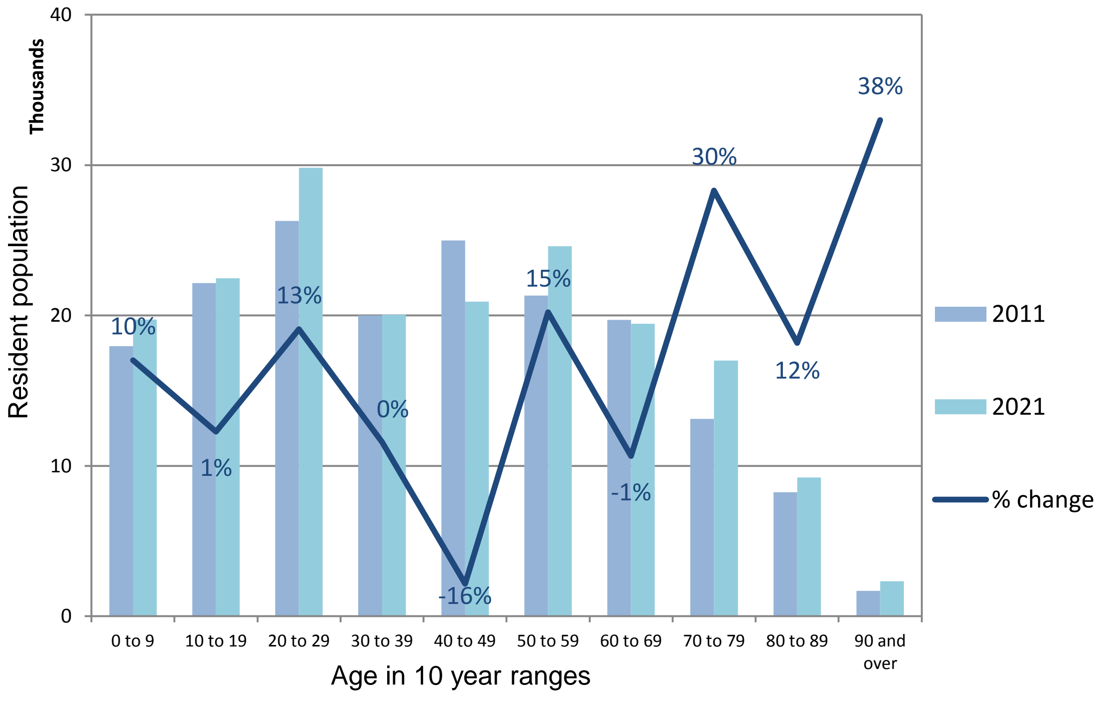


Figure: 8 – Sub national population projections, 2011-2021 comparison by 10 year age range: Bath and North East Somerset

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

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

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

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

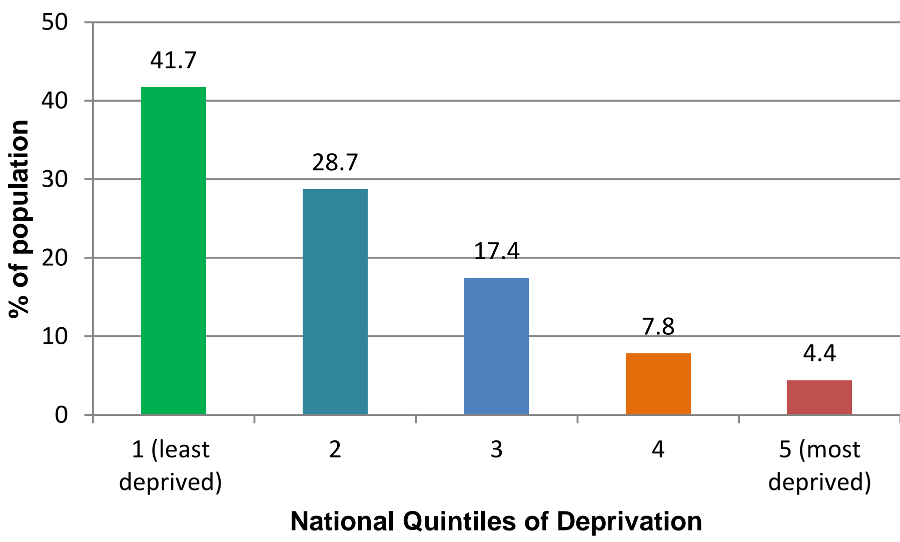
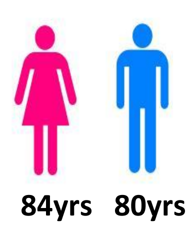


Figure: 9 – Deprivation levels in BaNES by LSOA showing percentage population.

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

Our Health



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

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

Infant, children and young people's health

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

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

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

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

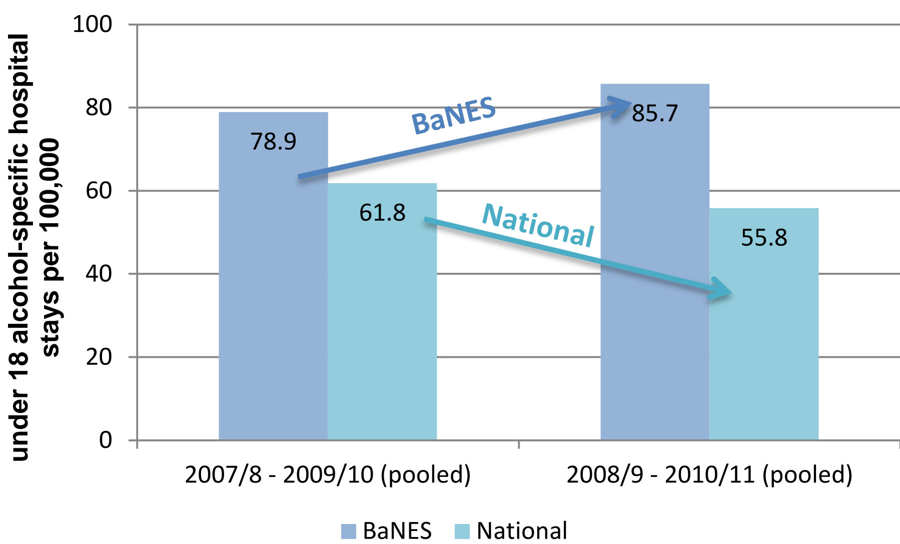


Figure 10: Rates of alcohol-specific hospital stays for under 18s per 100,000

Adult Health and Wellbeing

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

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

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

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

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

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

Free NHS Health Check
Helping you prevent heart disease, stroke, diabetes and kidney disease.

NHS Health Checks

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

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

DON'T BE SILENCED
SAY NO TO
DOMESTIC VIOLENCE

Domestic Abuse

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

Disease, Poor Health and Death

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

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

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

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

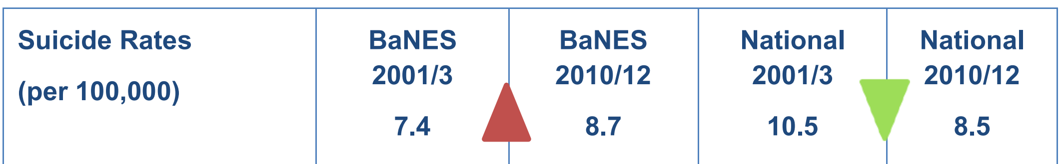
[8] NHS Health Checks http://www.healthcheck.nhs.uk/interactive_map/

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

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

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

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



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

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

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

Life expectancy and health inequalities

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

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

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

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

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

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

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

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

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

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

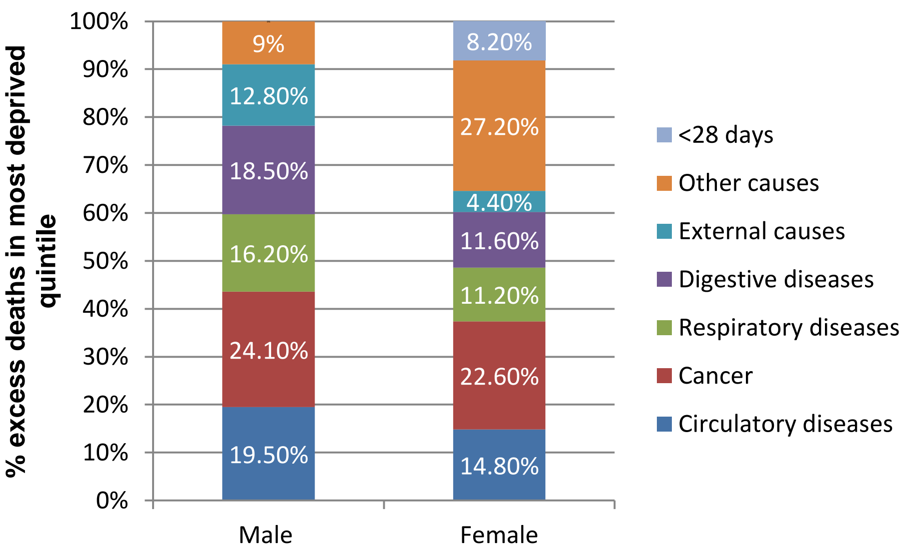


Figure 11: Breakdown of the life expectancy gap by cause of death between the most deprived and least deprived quintiles in BaNES, 2009-2011

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

	BANES	National
CVD	44.2	65.5

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

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

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

Respiratory disease	15.5	27.4
Cancer	100.6	123.3
Liver disease	10.8	15.4

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

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

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

Maintaining Strong Performance and Excellent Quality

Current Performance

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

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

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

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

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

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

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

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

National Quality and Safety Standards

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

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

Appendix 3 shows the National Quality and Safety Metrics.

Bath and North East Somerset
Clinical Commissioning Group

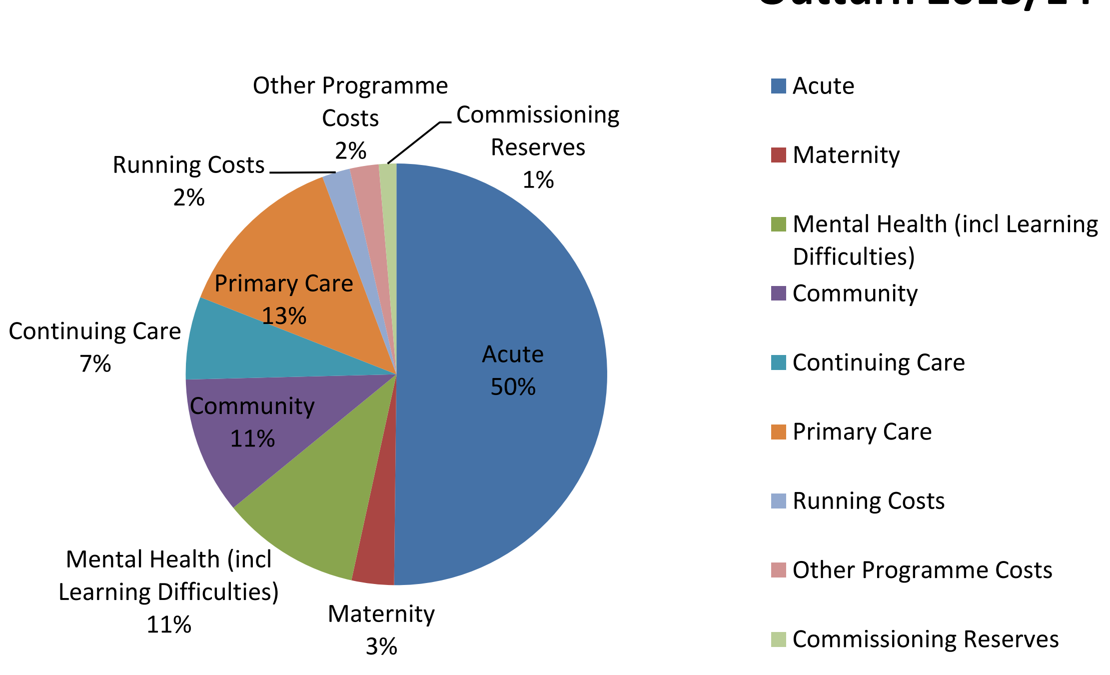
Ensuring Financial Sustainability

How We Use Our Resources

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

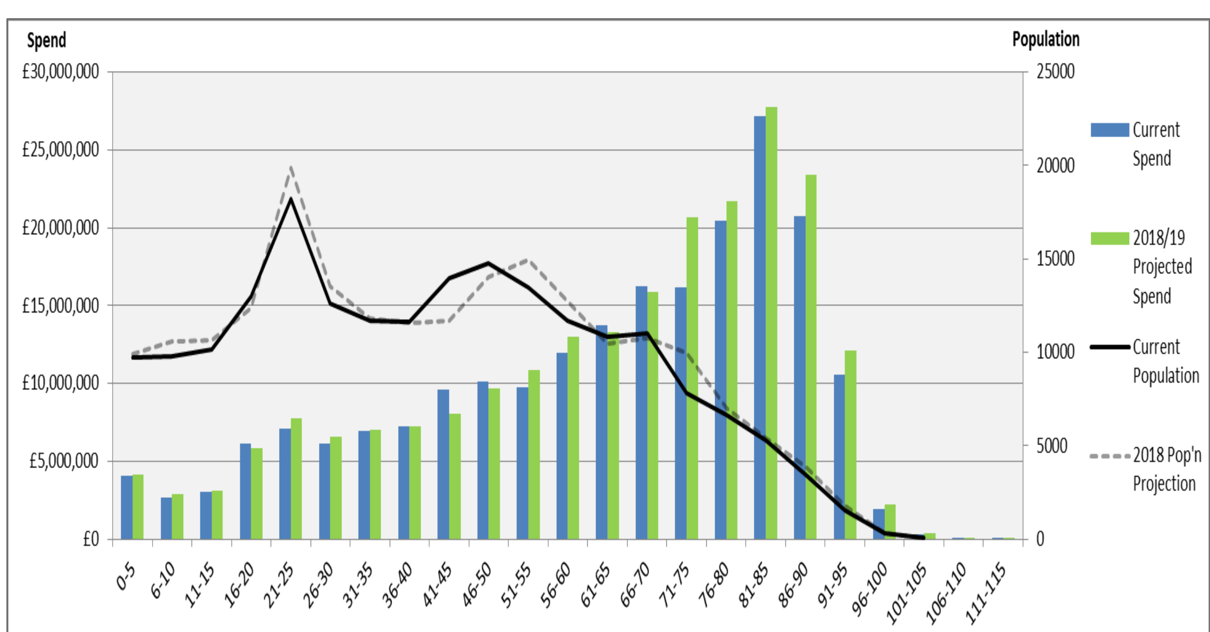
The pie chart below shows our forecast outturn expenditure by type of care for 2013/14, our starting point for understanding how our resources are used and identifying how we can use them differently to meet the challenges ahead. Over half of our commissioned service spend is allocated to acute services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

Figure 12: Outturn 2013/14



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

Figure 13: Spend against population by five year age band



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

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

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

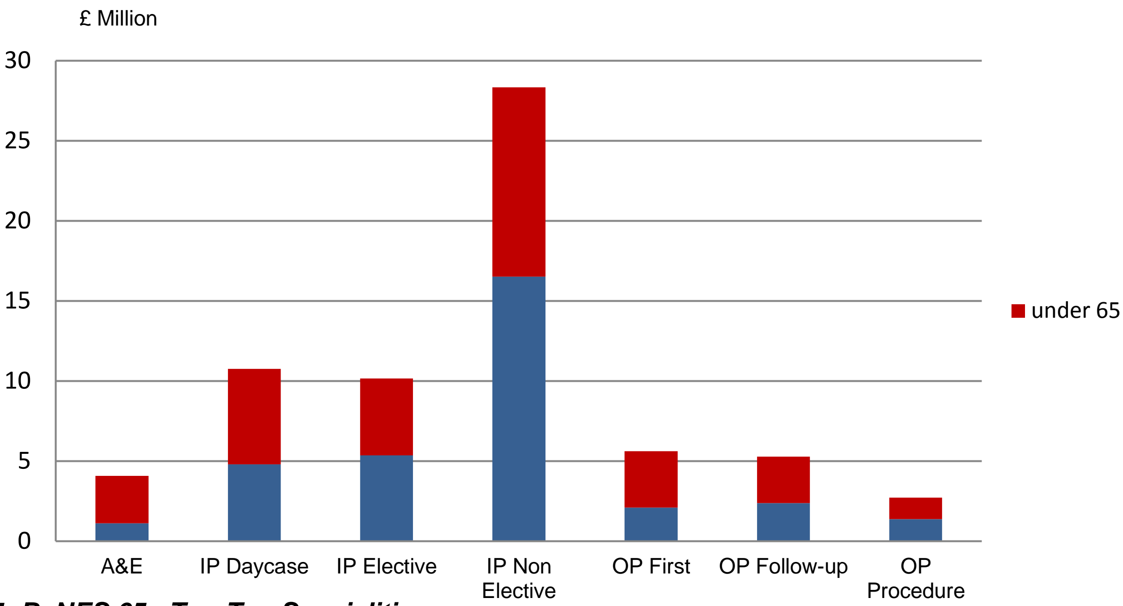


Figure 15: BaNES 65+ Top Ten Specialities for Non Elective Admissions

Source: April 13 - Jan 14 SUS PBR Data

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

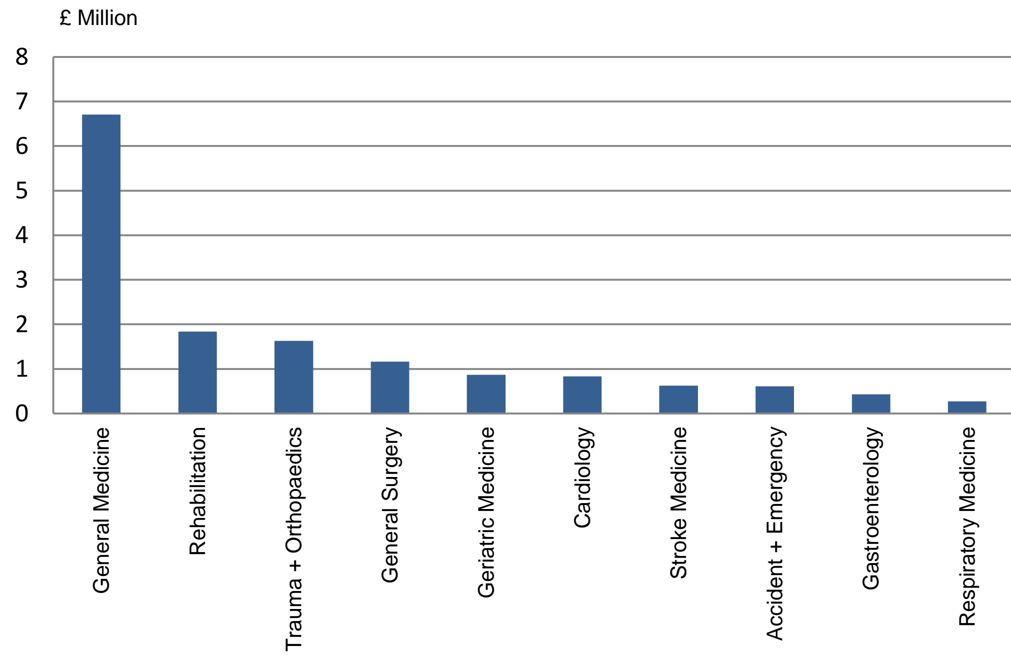


Figure 16: BaNES All Age Top Ten Specialities for Non Elective Admissions

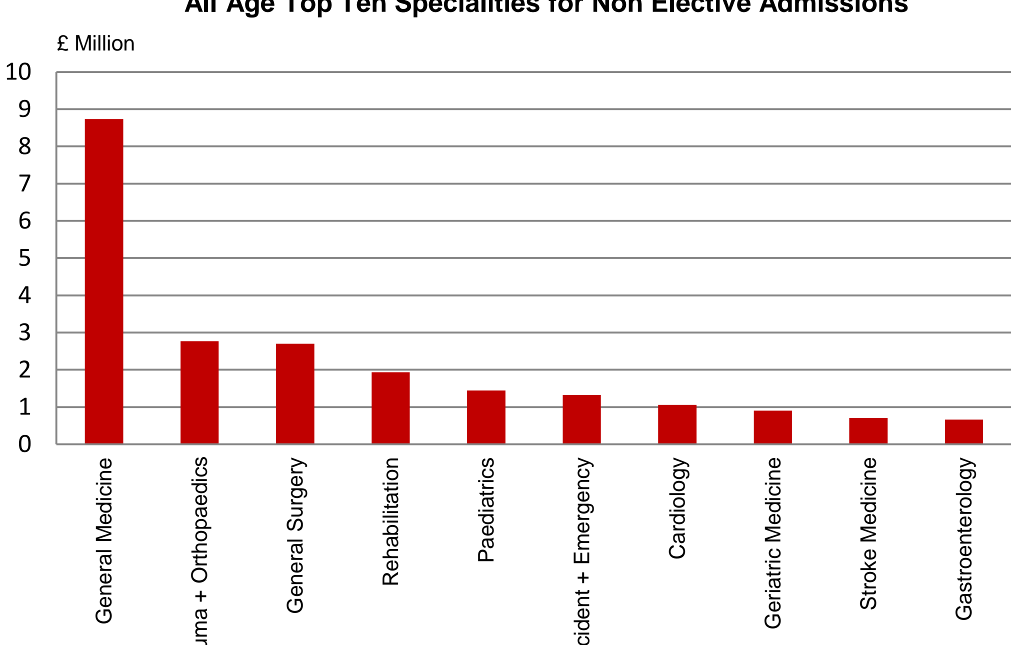
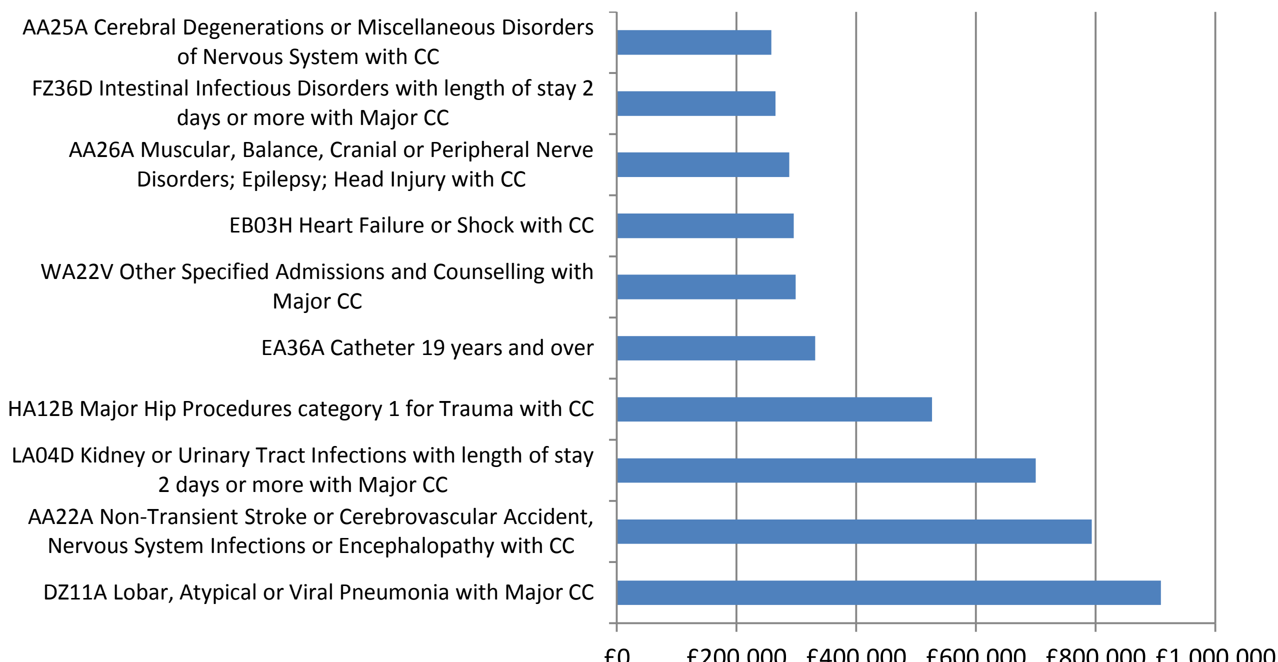


Figure 17: NHS Banes CCG Top 10 Non Elective HRGs by PbR Spend 65+



The Financial Position of the Health and Care Economy

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

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

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

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

We also face existing challenges in four areas:

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

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

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

How We Perform Comparatively

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

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

Our review of these sources provide the following intelligence:

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

Value Opportunities

Quality & Outcomes
MSK Problems, Circulation problems (CVD), Endocrine Nutritional & Metabolic problems, Cancer & Tumor

Acute & Prescribing Spend
MSK problems, Circulation problems (CVD)

Spend & Quality Outcomes
MSK problems, Circulation problems (CVD)

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

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

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

Value Opportunities

Higher Prevalence (from QOF)

Stroke or Transient Iscaemic attacks, Cancer, Asthma, Heart Failure, Artrial Fibrillation, Depression 18+

Better Performance

PYLL from causes considered amenable to healthcare, Proportion of people feeling supported to manage their condition, Patient reported outcome measures, Pateint experience of GP services, % of service users who feel safe, Healthy life expectancy (proxy), Differences in life expectancy (proxy)

Poorer Performance

Emergency admissions - alcohol related liver disease (proxy), Patient reported outcome measures for elective procedures - knee replacement, Emergency admissions - children (lower respiratory tract infections), Incidence of healthcare associated infection - MRSA, C Difficile,Social care related quality of life permanent admissions to residential & nursing care homes (age 64+)

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

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

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

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

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

Responding to the Views of Local Stakeholders and the Public

Engaging Providers and other Commissioners

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

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

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

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

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

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

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

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

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

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

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

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

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

Listening to the Public - A Call to Action

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

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

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

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

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

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

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

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

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

More specific themes also emerged across events which were:-

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

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

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

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

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

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

Chapter 4 - Summarising the Local Case for Change

Meeting the Needs of A Changing Population

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

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

- Of those aged over 65, half have at least three chronic conditions and 1 in 5 have five or more chronic conditions

- In deprived areas, multi-morbidity is more common and happens 10-15 years earlier and there are more people with mental as well as physical long term health problems

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

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

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

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

Figure 17: Shifting Resources within the System

High

Quality of Life

Low

Self-Care

Primary Care

Outpatient and Community

Hospital Inpatient Care

Low — Cost of care per day — High

Maintaining Strong Performance and Excellent Quality

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

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

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

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

Ensuring Financial Sustainability

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

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

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

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

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

Figure 18: Axis of Spend versus Outcome

SPEND

LOW

OUTCOME **GOOD** **POOR**

	LOW SPEND	
GOOD OUTCOME	Review for best practice to apply in other areas	Review need for investment to deliver quality improvements
	Review for value for money and innovation opportunities giving same or better outcomes for less cost	Investigate causes and develop plans for improved quality and **value for money,** including elimination of costs of poor service

HIGH

Responding to the Views of Local Stakeholders and the Public

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

A focus on prevention, self-care and education

More integration between health and social care services

Services provided in the right place, at the right time, by the most appropriately skilled

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

The Case for Change

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

Our local population needs

National requirements

Benchmarking intelligence

Our current performance – NHS Constitution and Outcomes

Our current use of resources

- Future financial pressures
- Views of patients, stakeholders and members of the public

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

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

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

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

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

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

PART B

Seizing Opportunities – Developing a Better Health

Chapter 5 – Our Priority Areas of Focus

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

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

To achieve this we believe we need to:

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

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

This means that we will:

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

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

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

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

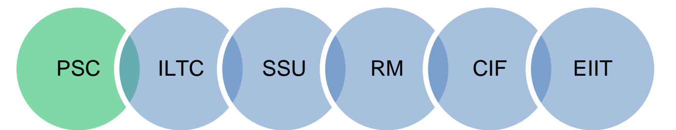
We have chosen a transformative approach, taking a system wide view on specialty and programme areas to ensure redesign improves the whole spectrum of service provision for specific areas of care.
The following is a summary of key messages from benchmarking and other information which have helped in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

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

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

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

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



High level description of the priority area:

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

Rationale for Inclusion:

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

The Local Case for Change:

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

Our Approach:

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

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

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

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

  Within the plan the CCG will consider how it could deliver elements of the PSC action plan through opportunities including:
- contracts to include prevention initiatives (employees and patients)
- incentivising prevention initiatives
- adding value to existing PSC and health inequalities programmes being implemented by partners in the wider health and social care family
- systematically developing PSC workforce skills
- using targeted communications based on social marketing principles

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

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

Timeline

2014/2015	2015/2016	2016/2017	2017/2018	2018/2019
• Establish PSC task force • Create health inequalities framework • Identify resources • Conduct PSC needs assessment (analyse key health problems, review existing self-care initiatives) • Engage with stakeholders to develop prevention and self-care action plan • Identify outcome and process metrics • Commission /deliver agreed programmes/action	• Commission/deliver agreed programmes/ actions • Deliver agreed support to existing programmes • Deliver agreed actions	• Evaluate and review	• Evaluate and review	• Evaluate and review

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

Prevention including Self-Care

Denotes characteristics impacted

Citizen Empowerment and Engagement

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

Integrated Care

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

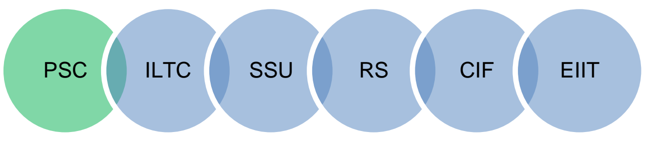
Primary Care Delivered at Scale

High Quality Urgent Care

Productive Elective Care

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

Specialist Services Concentrated in Centres of Excellence



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

High level description of the priority area:

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

Rationale for Inclusion:

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

The Local Case for Change:

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

Our Approach:

Years 1-2

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

Years 3-5

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

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

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

Timeline

2014/2015

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

2015/2016

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

2016/2017

- Review education for both patients and health care professionals

2017/2018

- Implementation of remodelled services.
- Evaluation and Review

2018/2019

- Implementation of remodelled services.
- Evaluation and Review

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

Improving the coordination of Long Term Condition management

Denotes characteristics impacted

Citizen Empowerment and Engagement

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

Integrated Care

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

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

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

Variation in diabetic care between practices will be reduced.

High Quality Urgent Care

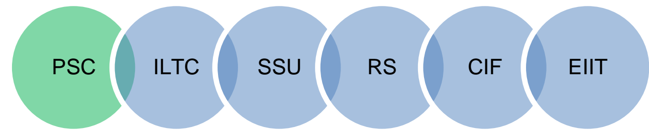
People with diabetic foot complications will receive rapid access (within 24 hours) to multi-disciplinary foot clinics

Productive Elective Care

N/A

Specialist Services Concentrated in Centres of Excellence

N/A



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

High level description of the priority area:

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

Rationale for Inclusion:

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

The Local Case for Change:

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

Our Approach:

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

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

Timeline

2014/2015

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

2015/2016

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

2016/2017

- Embed new MIU arrangements

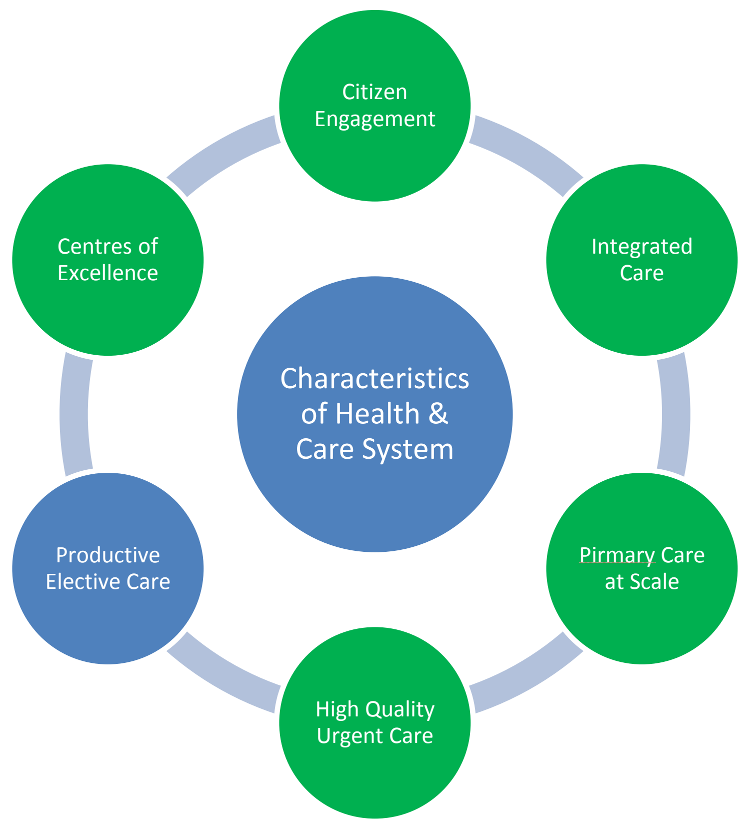
2017/2018

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

2018/2019

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

Stable and Sustainable Urgent Care



Denotes characteristics impacted

Citizen Empowerment and Engagement

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

Integrated Care

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

Primary Care Delivered at Scale

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

High Quality Urgent Care

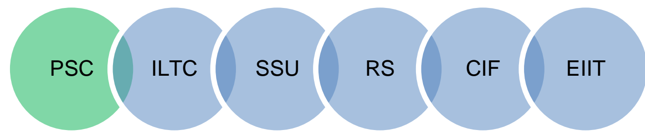
A streamlined urgent care system will reduce patient hand offs minimising clinical risk and deliver efficiencies to reinvest in other services.

Productive Elective Care

N/A

Specialist Services Concentrated in Centres of Excellence

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



Redesigning Musculo-skeletal pathways to achieve clinically effective services

High level description of the priority area:

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

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

Rationale for Inclusion:

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

The Local Case for Change:

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

Our Approach:

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

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

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

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

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

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

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

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

Timeline

2014/2015

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

2015/2016

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

2016/2017

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

2017/2018

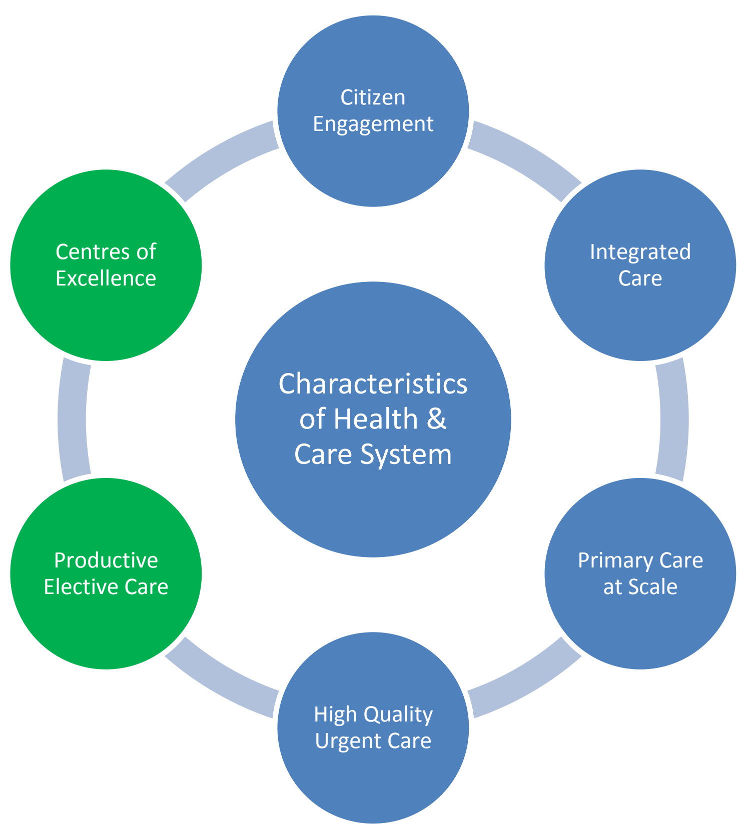
- Review a range of Orthopaedics pathways in line with best practice.

2018/2019

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

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

Redesigning Musculo-skeletal pathways to achieve clinically effective services



Denotes characteristics impacted

Citizen Empowerment and Engagement

Integrated Care

Primary Care Delivered at Scale

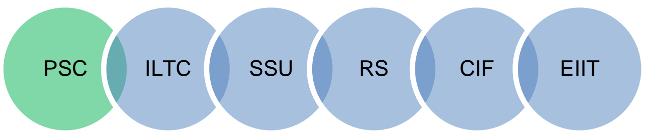
High Quality Urgent Care

Productive Elective Care

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

Specialist Services Concentrated in Centres of Excellence

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



Commissioning integrated safe, compassionate pathways for frail older people

High level description of the priority area:

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

Rationale for Inclusion:

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

The Local Case for Change:

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

Our Approach:

Years 1 - 2

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

Years 3-5

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

i. implementations of the House of Care approach,

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

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

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

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

Timeline

2014/2015

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

2015/2016

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

2016/2017

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

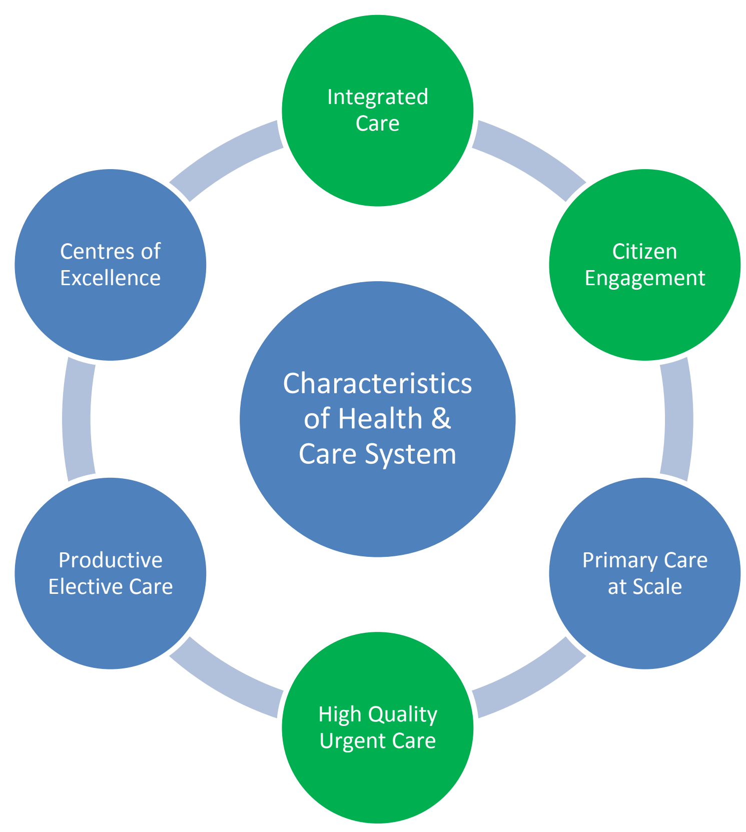
2017/2018

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

2018/2019

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

Commissioning integrated safe, compassionate pathways for frail older people



Denotes characteristics impacted

Citizen Empowerment and Engagement

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

Integrated Care

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

Primary Care Delivered at Scale

High Quality Urgent Care

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

Productive Elective Care

Specialist Services Concentrated in Centres of Excellence

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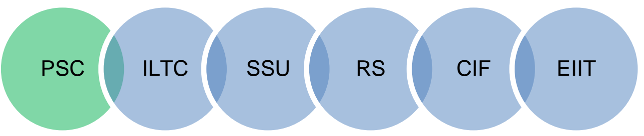


Ensuring the interoperability of IT systems across the health and care system

High level description of the priority area:

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

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

Rationale for Inclusion:

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

The Local Case for Change:

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

Our Approach:

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

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

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

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

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

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

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

Timeline

2014/2015

- Establish Governance & Project Team
- Appraise technical options & existing solutions

2015/2016

- Develop a shared vision for the health system and the IM&T strategy to support it
- Identify resource requirements and potential funding sources

2016/2017

- Establish scope of systems to support integrated care planning
- Develop consent model
- Development of Business Cases

2017/2018

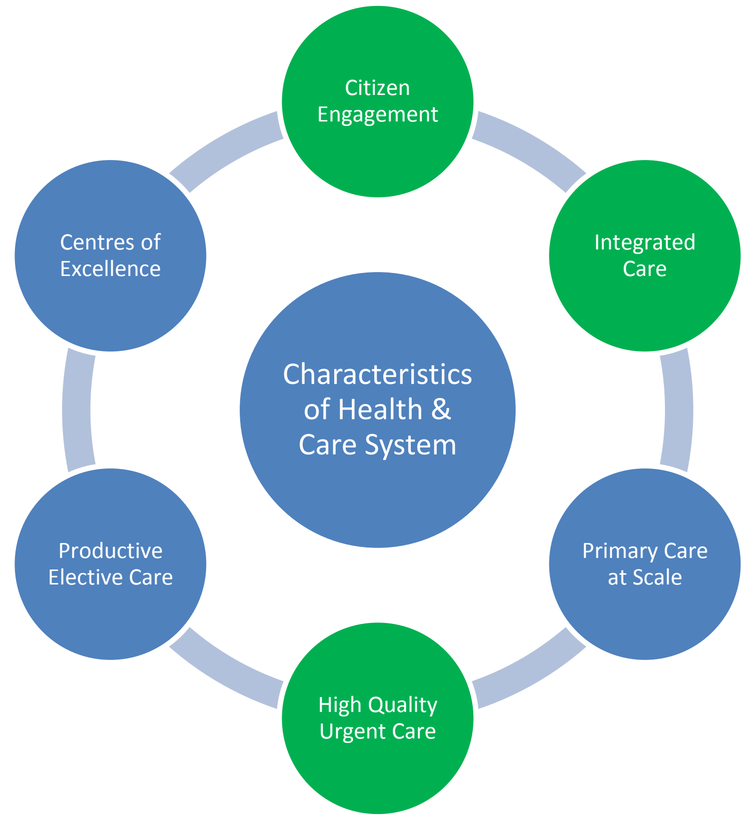
- Procurement of IT solution
- Develop new ways of working supported by IT solution
- Implementation of first wave

2018/2019

- Complete roll out of interoperability solutions
- Review of implementation

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

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



Denotes characteristics impacted

Citizen Empowerment and Engagement

Patient access to their own records

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

Integrated Care

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

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

Primary Care Delivered at Scale

High Quality Urgent Care

Decisions in urgent care made with access to more clinical information

Productive Elective Care

Specialist Services Concentrated in Centres of Excellence

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Anticipated impact of priority work programmes

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

Anticipated impact of priority work programmes - Key

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

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

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

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

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

Our local ambitions for the 7 Outcome Ambitions

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

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

Ensuring Financial Sustainability

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

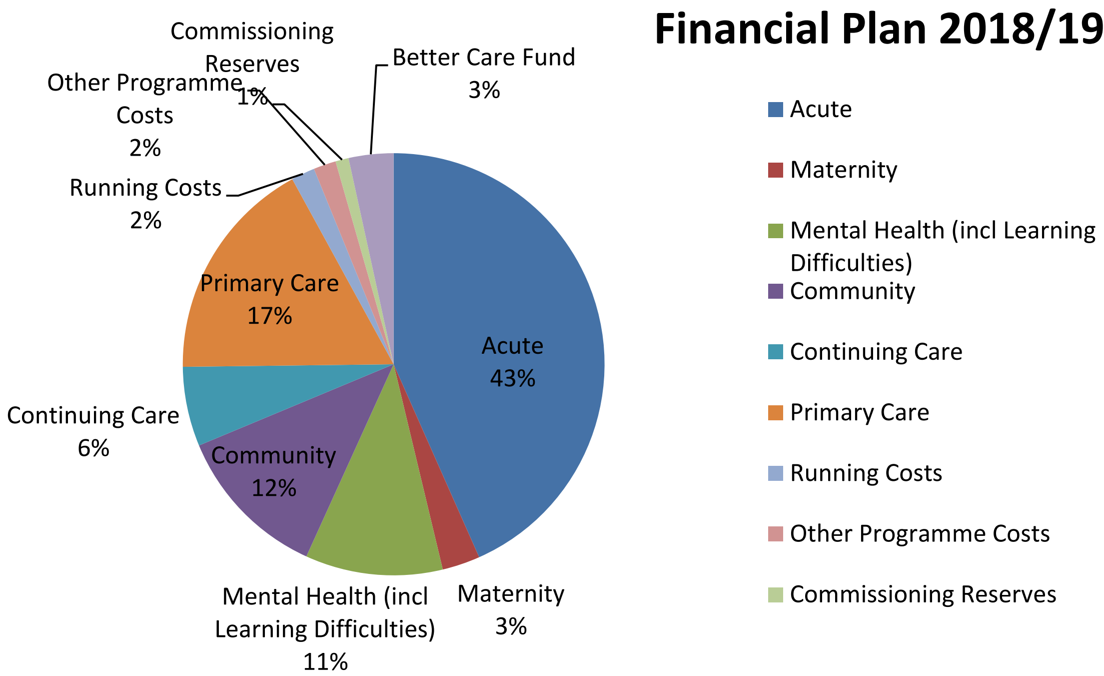
All providers who deliver good quality services which represent value for money will be able to thrive because they are fairly rewarded for their contribution to the health economy and they have the opportunity to work in partnership to share risks and gains and to drive beneficial change. For elective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

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

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

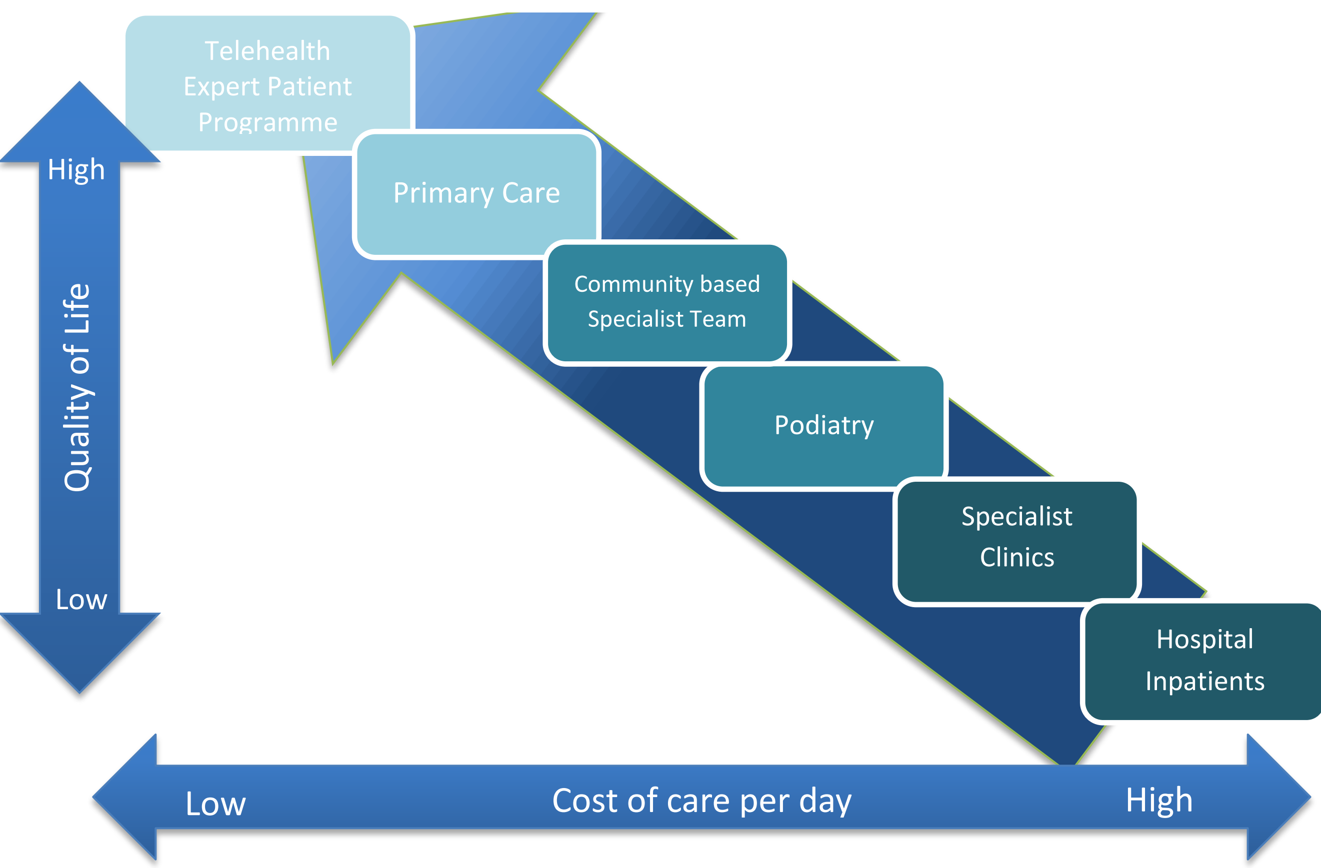
We will be spending more of our resources on community and primary care based services for both mental and physical health care, and seeing more people within these settings. We expect that the smaller number of people treated in hospital settings will have a higher unit cost of treatment than currently,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

Figure 19: Financial Plan 2018/19



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

Figure 20: Shifting Resources – LTC (Diabetes)



The impact of our plans on patients

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

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

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

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

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

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

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

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

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

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

Urgent Care System

(The name of the patient has been changed)

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

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

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

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

PART C

Making Change Happen

Chapter 7 - How we will commission services

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

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

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

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

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

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

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

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

Chapter 8 – Our Financial Plan

The Context

The existing financial position of the CCG is characterised by:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The key elements of our strategy to deliver this are:

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

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

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

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

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

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

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

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

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

Financial Plan Forecasts

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

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

Table 9: Income and Expenditure Position

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

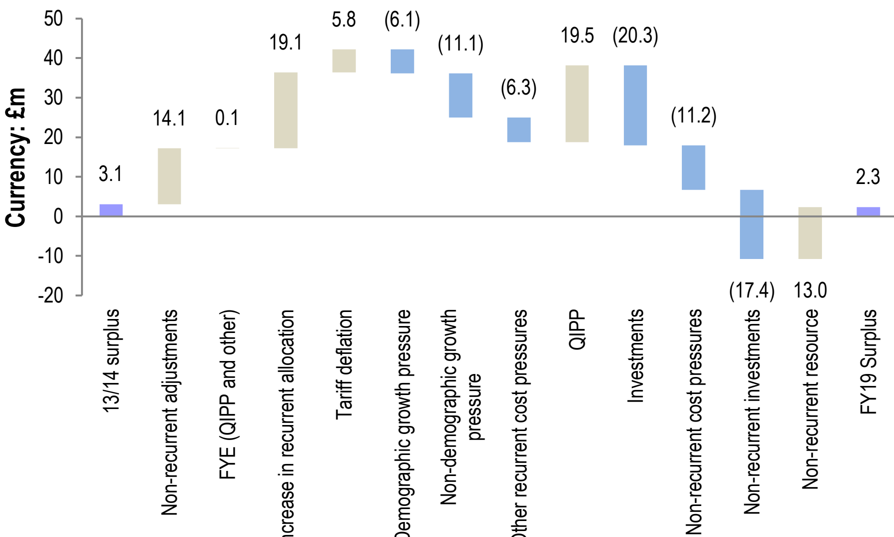
Better Care Fund: CCG contribution to establish the Fund at a value of £12.0m in line with the published allocation requirement.

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

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

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

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



QIPP

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

We have developed delivery plans to release resources to this level which align with our vision for the future shape of services. A summary of the plans identified to date, the remaining gap, and of provider efficiency requirements showing the total savings challenge for the health community, is presented in the table below. Whilst provider efficiency requirements will be delivered through internal cost improvement initiatives, it is essential to ensure that these are understood alongside commissioner QIPP plans.

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

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

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

Investments

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

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

Table 11: Recurrent Investments

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

Table 12: Non-Recurrent Investments

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

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

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

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

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

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

Better Care Fund

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

Capital Expenditure

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

Balance Sheet and Cashflow

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

Financial Risk and Mitigation

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

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

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

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

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

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

Sensitivity Analysis

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

The key planning assumptions flexed for this analysis are:

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

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

Current summary

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

5 year plan modelled with CHC to 3.5%

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

5 year plan modlled with prescribing to 5.5%

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

5 year plan modelled with demographic growth increase by 25%

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

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

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

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

All factors above

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

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

Mitigations:

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

Chapter 9 – The Better Care Fund

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

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

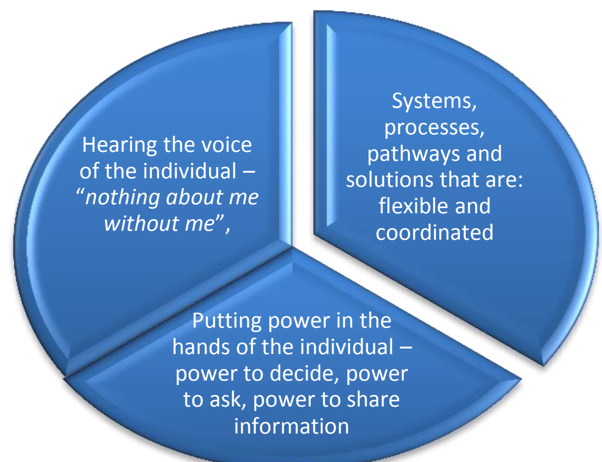
We see daily the benefit of close working between health, social care and third sector partners and we know from our experience the energy required to maintain an integrated approach to care. Our focus for the future is on further alignment of resources that influence the wider determinants of health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

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

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

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

Key elements of this transformation are:



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

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

Impact of the Better Care Fund

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

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

7 Day Working

Protection of Adult Social Care Services

Integrated Reablement & Hospital Discharge

Admission Avoidance

Early Intervention & Prevention

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

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

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

Chapter 10 – Enabling Plans

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

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

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

Quality

Quality in Everything We Do

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

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

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

The Current System

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

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

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

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

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

The Patients' Experience

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

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

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

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

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

The Quality Committee

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

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

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

Improving Outcomes

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

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

Data sources available to us include:

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

Safeguarding Vulnerable Children, Young people and Adults

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

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

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

Children and Young People Safeguarding

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

Adult Safeguarding

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

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

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

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

Key Safeguarding Priorities

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

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

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

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

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

Research within providers

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

Academic Health and Science Networks (AHSNs)

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

NHS Health Education South West Clinical Academic Training Programme

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

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

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

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

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

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

Organisational Development & Workforce

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

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

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

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

Table 13: OD Process

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

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

Workforce Planning

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

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

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

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

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

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

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

Developing our CCG Workforce

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

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

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

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

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

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

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

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

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

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

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

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

Developing the Provider workforce to deliver future models of healthcare

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

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

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

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

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

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

Structure of the CCG and Commissioning Support

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

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

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

Table 14: Provision of Commissioning Support

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

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

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

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

Estates

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

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

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

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

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

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

IMT Infrastructure

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

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

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

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

Chapter 11 – Managing Risk

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

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

- Delivery
- Financial
- Patient Experience and Outcomes
- Communications

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

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

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

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

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

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

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

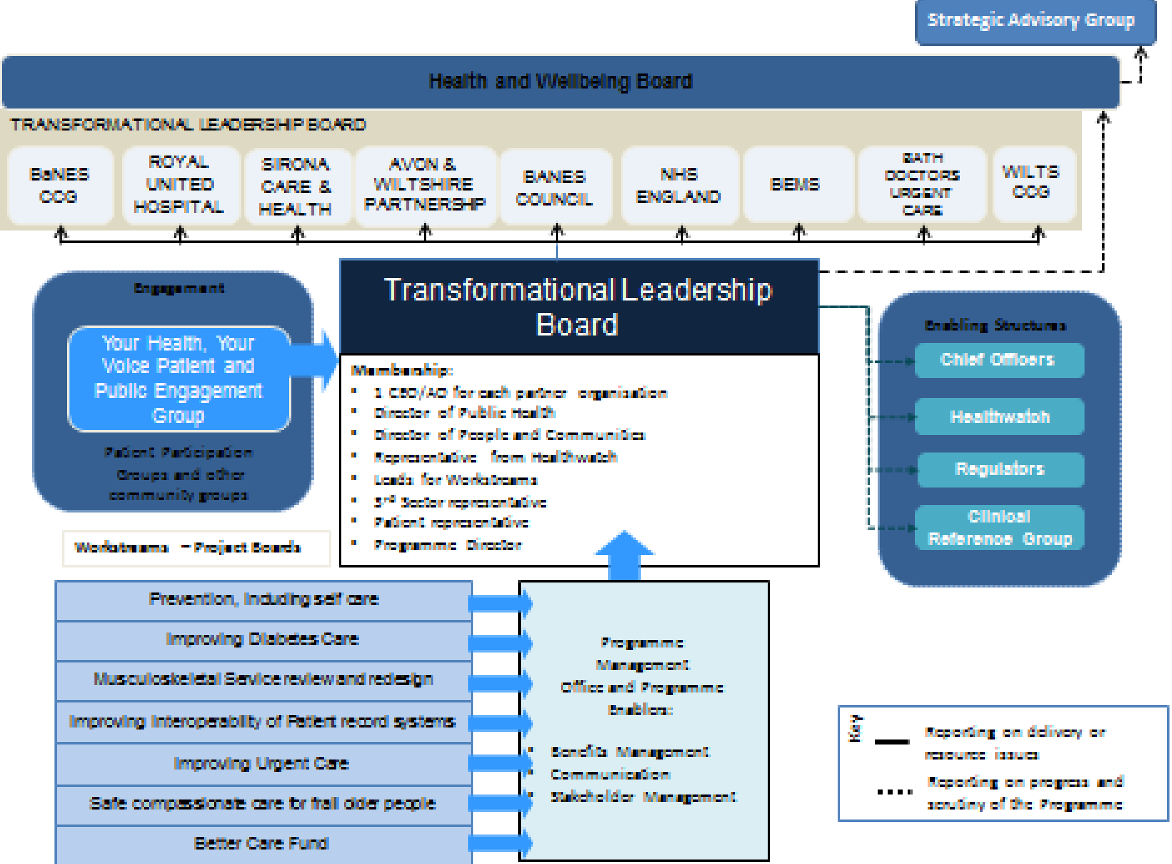
Chapter 12 – Governance and Delivery Plans

Governance

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

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

Figure 22: Governance Structure



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

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

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

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

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

Delivery Plans

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

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

We envisage that our implementation plans will include the following:

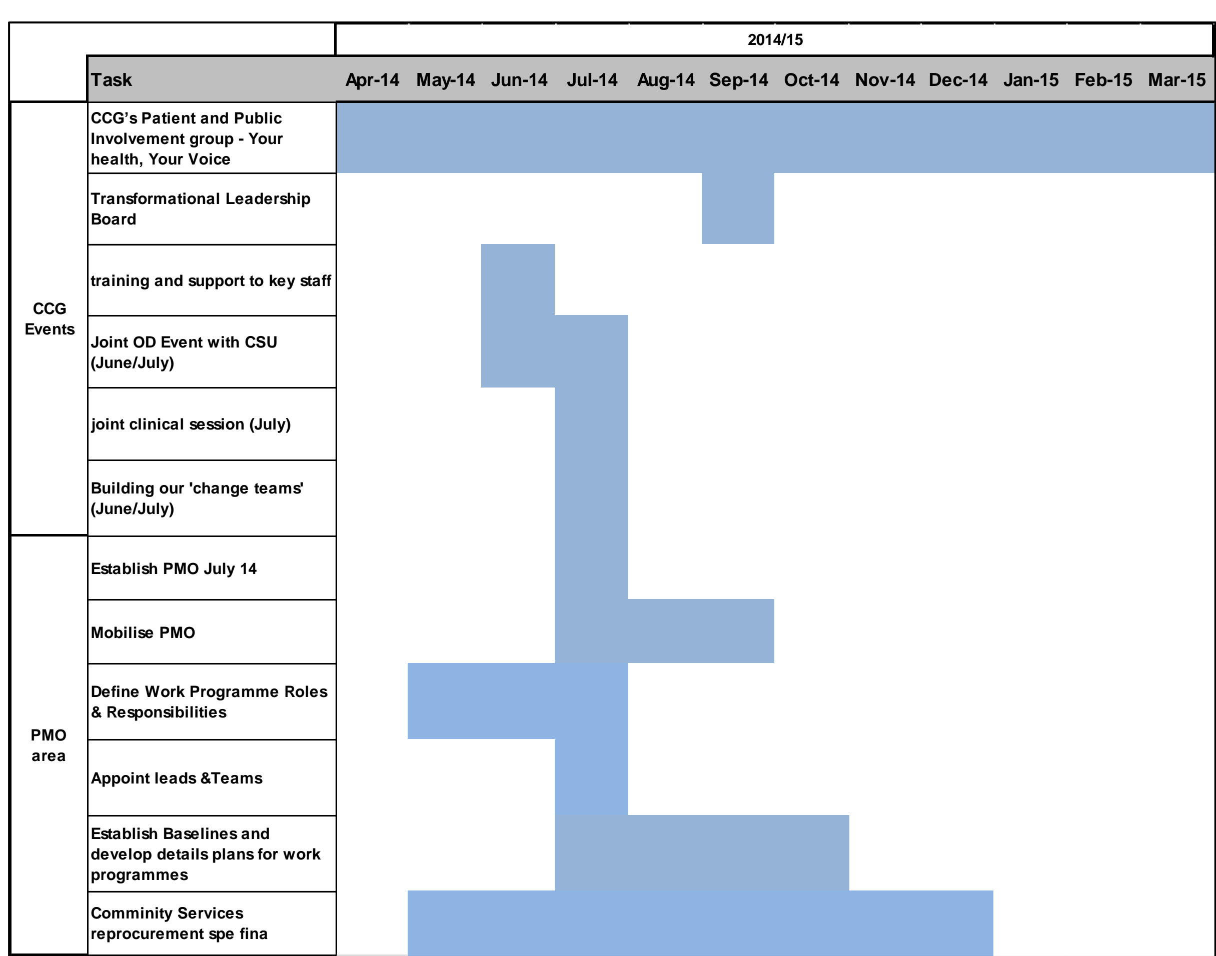
- Clear articulation of individual delivery roles and responsibilities
- Description of which stakeholders are engaged with each project and to what degree
- Delivery accountability mechanisms
- Reporting mechanisms including monitoring of progress, risks and issues
- Detailed delivery plans which include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

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

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

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

Figure 23: Key steps for implementation plan



Chapter 13 – Communication and Engagement Plan

Citizen Participation & Empowerment

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

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

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

Our Approach to Encouraging Citizen Participation

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

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

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

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

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

As a result this will:

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

Participants will be able to:

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

The benefits to the CCG mean that we will:

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

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Glossary and Abbreviations

Acute Providers / Care

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

ADHD

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

AQP Any Qualified Provider

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

Authorised

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

AWP

Avon & Wiltshire Mental Health Trust.

BaNES

Bath and North East Summerset

Berwick Report

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

BGSW

Bath, Gloucestershire, Swindon and Wiltshire.

CAMHs

Child and Adolescent Mental Health Services.

CCG

Clinical Commissioning Group

Census Estimates

Population estimates provided the Office of National Statistics.

CHD

Coronary Heart Disease.

CIC

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

CMT Community Mental Health Team

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

COF Commissioning Outcomes Framework

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

Commissioners

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

Commissioning for Value Packs

Comprehensive data packs to support CCGs in their commissioning activities.

Community Interest Company (CIC)

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

Community Providers

Organisations who provide services within the communities they serve.

COPD

Chronic obstructive pulmonary disease.

Council Health and Well Being Board

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

CQC

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

CQOG Clinical Quality and Outcomes Group

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

CQUIN

Commissioning for Quality and Innovation

CQUIN

Commissioning for Quality and Innovation.

CSI Commission for Social Care Inspection

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

CSU Commissioning Support Units

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

Elective Care

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

EoLC

End of Life Care

EPP

Expert Patient Programme.

Established

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

Everyone Counts: : Planning for. Patients

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

Exception Reporting Rates

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

FOI

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

Foundation Trust

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

Francis Report

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

Friends and Family Test

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

Health and Wellbeing Board

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

Health Inequalities

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

HealthWatch

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

HWB Health & Wellbeing Board

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

Integrate

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

ISTC Independent Sector Treatment Centre

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

IT / ICT - Information Technology

Computers and associated communications technology

JSNA

Joint Strategic Needs Assessment.

JSNA Joint Strategic Needs Assessment

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

KPI Key Performance Indicator

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

KPIs

Key Performance Indicators.

LA

Local Authority / Unitery Authority / Local Council

LD

Learning Disabilities.

Length of Stay

Period that a person is in hospital

Lower Super Output Area

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

LRTI

Lower respiratory tract infection.

LTC Long Term Conditions

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

Managing Successful Programmes (MSP)

A Government Framework and Standards for Managing Successful Programmes.

MH

Mental Health

MIU

Minor Injuries Unit.

Monitor

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

Morbidity

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

Mortality

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

Mortality rate

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

Multi-disciplinary Team

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

NBT

North Bristol Trust.

NHS Constitution

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

NHS England

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

NHS Health Check

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

NICE National Institute for Clinical Excellence

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

Nursing Home LES

Local Enhanced Health Care services provided in Nursing Homes.

Obese

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

OD Organisational Development

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

ONS

Office for National Statistics.

Operating Framework

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

Outlier Population

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

Outpatient

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

Overview and Scrutiny Committee

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

Package of Care

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

PALS Patient Advice and Liaison Service

A free service to support and signpost patients.

Patient Pathway or Journey

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

PbR Cost

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

PPE

Patient, Public Engagement

Prevalence

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

Prevalence

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

Primary Care

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

Primary Providers

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

Programme Management Office (PMO)

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

PROMs

Patient Reported Outcome Measures

Provider and Commissioner Resource Utilisation Gains

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

Provider Landscape

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

Public Health

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

QOF Quality and Outcomes Framework

The QOF is a voluntary incentive scheme that rewards GP practices for implementing systematic improvements in quality of care for patients, based on their performance against indicators. The QOF is part of the General Medical Services Contract

Quality Premium

This will be an element of income which is linked to the performance of the CCG. It is proposed that the quality premium will be paid to the CCG from the NHSCB if it performs well. The Health and social care Act 2012 now states that Regulations may prescribe how any payment made to a CCG in respect of quality may be spent, including the distribution amongst the CCG's

Quintiles

A statistical value of a data set that represents 20% of a given population. The first quartile represents the lowest fifth of the data (1-20%); the second quartile represents the second fifth (21% - 40%) etc.

QUIPP Quality, Innovation Productivity and Prevention

Quality, Innovation Productivity and Prevention (QUIPP) is the response to the challenge of improving the quality of care the NHS delivers, whilst at the same time making these savings

Rate

The number of observed events per total number in whom this event might occur over a specified time period, often expressed as per 1,00 or per100,00 (persons, male, female, children etc.)

Red Performance Recovery Plan

A plan that is agreed with a provider where their performance is below the national or local minimum threshold.

Registered Population

Is the population registered with a general practice constituent practice of a CCG.

RHU

Royal United Hospital (Bath)

RNHRD

Royal National Hospital for Rheumatic Diseases NHS Foundation Trust

RNHRD Royal National Hospital for Rheumatic Diseases

Specialist NHS Hospital (Foundation Trust)

RTT

Referral to Treatment Time

RTT Referral to Treatment

The period of time to the start of specialist treatment.

RUH Royal United Hospital NHS Trust

Local acute hospital in Bath, serving BANES and parts of Somerset and Wiltshire

Secondary Care

Hospital or specialist care that a patient is referred to by their GP or other primary care provider

Secondry Health Care

Usually refers to hospital treatment but increasingly secondry care is provided in a variety of community based settings including a patient's home.

SEND

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

Service Level Agreement (SLA).

A service level agreement is a negotiated agreement between two parties. It is not commonly legally binding although it may form part of a formal contract. SLAs would commonly include definition of services, performance measurement, problem management and termination agreement.

Sirona

Sirona Care and Health Community Interest Company (CIC) is an independent organisation providing publicly-funded health and social care services.

SMART

Specific – target a specific area for improvement, Measurable – quantify or at least suggest an indicator of progress, Assignable – specify who will do it, Realistic – state what results can realistically be achieved, given available resources and Time-related – specify when the result(s) can be achieved.

Socio-economic inequality

The gap between the top and bottom of a rating of the socio economic characteristics of a population within an area that lead to differences in health outcomes.

SWASFT

South West Ambulance Services Foundation Trust

Top Decile

The top 10% of a measure.

Transformational Leadership Board (TLB)

A BaNES sub-group of the Health and Wellbeing Board that oversees the implementation of the this 5 year Strategic Plan.

UHB

University Hospitals Bristol

Unify Templates

Planning Template as part of their formal planning submission to NHS England.

Unitary Authority

A unitary authority is a type of local authority that has a single tier and is responsible for all local government functions within its area or performs additional functions which elsewhere in the relevant country are usually performed by national government or a higher level of sub-national government.

Urgent Care

Urgent care offers treatment wher the patient is unable to be seen by their General Practitioner of Practice Nurse where the need for treatment has not been viewed as an "emergency", for example wher not receiving treatment at an emergency centre is not life threatening but.

Winterbourne View

Winterbourne View was a private hospital in South Gloucestershire where abuse occurred to people with learning disabilities and challenging behaviour.

APPENDICES

Appendix 1 – 2 Year Operational Plan
Appendix 2 – National Quality and Safety Measures
Appendix 3 – Equality Impact Assessment