Bath and North East Somerset Clinical Commissioning Group "Operational Plan on a Page" 2014 – 2016

Appendix 1

OUR VISION AND MISSION

Healthier, Stronger, Together

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

SERVICE PLANS

Urgent Care:
- Embed the new integrated urgent care centre and out-of-hours services model
- Review the role of the minor injury unit in light of the new service model and NHS 111
- Complete the DVT procurement and ensure new service is mobilised by September
- Explore opportunities to develop ambulatory care pathways that work across primary and secondary care
- Evaluate the impact of the 2013/14 winter pressure initiatives with a view to commissioning on a substantive basis to create additional capacity in the system
- Commence the vulnerable adults out-reach worker service as a two year pilot
- Ensure the on-going development of the urgent care system is integral to the development of out of hospital services to support the frail elderly and people with long term conditions to ensure pathways are joined up

Mental Health:
- Review and improve rehabilitation pathways of care
- Further integrate primary/ community services e.g. talking therapies & primary care liaison
- Scope options for improvement of acute mental health inpatient environment
- Implement Wellbeing College pilot alongside independent evaluation
- Move towards parity of esteem in all services, ensuring equal focus on improving mental health as physical health & patients with mental health problems do not suffer inequalities

Primary Care:
- Complete a review of local enhanced services to ensure they are "fit for purpose".
- Continue process of quality review of primary care in conjunction with NHS England and support practices to reduce variation
- Develop a local Primary Care Strategy
- Bed in new relationships with LMC and provider organisations
- Work with NHS England to make emerging Local Professional Networks a success with primary care contractors

Children's Services:
- Work to reduce paediatric non-urgent appointments (planned care)
- Ensure health visitors, school nurses, CAMHS in-patient bed provision meet local needs
- Work with education & social care to implement the Special Education Needs and Disability (SEND) Reforms for children and young people aged 0-25.
- Improve diagnostic pathway & support services for children/ young people with Autistic Spectrum Conditions
- Pilot on-line YP counselling service part of support package around emotional H & WB
- Ensure that all commissioned services adhere to local safeguarding standards
- Consider a new model for children's general community nursing service
- Develop strengthened strategies in health and in partnership for helping children and families cope with transition and change

Medicines Optimisation
- Improve quality of Clinical Medicines Reviews for our most vulnerable
- Continue work on getting best value from CCG commissioned high cost drugs
- Improve appropriate utilisation of antibiotics in our health system
- Roll out Electronic Prescription Service successfully across health community
- Maximise the benefits of Medicines Optimisation Services in Community Pharmacy

Long Term Conditions & Frail Older Person:
- Embed community cluster model, active ageing service & redesigned adult social care pathway
- Work with primary care to continue to improve dementia diagnosis rates
- Evaluate impact of dementia challenge fund initiatives with view to commission long-term
- Establish diabetes working group, design new pathway and agree requirements to meet the needs of the growing number of people with diabetes
- Review the falls and bone health pathway in light of the roll out of the active ageing service
- Develop clinical model for IMPACT (community COPD service) to support patients with non-cystic fibrosis bronchiectasis in the community in conjunction with Sirona and RUH
- Implement the NHS England model 'Safe compassionate care for frail older people using an integrated care pathway'

End of Life Care:
- Electronic Palliative Care Coordination System (EPaCCS) is embedded across all organisations to ensure patients are managed appropriately
- Ensure all end of life patients have advanced care plans in place and do not attempt pulmonary resuscitation (DNAR) orders in place

Planned Care:
- Develop proposals for an integrated MSK service, to include pain management and a community model for Rheumatology in conjunction with current providers.
- Jointly review Ophthalmology services with the RUH and Wiltshire CCG.
- Work with the newly appointed Macmillan GP to develop shared care and primary care support for cancer patients. This will focus on early diagnosis and cancer survivorship following treatment.
- Set up a Referral Support Service across BaNES. This will be supported by Map of Medicine which will be fully implemented across all GP practices during 2014/15.
- Review the provision of physiotherapy services across BaNES and then develop a service specification in preparation for the re-tendering of the community services contract.

Maternity and New Born:
- Work with providers and Wiltshire CCG as lead commissioner to embed the newly procured maternity service
- Work with providers, GPs & health visitors to agree and implement pathways ensuring close communication
- Review ambulance transfers and transfers from community centres to hospital care

Learning Disabilities
- Primary Care to continue to offer annual health checks to adults with LD (+ LD nurses)
- Improve access to screening and reducing health inequalities
- Embed commissioning and service delivery of LD mental health services into mainstream contracting with AWP.
- CCG to maintain joint commissioning arrangements with LA as lead commissioner, utilising pooled budget
- Ensure that recommendations arising from Winterbourne View serious case review are implemented locally with clear actions and lead responsibilities
- Develop local response in relation to the findings of the Confidential Inquiry into Premature Deaths of people with learning disabilities

QUALITY OBJECTIVES

Quality objectives - We Will:
- Adopt a patient-centred approach that includes treating patients, families and carers courteously and with compassion, involving them, keeping them informed and learning from them
- Foster a culture of continuous improvement and innovation with respect to patient safety, clinical effectiveness and patient experience
- Work collaboratively with our local providers to ensure that staff are delivering high quality, safe , compassionate care for all with increasing focus on frail older people
- Ensure that both patient and staff satisfaction with local services is monitored and that areas for improvement are identified and implemented at the earliest opportunity
- Ensure there is consistent access to effective treatments for patients in line with evidence based clinical policies, underpinned by clinical practice audit.
- Ensure our research, evaluation and development programmes contribute to improving outcomes and spreading innovation
- Ensure that equality, diversity and human rights values underpin and are central to our policy making, service planning, employment practices and community engagement and involvement
- Continue to establish effective early warning systems to ensure detection and prevention of serious failures and harm
- Establish a positive, open and fair and lifelong learning culture and ensure that staff are properly inducted, trained and motivated
- Ensure the principles and values of the NHS Constitution and NHS Mandate are integral to everything we do by providing safe care & ensure people experience better care

Safety outcomes:
- Reduce incidence of VTE
- Reduce incidence of community wide pressure ulcers in BANES
- Reduce the number of bed days occupied as a result of avoidable infection
- Improve quality of safeguarding practice by ensuring lessons learned and actions agreed as a result of safeguarding interventions are implemented by agreed timescales

Effectiveness outcomes:
- Reduce emergency admissions within 30 days of discharge
- Increase number of social care providers who have completed a satisfactory Quality Assurance process
- Improve the outcomes for people using mental health and LD services
- Implementation of new QOF and impact on referral management
- Implement vascular health checks programme
- Maximise functional recovery in hospital for elderly care patients
- Improve outcome on Friends and Family Test (FFT) including staff survey

Patient/ service user/ carer experience outcomes:
- Improve patient experience to top quartile and maintain high performance
- Improvement in social care users experience of our services and related quality of life
- Increasing the number of people who die in the place of their choice
- Improving the quality of life for people with long term conditions

PREVENTION & SELF CARE

- Analyse key health problems
- Develop self-care strategy
- Create health inequalities framework
- Identify current and new high impact programmes
- Identify appropriate outcome and process metrics
- Commission agreed priority programmes – mix of primary & secondary prevention

ENABLERS

- Citizen participation and empowerment
- Interoperability – integration of information systems
- Organisational Development Plan
- Integrated care – e.g. *House of Care*
- Personal Health Budgets
- Primary Care Development including referral support for General Practice
- Commissioning Support
- Contractual levers including incentivising innovation, improvement and integration