South Devon and Torbay
Clinical Commissioning Group

South Devon and Torbay Clinical Commissioning Group Plan 2012/13 and beyond

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Foreword

This Plan sets out the priorities and outcomes the South Devon and Torbay Clinical Commissioning Group (CCG) will be working with partners to achieve in the coming years.

2012/13 will be the final year of transition before the new commissioning structures are in place. It will be a critical year in which a strong focus on quality improvement and financial stability will need to be maintained, whilst preparations are completed to ensure the commissioning reforms are effectively put in place.

We know that next year will be demanding. The quality and productivity challenge moves into its second year and the requirement for us to meet our financial efficiency commitments continues, but significant progress has already been made and we are confident that the relationships we have built and the plans we are developing will allow us to make further steps towards delivering improved health and healthcare for the people of Devon.

Looking at the national reform agenda, it will be an important year for CCGs who will be supported by the Cluster to take on further responsibilities as they work in shadow form and move towards authorisation. The transition of Public Health functions and those to be directly managed by the new NHS Commissioning Board will need to be completed whilst ensuring organisational memory and knowledge is not lost. The development of effective commissioning support functions with CCGs will also be a key priority.

To be the best clinical commissioners there must be a focus on patients and populations, and CCGs must ensure that the services they commission represent value for money and offer the best outcomes for patients. The CCG will take responsibility for using commissioning budgets to improve the quality of healthcare, to benefit the whole population.

Involving patients and the public to improve key commissioning decisions around services will be very important and will be supported by the national reforms which will help to devolve decision-making to patients and clinicians, with Health and Wellbeing Boards providing local leadership to deliver quality improvements. Commissioning groups need to make best use of the experience of patients in respect of the care they receive. It is also important to ensure that collective public involvement is part of the work of commissioning groups to ensure that the right care is commissioned for the local population.

Partnership working with local authorities, providers of health services and other partner organisations will be vital in ensuring plans are aligned and further progress is made in providing integrated care between services. Working with partners we will look to promote innovation and ensure there is a continued high level of services offered to patients.

In summary, the CCG through its previous PCT's has a strong track record of delivery and in 2011/12 has made good progress in improving quality of services, meeting financial and performance targets (including waiting times), and working with GPs and partners to prepare for reform of commissioning structures. 2012/13 will be a challenging year but the CCG is in a strong position to effectively deliver its priorities. The dedication and professionalism of staff will be key in ensuring the CCG continues to ensure high quality, cost effective services are delivered consistently to patients during a time of significant structural change.

Within South Devon and Torbay we have a vision of a clinically integrated system, building on the successes that we have seen through our Clinical Pathway Groups and our integrated health and social care teams as well as joint commissioning arrangements We believe that seamless care pathways and packages will deliver higher quality patient care, in a more cost effective manner.

1. Overview

The Plan for the CCG sets out local priorities and reflects the four national themes identified by the Department of Health:

- Putting patients at the centre of decision making;
- Completing the last year of transition to the new NHS system;
- Increasing the pace of delivery of the quality, innovation, productivity and prevention (QIPP) challenge;
- Maintaining a strong grip on service and financial performance.

This plan structure is influenced by the transitional nature of 2012/13, with a clear commitment from the CCG to deliver the national quality, financial and reform requirements, but underpinned with a real emphasis on local clinically-led plans and priorities.

This plan sets out the priorities for the South Devon & Torbay CCG. The plan includes our vision for services and outlines the main areas of service change which will deliver high quality, efficient services.

In Torbay and South Devon there is a history of successful collaboration and innovation. The QIPP plans are built upon a sound clinical engagement model through clinical pathway groups, strategic groups such as elective redesign and the system wide leadership of the clinical cabinet/ transforming patient care.

The collective vision for the South Devon health system is one of clinical integration allowing patients to flow through evidence based standardised pathways with minimal organisational barriers.

The priorities for the CCG include:

- Developing a greater range of more integrated services in community settings designed around the needs of individuals. Where it is clinically appropriate to see as many services as possible transferred from the acute hospital environment closer to people's homes;
- Securing greater investment in upstream interventions that keep people healthy for longer, prevent ill-health and reduce health inequalities;
- Driving continuous quality improvement and innovation across the whole system, securing better value for money in the process;
- A clear focus on measurably improving patient outcomes and experience;
- Delivery of reform milestones;
- Commissioning high quality services within available resources;
- Strengthen and develop further joint commissioning arrangements with partners
- Supporting GP Practices whilst we take on commissioning responsibilities;
- Supporting staff through transition.

An overview of this year's plan can be seen at Appendix A – 'Plan on a Page'.

2. Local context

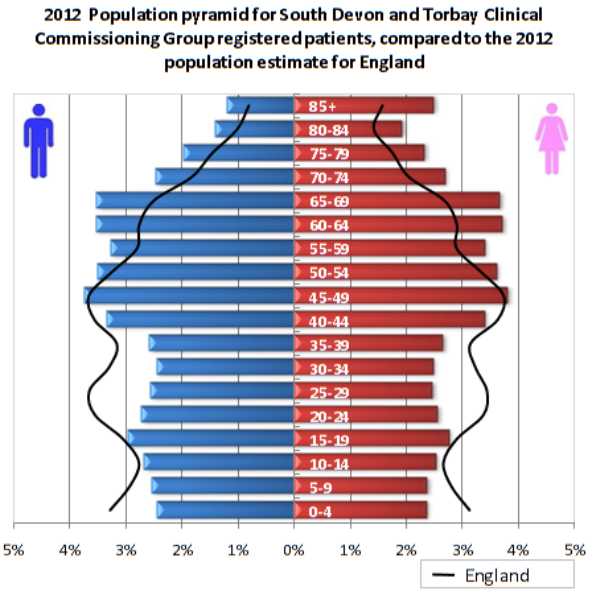
The South Devon and Torbay Clinical Commissioning Group (CCG) extends from the South Devon Coastline to the open moorland of Dartmoor. The CCG covers some 310 sq. miles and takes in a GP registered population of around 284,500.

This picturesque area proves a popular retirement destination, with a noticeably higher proportion of older people resident in the area (shown in the population pyramid). Having an older population brings challenges for the CCG around health and social care. These challenges include the management of long term conditions, injuries as a result of trips and falls and treatment of age related diseases, as well as balancing the health and social care needs of younger people.

South Devon and Torbay is also a popular tourist destination. With prominent tourist destinations such as Paignton Zoo, Kent's Cavern, Dartmoor and the sandy beaches attracting both day and longer staying visitors. In the peak of the summer, there are estimated to be up to around an extra 75,000 to 100,000 people potentially visiting attractions or holidaying within the area.

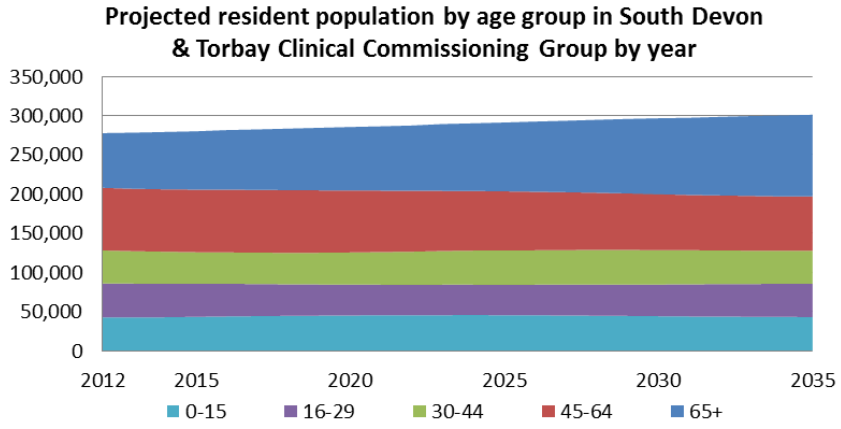
Population

The areas popularity as a retirement destination can be observed in the population pyramid. The current average age of the South Devon and Torbay population is around 44.2 years, compared to an England average of around 39.5 years.



There are estimated to be more people registered with a GP in the CCG area than live in the geographical footprint. The resident population living within the footprint of the CCG is estimated to be slightly lower than the registered population, at around 277,500. This resident population is projected to grow to around 290,000 by 2025, with around 30% aged 65 and over.

National population projections suggest the CCG area to grow by some 2.7%; this is a lot lower than the forecasted national growth of 6.7%. The population projections do not necessarily take account of local growth points within the CCG area, such as the Heart of Teignbridge which proposes significant developments in the Kingsteignton / Kingskerswell and Newton Abbot areas.



Currently, around a quarter (25%) of the population of South Devon and Torbay are aged 65+, this compares to around 17% for England. It is estimated that the older person bias will continue and also increase over the coming years.

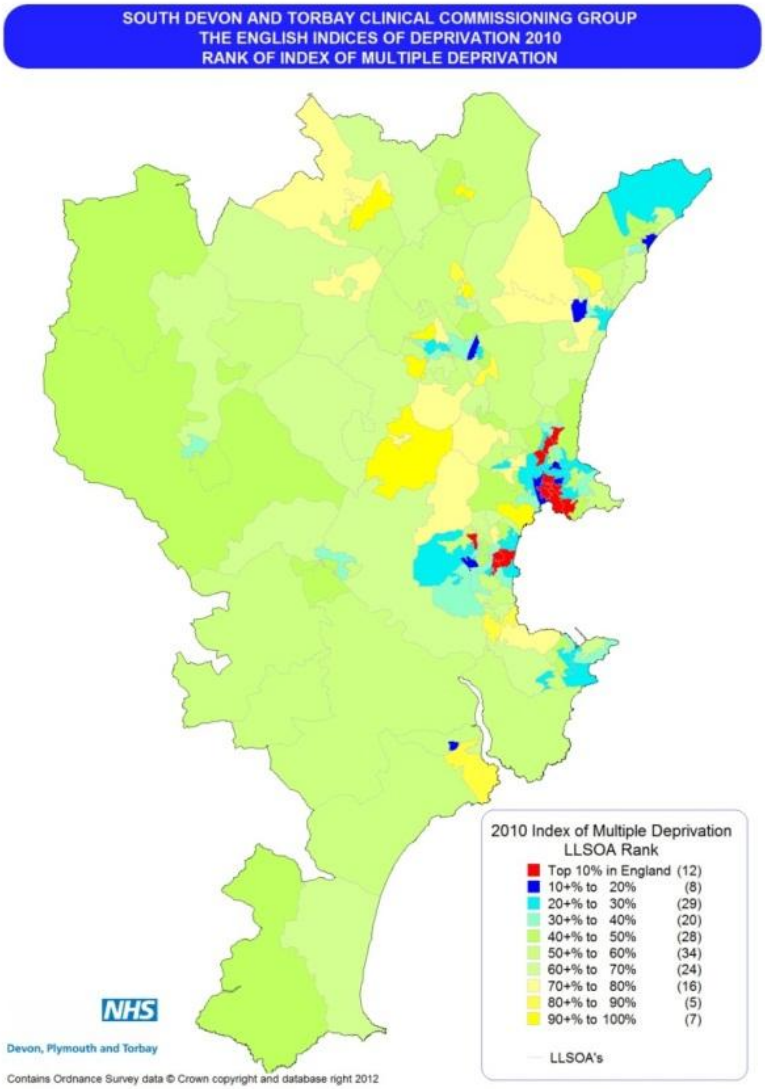
Population projections by age group and year in the CCG	2012	2015	2020
0 to 15 years	42,600	43,200	45,000
16 to 29 years	43,000	42,200	39,400
30 to 44 years	42,400	40,400	41,000
45 to 64 years	79,800	79,800	79,200
65 and over	69,800	74,400	80,900
All ages	277,500	280,000	285,000

Source: ONS 2010 Based, 2012 Sub National Population Projections. Distributed based on 2010 LSOA population. Numbers may not add due to rounding.

Deprivation

Within the South Devon and Torbay area, there are pockets of severe deprivation. These pockets are located mainly in the urban areas such as Paignton and Torquay. The residents living in these areas tend to experience noticeable inequalities; including lower life expectancy and higher rates of premature mortality. This, in part, is through higher prevalence of risk taking behaviours such as higher rates of alcohol related hospital admissions and higher smoking rates. Other inequalities including housing, employment and educational attainment also exist within these communities.

The areas in red in the following map are amongst the top 10% most deprived in England, areas in dark blue are within the 10+% to 20% most deprived in England. These areas are in stark contrast to the relative affluence shown in the yellow areas, which are amongst the least deprived in England.



Life Expectancy

Overall, life expectancy at birth is generally higher within the CCG area, with a large number of communities experience significantly higher life expectancy compared to the England average. However, there are pockets where life expectancy is significantly lower than the England average; these are communities within larger areas such as Newton Abbot, Paignton, Teignmouth and Torquay.

There is a well evidenced relationship between poorer communities, in terms of income, and poorer health outcomes such as life expectancy. People in our more deprived communities tend to die earlier than those in the least deprived; they also tend to live longer with poorer health, such as disabilities or morbidities.

Nationally, there is a gap of some 17 years in the more deprived communities between disability free life expectancy and life expectancy. Within the South Devon and Torbay CCG area, this is around 20 years for females. This suggests that females living in the most deprived communities live for around 20 years of their life with a disability. The gap is smaller, around 14 years, for those living in the least deprived communities in South Devon and Torbay.

Starting Well

Disadvantage starts before birth and accumulates throughout life. Giving every child the best start in life is crucial to reducing inequalities across the life course.

Child Hood Immunisations within the CCG area, such as MMR, are generally similar to national uptake. However, there are some communities such as Ashburton, Buckfastleigh and Totnes, where the level of immunisation is noticeably lower.

Smoking during pregnancy has been linked to increased risk of cot death, being born prematurely, having poorer lung function and having organs that are smaller than babies born to non-smoking mothers. Children born to mothers that smoke are also more likely to smoke themselves in later years.

Low breastfeeding rates contribute to health inequalities and breastfeeding is one of the indicators in monitoring progress towards Infant Mortality targets. Evidence shows that breastfeeding has both short and long-term health benefits by reducing the risk of infections such as gastroenteritis in infancy and could help to reduce the risk of obesity in later childhood.

Childhood and early adulthood are key periods in the development of personal resilience and educational and social skills that will provide the foundations for good mental health across the whole life course. There is increasing evidence that early intervention, prevention and the promotion of better mental health and wellbeing can have multiple benefits.

Developing Well

The accumulation of childhood experiences shapes the outcomes and choices made in adulthood.

Inequalities in the developing years, such as educational outcomes affect physical and mental health, as well as income, employment and quality of life.

Childhood obesity has been linked with poorer health outcomes for children, such as asthma, diabetes, psychological ill health and cardiovascular risk factors. There is also evidence to suggest that obesity in childhood extends to poorer health outcomes in adulthood. This is through persistence of obesity, cardiovascular risk factors and premature mortality. Levels of childhood obesity within the CCG area are not, generally, significantly different to the England average.

Rates of teenage pregnancy in parts of the CCG are amongst the highest regionally. There are noticeable variations across the area with the highest rates seen in the most deprived areas in Torquay, Paignton and Teignmouth. In addition, Termination rates continue to be some of the highest in the region particularly among Under 25 year olds.

Living and Working Well

Being in good employment is protective to health. Insecure and poor quality employment is associated with increased risks of poor physical and mental health.

Alcohol related admissions to hospital have been increasing in recent years. The overall trend suggests that they have been levelling off, however higher admission rates are noticeable in the more urban areas such as Newton Abbot, Paignton,

Teignmouth and Torquay.

There are rising numbers of diagnosed cases of malignant melanoma within the CCG. The rates of incidence of malignant melanoma are amongst the highest in the country, and are significantly higher than the England average.

Smoking is known to be one of the biggest contributors to ill health and mortality as well as the enormous cost burden to the NHS, there are estimates that suggest just under a quarter of all NHS costs are smoking related. Rates are known to be higher among routine and manual groups and those living in the more deprived wards of the CCG area.

Rates of hospital admissions for self-harm vary across the CCG, with higher rates in the more urban areas. The CCG footprint has experienced relatively high rates of suicide in recent years, however, the rate is currently relatively low. Nearly 4,000 are claiming incapacity and severe disablement allowance for mental and behavioural disorders.

Ageing well

Our age is the single biggest influence on our health. Ageing well and healthily into retirement and remaining active brings noticeable benefits.

People with long term conditions are the most frequent users of healthcare services. Those with long term conditions account for around 29 % of the population, but use around 50 % of all GP appointments and around 70 % of all inpatient bed days.

The South Devon and Torbay community illustrates higher prevalence rates of long term conditions such as, Coronary Heart Disease, dementia, Diabetes and Obesity. Without intervention in the future aged population, we might expect the prevalence of these conditions to increase in the future.

Everyone can be at risk of having a fall, but older adults are more vulnerable than others. This is mainly due to long-term health conditions that can increase the chances of a fall. Within the CCG area, there are relatively high levels of fractured neck of femur associated with falls. Around 30% of adults who are over 65 and living at home will experience at least one fall a year. This rises to 50% of adults over 80 who are either at home or in residential care.

The South Devon and Torbay area has contrasting urban and rural localities. In parts, residents live in isolated rural communities or small/medium sized towns with strong local roots. A combination of long life expectancy and rurality provide challenges for patients accessing healthcare appointments and avoiding social isolation.

Inequalities gap in life expectancy

The gap in life expectancy between the most deprived quintile (20%) of the South Devon and Torbay population and the least deprived quintile in England is around 5 years, slightly more for males and slightly less for females. The biggest contributing disease to the gap in life expectancy is Coronary Heart Disease (CHD), CHD accounts for around 15% of the gap. Lung cancer accounts for around 10% of the gap, with other cancers, such as breast, stomach and Colorectal, also accounting for around 10%. Cirrhosis of Liver, generally caused through alcohol abuse, accounts for approximately 5% of the gap in life expectancy.

Summary of progress in 2011/12

The progress has been dominated by the success in the commissioning architecture that has been established. Centred around the acute hospital we have 21 clinical pathway groups. These are groups for clinicians and health professionals, from primary, community and secondary care, supported by operational, commissioning and financial managers, to discuss pathways. All groups have standard terms of reference and data dashboard. These groups have had a number of successes such as the establishment of a virtual follow up tracker for stable prostate cancer, the development of virtual diabetes clinics in the community, the introduction of a level 3 obesity service, the agreement to utilise technology for dermatology referrals and the standardising and publishing of in excess of 100 clinical pathways.

We have also seen great success through our predictive modelling and proactive case management. The top 0.5% of risk stratified patients have seen a 16.3% reduction in admissions after being admitted to the virtual ward.

Despite the unprecedented challenge facing the NHS at present the community has also pushed forward to achieve some of the highest levels of performance against many of the key quality indicators. Over 98% of people are seen within 4 hour in the A&E department, over 90% of stroke patients spend 90% of their time on a stroke ward, waiting times continue to be amongst the lowest nationally and handover delays are the lowest in the South West.

3. Vision for services

Key themes for focus in 2012/13 and beyond

Locality Commissioning Groups - We intend to set up 5 localities within our CCG area that will provide a population base to commission local services that provide responsive care to people within their natural neighbourhoods. It is through these Locality Commissioning Groups that we will tackle the health issues that arise through our JSNA. We have already set up a virtual ward system that allows us to identify patients with a high risk of admission and provide a tailored care plan, this will allow us to be proactive with those patients who have issues such as alcohol dependency. The LCGs supported by expert commissioning support as well as business intelligence will produce locality plans to form part of our strategic intention for 13/14.

Developing community services - to provide focused and robust alternatives to admission at a local level. We are striving for true integration, not just between health and social care but between our community provider and general practice. We will continue to work with Local Authority partners on the projects funded through s256 monies.

Referral management - we wish to build on the success of the DART referral management system, which will be expanded to cover the Torbay area practices but also to provide referral refinement schemes within the pathway such as advice & guidance services and access to community based diagnostics.

Clinically effective pathways - our vision is to create seamless patient pathways through the use of experienced based design and participation, where the most appropriate professional provides care to the patient in the most appropriate place. We continue to work closely with our local providers and are pursuing the option of a virtual model of care that is free from traditional organisational boundaries.

Promote innovation - we continue to strive to be at the front end of innovation utilising our learning from pilots such as COPD telehealth, working with community teams to create virtual wards for complex patients, and whilst we were unsuccessful in the final

stages of the DALLAS bidding process we still hope to work with private & public sector partners.

Unify commissioning structures - we are in the first stages of bringing together commissioning structures both from Torbay Care Trust & NHS Devon and Baywide & South Devon clinical commissioning groups. This has so far been successful and we will continue to work on both organisational and individual development.

Health and Wellbeing Board – we continue to be an active member in the development of the Health and Wellbeing Boards ensuring that priorities and strategies are aligned and opportunities for joint commissioning are explored and maximised

Performance improvement

In addition to working to improve performance against the NHS Outcomes Framework indicators the CCG will also focus on maintaining or improving performance against key national performance targets, including the following:

- Referral to treatment and diagnostic waiting times, with a particular focus on reducing the small proportion of long waiters and improving performance against the diagnostic 6-week target;
- Cancer waiting times, maintaining good performance against national waiting times targets and working with partners on increasing early diagnosis and improving survival rates;
- Mental Health performance indicators;
- Accident & Emergency waiting times, improving performance against the national 4-hour A&E waiting times target;
- Healthcare acquired infections, with a specific focus on reducing cases of clostridium difficile;
- Mixed sex accommodation, building on significant reductions in breaches in 2012/13;
- Venous thromboembolism, ensuring all providers consistently meet the assessment target.

4. QIPP and Service Change Priorities

INTEGRATION – LYNNE NEEDS SOME WORDS UP FRONT HERE

Commissioning Architecture

The CCG will provide leadership for Planned and Urgent care system change and work with colleagues within the cluster in areas that are jointly commissioned such as mental health, children and young person's.

The CCG has a redesign architecture that is built upon Clinical Pathway Groups, these provide an opportunity for clinicians and managers from primary and secondary care to review pathways and processes and recommend and implement service change. The groups are supported by a dashboard holding all relevant information including the agreed QIPP targets. Each CPG is strategically led by a redesign board (five in total) that provide strategic direction, prioritisation and hold CPG areas to account for delivery. Clinical cabinet, which holds the redesign boards to account, is an overarching strategic group that looks at health priorities for the whole system.

Membership includes clinical and managerial leaders from the Acute provider, primary care and 2 local authorities. The group ensure that whole system transformation takes place and remove any barriers that get in the way of doing the right thing for patient care.

The CPGs all report into an appropriate redesign board and there will be a clinical lead for each work stream.

The CPGs will be joined by Locality Commissioning Groups who will focus on the population need for each of the 5 localities. The localities will each be clinically led but supported by both expert commissioning and primary care management.

Localities and work stream leads will come together with the Governing Body Clinical Commissioning lead within a sub-committee of the Governing Body to ensure there is strategic coherence with all plans.

The service changes which will be the focus of these groups this year are as follows:

Planned Care initiatives for 2012/13

The work through the Clinical Pathway Groups in 2011/12 has included referral and follow up audits, as well Low Value Procedures reviews, conducted jointly by consultants and GPs. The results of these audits vary from specialty to specialty. To build upon this work the QIPP plan for next year will focus on two areas: Referral Refinement and Alternatives to Follow-up.

Referral Refinement

Use of DART

The work through the Devon Access & Referral Team (DART) suggests that compliance with previously agreed clinical pathways materially affects the activity levels required in secondary care. In the case of Limited Value Procedures and varicose veins in particular we have seen a reduction in activity of 35%. The good work carried out through Clinical Pathway Groups provides us with a suite of evidence based standardised pathways. All referrals will be processed by DART (where appropriate) as agreed by both South Devon and Baywide Clinical Commissioning Group Boards. A consistent education based model to ensure pathway compliance will be rolled out through GP practices and secondary care. Commissioners will use DART data in specific specialities to further understand patient pathways and referral patterns.

Clinical Referral Triage

We intend to support the provision of a Clinical Referral Triage service for a number of specialities starting where Clinical Assessment Services already exist. For example gastroenterology, paediatrics, neurology and cardiology. Where appropriate, this will replace/formularise the existing ad hoc Advice and Guidance service provided by specialities. Adoption of this scheme will mean that all referrals are assessed by a senior clinician, giving them the ability to decide the most appropriate method of delivery of high quality care e.g. Advice and Guidance, request for further diagnostics or a face to face consultation. GPs would also be able to request Advice and Guidance.

For example, a service already set up in Taunton focusing on Paediatrics has seen a reduction in the region of 25% for face to face outpatient appointments.

Clinical Assessment

The aim is to support GPs to make the most appropriate clinical decisions when it comes to referral into secondary care. There are a number of methods that can be used to provide this support.

For example: The dermatology Clinical Pathway Group has agreed to the process of implementing an electronic triage system for minor skin conditions. In partnership with a commercial company 26 practices will use a digital photography system and secure email to get consultant opinion for the patient within 48 hours. The evidence from other parts of the UK suggest that up to 70% of patients can be saved a visit to the acute trust. We will learn from this triage system to see if it is applicable to other clinical areas.

Alternative to follow-up

The Clinical Pathway Groups have undertaken much work to understand what constitutes a follow-up, through detailed analysis of individual patient journeys. This can be very complex and involve a number of appointments with different types of clinicians and for different diagnostic tests. We have identified two broad categories of follow up: those which involve face to face consultations with clinicians and those which involve additional steps in the patient journey i.e. diagnostics.

Face to face follow-ups

Where a clinical, face to face follow up is appropriate, we will ensure that it is delivered by the appropriate professional, in the appropriate setting and a time and place suitable for the patient. Examples may include delivery of follow ups by staff other than hospital Consultants and clinics in settings other than the Acute Trust.

Virtual follow ups

Where an alternative method of delivery is appropriate we will commission innovative methods of care delivery.

An example of this is the Prostate cancer PSA tracker. Building on the work initiated in the Urology Clinical Pathway Group with regards to stable prostate cancer, all specialities will be asked to review which follow-ups could be performed virtually. This could be either utilising the tracker that has been designed within the Infoflex system or through other controlled methods.

Appropriate setting for Diagnostics

We have identified ‘follow-ups’ that are additional and necessary diagnostic steps in a patient’s pathway of care. We will analyse these steps to ensure they are carried out in the most clinically and cost effective setting.

For example, work through individual Clinical Pathway Groups has highlighted anomalies within individual patient journeys, for example Cardiac Monitors. Detailed work suggest that the fitting and removal of monitors for patients that do not then go on to further work for the Acute Trust could cost in the region of £200k, but the cost under

any qualified provider would be in the region of £70k.

Whilst this allows the commissioner to make a "saving" the cost implication for the Trust remains the same, however the work across all specialties for diagnostic testing that could be done in a community setting at a truly reduced cost must be explored. Where the Trust has proposals to reduce operating costs the commissioners will, where possible, support such schemes.

Best value tariffs

Where a Clinical Pathway Group can identify episodes of care delivery that can be performed in a way that improves efficiency, reduces patient appointments, enhances patient experience and improves outcomes then the commissioners will promote the development of best value or unbundled tariffs.

Urgent Care initiatives for 2012/13

Proactive Case Management

Virtual Ward

Building on the work of the virtual ward in South Devon we will seek to proactively case manage those patients that are deemed most at risk of admission to an acute hospital. There are a range of predictive modelling tools in place in addition to the knowledge of primary care clinicians and the complex care teams; these together should be used to design the admission criteria to the virtual ward.

Multi-disciplinary teams

It is the aspiration that the multi-disciplinary team includes not only primary and community care but also specialists. The diabetes service is a good example of the vision for proactive case management, an approach that brings together consultants, specialist nurses and primary care in a community based education model that ensures only those patients most in need of an acute intervention will be seen in a hospital setting. Each long-term condition area will be asked to review this model and if appropriate mirror this approach.

Self-care and education

Personalised care planning through shared decision making should enable people who live with Long Term Conditions to develop knowledge, skills and confidence to manage their own health and healthcare and to produce a personalised care plan.

Torbay is one of a small number of pilot sites for co-creating health, building on the previous work in expert patient programmes and self-care. This allows patients to take ownership of their condition and live independent lives.

In addition we are currently developing a LTC strategy supported by the CCG group of which systemising Self-care is one of the key drivers. The work is being developed as part of the national Long Term Conditions Network being led by Sir John Oldham. Self-care will be integrated into all CPG care pathways and plans are already being developed in Diabetes and COPD.

There is already local evidence demonstrating a reduction in contact with secondary care services for patients who have completed the local self-management programme for depression. Self-management can improve patient experience, with patients reporting benefits in terms of greater confidence and reduced anxiety.

Alcohol Support programme

Evidence collected through a pilot carried out in Torquay North supports the roll out of a targeted and assertive alcohol support programme. The pilot suggests that savings will be made in the acute sector, community health, social care and within GP practices.

Fracture Liaison Service

Torbay commissioned a Fracture Liaison Service last year to support patients who had suffered a fragility fracture. The service is in its first year and although a thorough evaluation is required there is robust evidence from around the country that this will have a positive impact on reducing secondary fractures in the future. Consequently, there is an aspiration for this service to cover the entire population of South Devon.

Telehealth & Delivering Assisted Living and Lifestyles At Scale (DALLAS)

Following a limited but successful pilot of a telehealth project for COPD patients in Torbay, whilst the health community failed to secure funding to work with commercial partners to implement schemes under the DALLAS banner we are still keen to work with those partners identified through the process.

Robust Alternatives to admission

Increased number of intermediate care therapists

We intend to provide an alternative to hospital admission and/or to facilitate timely discharge by increasing the numbers of therapists and intermediate care support workers. We will also provide comprehensive discharge facilitation and co-ordination across acute and community hospitals in Torbay and South Devon. This approach will prevent dependence on bed based care, allowing patients to remain in a supported cared-for environment with less reliance on emergency services or hospital stay, as well as reducing delayed transfers of care. We will also spot purchase beds in nursing homes for individuals who are unable to be left at home but for whom a hospital admission would be inappropriate.

Single point of access and coordination (SPOA)

Building on the successful model implemented in Torbay, the test of change projects in Teignmouth, Dawlish and Ivybridge cluster areas aspire to work in partnership with Devon County Council's Care Direct Plus to establish a single point of access for health and social care services. Offering a single referral route to mobilise, in a timely manner, the most relevant and effective services to support patients in the community setting, evidence from these projects will inform the wider design for integrated working, information sharing & integration of patient record systems and the coming

together of contact points for health and social care services.

111/ Directory of Services

The development of 111 as a single point of contact for the public for urgent, but non emergency health service access. NHS Pathways will, as the front line assessment tool for telephone triage, integrate with a locally defined Directory of Service (DOS) to ensure every patient is directed to the right care at the right time.

SWAST Non-conveyance

SWAST have their own overarching target to reduce conveyance rates by 10%, through a series of initiatives under the "Right Care, Right Time, Right Place" banner. This focuses on ensuring patients receive the most appropriate treatment in the most appropriate setting. We will work with SWAST to develop strong links with the community teams to ensure SWAST paramedics are able to signpost to alternative services with confidence.

GP 8-8 service

There is currently a GP service located within the A&E Department of Torbay Hospital, co-located with the Out of Hours service, and providing cover 8am – 8pm. This enables all patients to be treated by the most appropriate clinician in a timely manner. We intend to work with SWAST and primary care to pilot the placement of a SWAST Emergency Care Practitioner in A&E for three months to monitor and triage admissions. This pilot will also include the short term placement of a GP in A&E to ensure we capture the view from primary care to inform future provision of the service. As part of this process we will evaluate the 8-8 service and its role in the emergency care system.

Improving Mental Health services

The community will continue to work with mental health providers, service users and carers to develop locally based, high quality, responsive care for people using mental health services. A key focus will be on prevention and recovery away from a bed-based model.

Examples of projects and initiatives:

- Improved access to psychological therapies as part of the commitment to full IAPT programme roll-out, including employment support workers, to enable the service to meet at least 15% of common mental health disorder prevalence, with recovery rate of at least 50%.

- Improved access to psychological therapy for patients, particularly those with medically unexplained symptoms; long term conditions, older people and people with severe and enduring mental illness.

- Offender Health - focussing on the need to improve offender health by developing effective partnership working between probation, criminal justice and mental health services.

- Perinatal mental health services - continue to develop a pathway to meet the

perinatal mental health needs of women and their families through the perinatal period up to one year postnatal.

- Further development of improved care pathways for people living with an eating disorder, autistic spectrum condition or a dual diagnosis.
- Progressing implementation of the mental health strategy, 'No Health without Mental Health'; developing parity of esteem for mental health services as physical health.
- Improving the physical health of those with mental health problems.
- Mental health Service Development and QIPP:
    - Consider developing services to enable individuals with complex needs, currently out of area, to be repatriated and supported in the local community, where possible e.g. by a specialist personality disorder service and community forensic service.
    - Medically Unexplained Symptoms – building on the learning from pilot work to date to develop an appropriate care pathway.
- PbR for mental health to be developed as the currency during 2012/13. As well as the development of integrated care cluster care pathways.

Priorities for 2013-14 will include:

- Continuing to implement the National Mental health Strategy, 'No Health without Mental Health' across South Devon and Torbay.
- Continue the implementation of the Devon and Torbay four year improving access to psychological therapies strategy.
- Implementation of PbR tariff for Mental Health as per national timescales.
- Improved access and choice for people who use services and their carers.

Living Well with Dementia

The CCG is committed to improving services for people living with dementia and their carers and will support the implementation of the Prime Ministers Dementia Challenge (March 2012).

Priorities for 2012-13 include:

- Improving acute care for people living with dementia and their carers, by continuing to implement the Dementia Acute Hospital Standards (developed by the SHA regional expert reference group) and continue to embed and evaluate the Psychiatric Liaison service at Torbay Hospital.
- Improving earlier diagnosis rates, by completing the education and awareness programme in Primary care; finalising the EDI care pathway, through Map of Medicine, develop and implementation of an outcome focused EDI service specification and develop a public awareness campaign emphasising the benefits of early diagnosis, working in partnership with the third sector and the local Dementia Alliance.
- Improving care in care homes, by considering the benefits of a specialist liaison service to work proactively with residential and nursing homes by providing

advice, support and an awareness and education programme. We will work with Devon County Council to support their ambition of developing "Dementia Residential Homes of Excellence"

- Ensuring appropriate use of antipsychotics, by continuing to audit and monitor local prescribing.
- Peer support services – continue to commission a range of peer support services from the third sector including memory cafés, singing for the brain.
- Carer support - continuing to commission a wide range of carer support services, as identified by carers themselves.
- Enabling easy access to care, support and advise following diagnosis, by commissioning a dementia advisor service across South Devon and Torbay
- Improve workforce awareness of dementia across all organisations.

Priorities identified for 2013-14:

- Continue to work with the local authority, services providers, people living with dementia and their carers to implement the local dementia strategy and the priorities as identified in the "Prime Minister's Dementia Challenge"

Improving care for people with learning disabilities

An important priority is ensuring people with learning disabilities have more choice and more control over their care, making sure that they have equal access to all services. The aim is to improve services so that more people can be supported to live independently, as an alternative to residential care.

Examples of projects and initiatives:

- Develop community services in South Devon and Torbay so that fewer people with learning disabilities are only offered care outside the county,
- Complete a quality review of care in independent hospitals for people with a learning disability in Southern Devon and Torbay,
- Redesign care so that services are more effective and so that mainstream services are more accessible to people with learning disabilities,
- Improve local opportunities for independent living, so that fewer people have only the choice of residential care, or are admitted to a hospital setting that is not appropriate for their individual needs,
- Making sure lead commissioning arrangements are in place to ensure that there are effective communication links between commissioners, care coordinators and safeguarding teams in reviewing placements,
- Improving information in our joint strategic needs assessment, this is to ensure that commissioning is based upon known need identified within our community and joint health and wellbeing strategies,
- Annual health checks for people who have a learning disability will continue in order to maintain the monitoring currently in place. In 2010/11 Torbay achieved the highest uptake of annual health checks in the country with

87% of people receiving a check,

- Improving the screening for mental health needs in people who have a learning disability, this will enable effective early support for people diagnosed with dementia and also those with psychosis and other mental health needs,

- Completion of the annual health self-assessment by July 2012. This will include an assessment of the effectiveness of joint strategies to address the needs of people with a learning disability with behaviours that challenge. The health self-assessment will be validated using feedback from people who have a learning disability and carers.

QIPP for Learning disability services:

This QIPP approach is strongly based upon the rights of people who have a learning disability, recognising that people with a learning Disability have the right to access universal (mainstream) services. That those services should make reasonable adjustments to ensure fair access and where reasonable adjustments have been made but the disability is such that services are inappropriate a specialist service should be there to intervene.

We know that people with learning disabilities have poorer health than their non-disabled peers, and that there are differences in health status that are, to an extent, avoidable.

The QIPP initiative currently being developed challenges both commissioning and provision of health services, and aims to produce a strategy that will make a real difference whilst improving quality and productivity.

Through the development of primary, secondary and mental health, liaison nurses in learning disability we have a good understanding of what works. The strategy aims to support mainstream services to enable people with a learning disability to access services, and benefit fully from them. This recognises that there is a need to make sure that learning disability expertise is embedded within those services to promote access. The strategy also acknowledges that the specialist services are there to offer additional support, advice and intervention to support universal access when required.

In reality this means we have to achieve the correct balance of three key elements support:

- **Enabling -** To help guide a person through the system. This is about providing hands on support to enable access to primary and secondary care.

- **Change agents -** This is work attached to primary and secondary care. Working, primarily with systems. To advise on processes and on individual cases where required. To help systems make reasonable adjustments in mainstream care, and provides support for intervention taking on expert intervention where required e.g. desensitisation work around specific procedures where someone may feel anxious.

- **Specialist support and Intervention -** to provide expert intervention. To ensure quality of work with other specialist providers. This function will support networks for learning disability provision in all tiers, supporting good governance. This work is orientated around the work of multi-disciplinary

teams, dealing with most complex cases. To enable navigation through the tiers of support from stages 3-1 to enable the optimisation of health for people as their needs change in a flexible and responsive way.

Children and Young People

The community will continue to work with acute and community providers, children, young people and their parents and carers to develop locally based, high quality, responsive care for Children and Young People.

Examples of projects and initiatives:

- Delivering integrated pathways of care with South Devon and Torbay Children's Services for child development assessment, assessment of neurological conditions and Community Children's Nursing services
- Providing targeted support for Children and Young People at risk of developing mental health problems such as Looked After Children
- Enabling improved access to psychological therapies for Children and Young People and putting in place the infrastructure to enable children and young people to shape CAMHS services
- Establishing clear transition pathways for children and young people with complex health needs
- Developing the postnatal pathway for the Perinatal Infant Mental Health pathway

Service development and QIPP:

- Continue to monitor the impact of the Specialist Bladder, Bowel and Continence service
- Explore the use of Clinical Referral Triage to ensure that care is managed in the most appropriate setting
- Establishing a clear service specification to describe community children's nursing for children with acute, chronic and palliative nursing needs to ensure consistent, equitable and safe services across Devon

Improving primary and community care

The CCG will work with primary care to ensure contracts deliver high-quality, cost effective care for patients, with easy, equitable access to a range of primary care services including GP practices, dentistry, optometry and pharmacy. Community care services will be developed to provide patients with more choice and more appropriate, local services as alternatives to hospital care.

Improving Medicines Management

The most common therapeutic intervention made in the NHS is the use of medicines. Medicines have benefits and risks to people. Research has shown that at least 50% of patients do not take their prescribed medicines as intended.

Historically, the sole remit of the Medicines Management Team was to ensure the cost-effective use of medicines and to manage the prescribing budget but the agenda has transformed from not just the cost-effective use of medicines, but also quality and

safety of medicines use.

The current thinking from the government is to expand medicines management to medicines optimisation. This means a have a greater focus on optimising medicines use to achieve the best outcomes for patients.

The CCG is committed to transforming the ethos of medicines management to medicines optimisation.

Priorities over next two years include:

- To continue the work with the Quality and Patient Safety team to maintain and improve the quality of patient care in relation to medicines.
- To ensure that all care pathway groups have access to clinical pharmaceutical advice and support.
- To align the resources in primary care. Medicines Management pharmacists and technicians will continue to support GP practices on clinically and cost-effective prescribing.
- To maintain the high performance of the South Devon Joint Formulary.
- To actively work with patient groups.

Health Visitors

Early intervention and preventative measures are key drivers to tackling and reducing health inequalities and stem the escalation of ill health. The role of the health visitor is acknowledged as an effective resource working universally with families and they are in a position to identify early on health and wider social issues facing families. Troubled families face a number of wider challenges including unemployment, mental health problems, crime and anti-social behaviour as well as children not in education making them more vulnerable to risk taking behaviours.

Recognising this challenge the Government has set a target to increase the numbers of qualified health visitors by 4,200 by 2015. The plan for growth across the Devon Plymouth and Torbay Local Authority areas is 106 additional qualified health visitors based on a model using deprivation index, maternities and births (58 Devon and Torbay). There is an expected minimum growth investment of £3,869,000 across the 2 CCG areas (3 local authorities, Devon, Plymouth and Torbay). Although the Commissioning Board will retain commissioning responsibility for this target before passing to Public Health in the Local Authority in 2015 there is close collaboration between CCGs and Public Health departments to use the opportunity to work with providers on their business plans in increasing staffing levels and remodelling the service to deliver the 'The Healthy Child Programme 0-19 (Department of Health, 2005)'
Priorities over the next two years include:

- Recruit and train a student workforce to meet the increased numbers of qualified health visitors.
- Develop wider integrated frontline staff teams across public health nursing as well as partners to provide a response at universal ; universal plus and universal partnership plus levels.
- Increased alignment with primary care teams responding to the needs of families living within the localities.

Carers

South Devon & Torbay have a strong history of developing support to unpaid carers and partnerships are well developed. In Torbay, 'Measure Up 2012-14' is the interagency carers' strategy and for Devon, the joint carers' strategy is "Carers at the heart of families and communities in Devon (2009)". These local strategies reflect key national priorities for joint commissioning:

- Recognised valued and supported - Next steps for the Carers Strategy (2010) in which the government identified 4 priorities:

    - Early identification of carers,
    - Supporting carers to achieve their full educational and employment potential,
    - Personalised support to enable carers to have a family and community life,
    - Supporting carers to remain mentally and physically well.

One in ten people in the UK is a carer which equates to six million carers.

- 42% of carers are men and 58% women.
- 175,000 are children.
- 1.2 million carers care for over 50 hours a week.
- Around two million people move in and out of caring every year.
- Thirteen million people can expect to become carers in the next decade.

Evidence shows that carers suffer poor health through caring. Carers are at risk from health problems varying from stress-related conditions to injury caused by lifting. For example:

- More than 80% of carers say that caring has damaged their health.
- Three out of four carers are worse off as a result of caring.
- Out of all carers caring for more than 50 hours a week, one third report depression, half report disturbed sleep and 25% report back and other strains.
- The prevalence of psychiatric morbidity is significantly higher in those who care for others in their own homes.
- When a carer's health deteriorates to crisis point, the unplanned hospital admission of the carer can sometimes mean that a hospital / nursing home bed is needed for the person they care for too.

The evidence is that many carers are caring at the expense of considering their own needs. We need to see carers as an excluded group in terms of their own health and well-being and expect carers' needs to be reflected in local Joint Strategic Needs Assessments.

Young Carers:
Research highlights particular risks for children and young people with caring responsibilities and there is a need to identify and protect young people from inappropriate caring. Risks include poor academic achievement, limited life opportunities and some safeguarding issues. The Memorandum of Understanding on Young Carers (ADASS/ADCS) provides a model for joint working and whole family approaches and implementing this good practice framework will be a priority for young carers.

Carer Involvement:

Direct carer involvement in evaluating existing services and designing new solutions has been well established in South Devon and Torbay and will continue to be an essential element of our approach.

CCG Priorities for 2012 – 14:
We are committed to maintaining a long term strategic approach to carers, building on past development and learning in South Devon and Torbay, and encouraging a culture of innovation and joint working. The CCG approach will aim for equity in provision whilst recognising local needs and opportunities. Our priorities for the next two years will be:

- Early intervention and direct access to information, advice and support.
- Identification of hidden carers and those who do not see themselves as carers.
- Linking carers needs in to other key strategic developments eg. Dementia and self-care.
- Incorporating carer support at key points of care pathways eg. hospital discharge.
- Development of flexible breaks services and personalised solutions.
- Incorporating a focus on carers physical and mental health into Carers Assessments.
- Systematic evaluation of carers services to build an evidence base for what works.
- Maintaining innovation and community engagement in carers services.

WORKING AS PART OF THE HEALTH & WELLBEING BOARDS
The CCG is engaged in the shadow health and wellbeing boards of Torbay and Devon which are committed to provide systematic on preventative approaches as much as treatment and care and agree shared priorities leadership bringing about more integrated commissioning, which aligns resources and focuses.

Joint Health and Wellbeing Strategies are being developed by the boards and early work has identified some emerging priorities which the Boards feels they can 'add value' to the health and wellbeing experience of local people. These include Troubled Families, Obesity, Alcohol, Dementia.

Innovation

The spread of innovative approaches will be vital in transforming patient services, improving quality and supporting delivery of QIPP. There are many existing examples of innovation leading to more efficient, higher quality services in Devon and the Cluster will work with providers in 2012/13 to ensure further progress is made and to encourage innovation in every service area. During 2012/13 Commissioning for Quality and Innovation (CQUIN) will be used to stretch quality improvements further in the delivery of local and national priorities that will support and incentivise innovation and productivity. CQUIN schemes will be aligned with QIPP initiatives and will include the four national CQUIN targets as well as a focus on incentivising community working. The Department of Health report '*Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS*' set out a delivery agenda for spreading innovation at pace and scale throughout the NHS. The high impact actions referred to in this report will

be brought into CQUIN for 2012/13.

5. Quality

The CCG will exercise its functions in relation to improving quality, reducing inequality and delivering improved outcomes. Quality is the organising principle for delivery in the NHS and as such is wholly embedded in our plans. The 2012/13 Operating Framework continues to describe quality within the three domains of patient experience, patient safety and clinical effectiveness with the NHS Outcomes Framework describing the development of a system where the NHS will be held to account for high quality care based on outcome measurement.

The CCG will ensure it has local systems of intelligence gathering and evaluation and that it enables effective collaboration between partners and stakeholders to redesign care in shared pursuit of better outcomes and improved quality. We see building a new relationship with patients and local communities as key to establishing the CCG as a real advocate of high quality care on behalf of all of our communities. Supporting the improvement of quality where we identify poor care, and rewarding good quality where that is evidenced will be at the heart of the work of the CCG and we will focus on ensuring the best possible outcomes for all of our population.

The CCG is determined to achieve excellence in commissioning and has asked itself what excellence really looks like.

What does 'excellent' look like?

Excellent commissioning depends on commissioners having a very clear idea of the needs of their populations and what the patients and their carers/families and staff think of the services they experience or witness. It is important that commissioners are able to gather, analyse and act on information from people who use the services. CCGs must be able to detect as early as possible any potential deterioration in the quality of services and should employ diverse mechanisms for seeking out this vital intelligence.

'*Well informed and high quality decision making is a critical requirement for a board to be effective and does not happen by accident'* [1] and there must be mechanisms in place to gather patient experience knowledge to influence CCG decision making at all levels, from the localities to the Governing Body.

The CCG will have demonstrable links to the needs of users, patients and the wider communities and must prioritise inclusion, safety and quality. Enabling and encouraging people to tell of their experiences (good and not so good) is essential to understanding the quality of care commissioned. This knowledge will not, of course, all come from complaints. Every day, health professionals and other staff working in GP practices, clinics, community services, acute trusts and other care environments hear the stories of patients and their carers, and also witness what is sometimes not said. These peoples also must have an easy way to raise concerns, to say what is going well and to identify what needs to change.

As well as proactively seeking feedback from patients and the wider community, the

[1] Financial Reporting Council (2011,p8) Guidance on Board Effectiveness.

CCG will have arrangements in place to handle any complaints raised within the statutory complaints management framework. The public have information easily available to tell them how to make a complaint and it will be very easy for them to do so. There will be systems in place for recording complaints, managing them within the rules, and taking actions as a result. The public will also be told what has been learned from their complaints and what actions have been taken to improve the quality of care and patient experience.

Additionally, there will be systems and processes in place for monitoring and acting upon patient feedback that is not made as a formal complaint. Patients and their families or carers, and indeed other people who witness poor care (including care workers and members of the public) need to be able to raise concerns quickly and easily. They may not always wish to identify themselves or require feedback but if they do, timely feedback should always be given.

What is learned from such feedback will inform a triangulated picture of the quality of care and of patient safety. This way early warning of risks to patient safety or a failing provider can be spotted and the appropriate commissioning actions taken.

The CCG will ensure it is:

- **Listening** – making it easy to give feedback, providing good information about providing feedback or making a complaint, getting complaints handling right first time, and ensuring peoples' rights under the NHS Constitution are met.

- **Responding** – able to handle the complaint at the level it requires, whether simple or more complex; supports people well when they make complaints and ensures they are not disadvantaged by raising their concerns; mediates when issues can't be resolved; investigates concerns or causes concerns to be investigated and is open and transparent in its dealings with people who raise concerns or makes a complaint; by regular and timely communication with the patient or individual raising the concern and offering appropriate support such as advocacy.

- **Improving** – by using the intelligence gained from patient and public feedback to influence commissioning decision making or to change the way the CCG or its processes works; by providing training for CCG staff and members as a result of such intelligence and in handling complaints;

The ideal, therefore, is a CCG that is easy to contact, is responsive to the people who make time to make contact, analyses and collates information to feed back into localities and into the commissioning process, raises red flags when patient experience of a provider is poor, and reflects local populations in its analysis of data.

Dealing with complaints made should occur as near to the population base as possible so that people feel they are being listened to in their own locality and the feedback to them should be prompt, personal and satisfactory. We will always seek to explain amd to answer the complaint in an open and transparent manner, and reassure the complainant the lessons have been learned and action taken.

The process for receiving and acting upon complaints and concerns raised is part of our wider focus on patient experience, and will dove-tail with other initiatives described elsewhere (in the Communications and Engagement strategy, for example) particularly

with the use of the Net Promoter Question, and Patient Opinion. These elements are also 'Insights' into care quality and are described in more detail below. They are all part of 'Making Insights Count in Commissioning'.

Also to be considered here is the importance of feedback. An 'excellent' system will ensure that feedback is given to those who raise complaints and concerns, in line with the national guidance and also in line with the locally set values.

Everyone who has taken the time and made the effort to report a concern about quality of care deserves both an immediate response and later, feedback to say what changed as a result of their highlighting the issue. Mechanisms will be put in place to let individuals, patient groups, community groups, GP practices and GPs themselves know what has changed as a result of feeding in their 'insights'. Feedback is known to promote reporting and thus is an important part of the 'Making Insights Count in Commissioning' design.

Meaningful Engagement

The CCG will demonstrate how it engages with patients, carers and the wider community as part of its commitment to reduce inequality, improve quality of care and patient experience. The most important way to do this is to harness insights from patients and carers about the experiences they have of care. Such insights will be central to the way we commission and will ensure that what matters most to our patients, their families and carers and our wider communities is at the heart of our commissioning decision making.

There are myriad ways to ensure we listen to the things that matter to people who need to access the care we commission. Patient and carer feedback gathered through hearing complaints and concerns will be a significant way to detect poor quality care or service failure. We will have robust mechanisms in place to manage complaints and deal with concerns and to ensure that any potential deterioration in care is detected as early as possible, and acted upon swiftly and appropriately.

To this end, we will embed MICCs into our commissioning way of life. MICC stands for 'Making Insights Count in Commissioning'. We will have a MICCs team as part of the CCG Quality Team, who will ensure that complaints are managed according to the national guidance but who will also spearhead meaningful engagement with individuals, patients, health professionals who wish to raise concerns, groups and communities.

Mindful of our duty under the Equalities Act, we understand the need to ensure that people who might not normally get heard are sought out and listened to, and that their voices are heard too. We know that often people with the most complex needs and the worst experience of care are neither asked, nor listened to, by commissioners or providers. Children and young people are also often overlooked and have much to say in shaping services from their experience. We want to change that by engaging with Healthwatch, with interest groups locally and with hard to reach individuals and groups directly and to ensure their opinions are fed into the commissioning process. There will be MICCs champions within each locality whose role it will be to build strong relationships with the people in the community, including unregistered populations (gypsies and travellers, homeless and transient people for example).

The MICCs Champions are likely to be based within member practices so that the important messages about engaging with local people is truly embedded at practice

level. The intelligence MICCs champions glean from their engagement with their communities will be fed back into the central MICC team to be triangulated with information gathered from other sources, and thus an accurate picture of the quality of care will be developed throughout the commissioning year.

MICCs champions will be supported by the MICCs team and we will make 'Telling MICC' a phrase that is understood by the population at large by publicising widely how to contact MICC.

Tell MICC

If you have concerns about the quality of care you or someone else has received, please **tell MICC** on 0845 xxxxxx.

If you prefer, please email **MICC** at www..... and tell us your concerns.

You can also contact us through 'Patient Opinion' by going to www.....

Would you like to rate the care you received? go to our website or phone 0845 xxxxxx and **tell MICC** if you would recommend the service you used to your family or your friends.

Please **tell MICC** what you think of your local health services. We are here to ensure the quality of your care improves. We will listen, we will help and we will take your concerns very seriously.

MICC – Making Insights Count in Commissioning. Part of your local Clinical Commissioning Group improving Quality of Care

We

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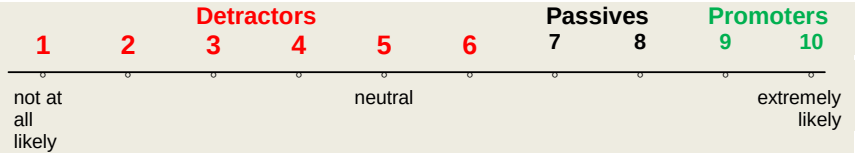
a provider on good care should be able to do so easily. By putting in place a single point of contact we will ensure that private citizen and care professionals alike know how to contact us when they need to.

- We will ensure that people can let us know of their experience of care by using a web based package called 'Patient Opinion' which we will embed on our website and publicise widely. This independent site is already used by our local Access and Referral team 'DART' ; Patient Opinion is an non-profit making company who believe that patients' feedback – good or bad – is essential to improving health services. Using Patient Opinion provides an opportunity for people to tell their story of what was good and what could be improved and they can do this anonymously if they wish, or not. The site allows for providers and commissioners to respond to the insights reported, which is an important part of the engagement process and then the stories are passed to MICC and MICC champions for response and for including in the overall insight analysis. Using Patient Opinion will be an important part of the MICC toolbox and will be accessible by all people who can use online services.

- We will utilise the 'Net Promoter Score' (NPS) wherever possible and work with providers to support them to use NPS too. NPS is a straightforward metric that can demonstrate to organisations how customers feel about a service. It is easy and very understandable both to patients and carers, and useful to providers and to commissioners. The Net Promoter question is very easy to ask, and very

easy to answer. It asks people to tell us how likely they are to recommend the service/care they have experienced to a friend or member of their family, on a scale of 0 – 10. Those people who score the care at 9 and 10 are classed as Net Promoters of a service and are 'happy customers'. People who score 7-8 are 'Passives' and are satisfied but no more than that. People who report a score of between 0 and 6 are Net Detractors and are unhappy with the services they experienced. Using NPS can allow patient experience to be benchmarked easily and although it won't tell us what is wrong with a service or a provider, it will raise a red flag and alert us to failure in care or high levels of poor patient experience. It can serve as a trigger for a deeper look at quality of care.

How likely are you to recommend this service to your family or friends in a time of need?



- We will ensure that we are open and transparent about the decisions we make and will include a wide range of individuals, groups and communities in our work. We will forge strong links with our communities so that they know who we are, what we do and so they feel involved in our decision making processes.

- We will analyse and act on information received from patients, carers and the wider communities so that what they are telling us is translated into priorities for improvement in the quality of care or service provision.

Empowering patients

NHS Constitution sets out how the NHS aspires to the highest standards of excellence and professionalism – in the provision of high quality care that is safe, effective and focussed on patient experience and in the planning and delivery of the clinical and other services it provides. The NHS must reflect the needs and preferences of patients, their families and their carers. We will ensure that we have the NHS Constitution at the forefront of the CCG, and that as commissioners we act as the advocate of patients and carers, and our wider public.

Under the NHS Constitution, people have the right to have any complaint they make about NHS services dealt with efficiently and to have it properly investigated. They have the right under the constitution to know the outcome of their complaint investigation and to take the complaint to the independent Health Service Ombudsman if not satisfied with the way that complaint has been handled. The NHS commits to ensuring people are treated with courtesy and receive appropriate support throughout the handling of a complaint; and won't let the fact someone has made a complaint adversely affect future treatment. When mistakes happen, the NHS commits to acknowledging them, apologising, explaining what went wrong and to put things right quickly and effectively. The NHS will also ensure that lessons are learned from complaints and use these to improve NHS services.

We will ensure that the new CCG constitution upholds all the values and pledges made in the NHS Constitution and we believe that, by putting MICC in place with all its various facets for proactively seeking and listening to patient and carer feedback, together with robust governance arrangements for assuring provider quality of care

and contract monitoring, we will be able to provide on-going assurance of excellence in commissioning.

Involving Patients and Communities in Planning and Designing Services

We acknowledge that involving people in planning and influencing commissioning is fundamental to what we do, and that shared decision-making at an individual patient level and at the collective level is more likely to lead to supported, legitimised and value for money health care decisions for the community locally.

This is why we intend to have patient representatives connected with all of the Clinical Pathway Groups. The MICC team will develop a range of engagement tools for the CPGs to use when undertaking service redesign to enable them to choose the best way of seeking patient insight. We will also be working with patient participation groups in the various communities and localities to ensure their voice is heard by the CPGs.

We acknowledge the fundamental requirement to ensure continuity of care and to track experience along patient pathways as well as by individual services and care providers. We are developing and investing in new and innovative ways to access some of the hard to reach groups. For example, we have recently implemented 'Looking Local', which is a system people can access from their own homes, including the television, telephone and even their games consoles. This will provide both information about services in the area and an opportunity to feedback their thoughts using 'Patient Opinion'. This intelligence will feed into the commissioning design process.

Involving Patients and Communities in Quality Assurance

Following the learning from a number of high profile investigations at a national level where the dignity of patients was not respected and the experience of patients was not as good as it should have been, we will work to develop a different approach to quality monitoring. Listening to patients and those who care for them will be key to our monitoring processes.

The lessons from the Review into the Mid Staffordshire NHS Foundation Trust underlined the vital link between the experience of the public and the quality assurance agenda for commissioners, and the high level of risks when the two are not linked. We will seek to understand the challenge and scope for improving patient experience in our provider organisations and will evaluate and support them to provide a positive patient and carer experience.

We acknowledge that there is learning to be had from events in Mid Staffordshire. Dr Colin-Thomé surmised in his review of the Mid Staffs events [2] that 'Patient feedback is essential for a responsive service. There are many ways ... (to) listen to and act on feedback from local patients and populations.' He also felt strongly that lack of good patient engagement contributed to the continuation of the provision of poor care for a protracted period of time.

[2] Mid Staffordshire NHS Foundation Trust: Review of lessons Learnt for commissioners and performance managers following the Healthcare Commission investigation. Dr D Colin Thomé 2009

We think this is sound advice and we will ensure that our CCG is always proactively seeking to obtain current patient experience feedback. We will be focussed on the true insights of patients and wider populations it serves and will seek to understand our 'customers' and form strong relationships with them, encouraging feedback and using that knowledge to improve and develop services.

Colin Thomé also says in his report that '*real patient and public power, information and choice are strong drivers for improving the NHS and making it a dynamic, responsive service rather than a service that gives patients the message that they should accept what they are given*' and that commissioners must be held to account for their responsibility for engaging patients and the public in design, delivery and quality assurance of health and care services, and for ensuring that the providers they commission do likewise.'

Our approach will, of course, include the use of metrics and quantitative data but will place the experience of patients at the centre of quality assurance. We have described the ways we will collect intelligence about patient and carer experience and how we will encourage people, whether patients, staff or the wider community, to tell us what they see and hear about care services we commission. We will garner patient experiences to create a vivid picture of the quality of care and of how people are treated by providers. Through the quality monitoring arrangements agreed as part of the contractual process we will ensure that providers have a systematic approach to improving quality and dignity in care for patients which can be measured through user surveys and used to inform continuous quality improvement. We will compare what we know with what providers are telling us and form judgements about quality based not only on the achievement of targets, but mostly on patient experience.

As part of our clinical governance we have a dedicated sub-committee to the CCG Governing Body. This committee, Commissioning Quality Improvement and Patient Safety Committee (CQIPS) receives reports from commissioning & quality leads on the quality of care evidenced by all providers. It will receive reports monthly from the MICCs team, which will include locality reports from the MICCs Champions. It receives risk-based reports on various aspects of quality, across the locality, looking at issues such as Infection control, Safeguarding Adults and Children, Medicines Management, Patient Safety and Clinical Effectiveness. The Committee is chaired by a GP and minutes from the meeting are received by the Governing Body.

The Governing Body also receives a monthly Quality Report, which covers national, regional and local quality issues plus provider quality assurance information. This document, combined with the performance data presented to the Governing Body, will serve to provide the CCG with an holistic view of the state of quality in the locality, and will alert them to any risks that need to be addressed or any national issues that require action or translation locally.

The Quality team and the various Contract leads will work together to ensure that regular Quality Review Meetings take place with all providers, seeking ongoing assurance of good quality care and with a focus on the experience of people who use the services, either as patients or as carers. Evidence from patients that care is below expected standards will promote an enquiry and follow up, and we will work to support providers to improve their care standards.

A focus on Outcomes

Improving the quality of care and outcomes for patients is our major driver and influences everything we do. The Health and Social Care Bill places statutory duties on the Secretary of State, the NHS Commissioning Board and CCGs to promote continuous improvements in the quality of health services, with particular regard to clinical effectiveness, patient experience and patient safety.

The NHS Outcomes Framework, a set of key national indicators, shifts the focus from measuring processes to measuring outcomes for patients. The NHS Outcomes Framework covers the following areas:

Domain 1	**preventing people from dying prematurely**
Domain 2	**Enhancing quality of life for people with long term conditions**
Domain 3	**Helping people to recover from episodes of ill health or following injury**
Domain 4	**Ensuring people have a positive experience of care**
Domain 5	**Treating and caring for people in a safe environment; and protecting them from avoidable harm**

The existing quality monitoring systems in place already align well with the NHS Outcomes Framework. For 2012/13 we will continue with our current arrangements for monitoring of quality requirements and outcomes within the locality served by the CCG. We will monitor providers to ensure that where there is potential for avoidable harm (for instance, incidence of venous thrombo-embolism, pressure ulcers, Healthcare associated infections and serious incidents) we can work with care organisations to support improvements. Regular monitoring will allow us to provide assurance to the local communities that the care we commission on their behalf is safe and of good quality. We know can have a great impact on quality of care and positive patient experience as well as on the cost of care by continually seeking to gain assurance and promote improvements.

The CCG will work with Health and Wellbeing Boards and other partners to review and publish progress against the NHS Outcomes Framework (and other quality indicators including NICE quality standards) and identify where improvements can be made. We will triangulate this information with what we are hearing from patient and carer stories and make sure this influences our commissioning decision making.

Values Based Operating Principles

In addition to the quality requirement set out in the NHS Contract with providers, the CCG has developed a suite of values based Operating Principles (OP's) that are embedded in the major contracts and which we plan to include in smaller contracts in the future. These OP's set out commissioning intentions and provider requirements against a set of quality issues, which all align to the quality domains and the NHS Outcomes Framework.

The OPs have been developed together with the provider organisations to ensure maximum 'buy-in' to the quality agenda, which after all is their agenda as well as ours. It is vital that we enlist providers in the commissioning task of ensuring best and better quality and that we avoid being over prescriptive in contract terms. We believe that this is why the introduction of the new Operating Principles has been universally welcomed by our providers – they encourage joint working, they set out principles for best practice, they are mutually designed, and they reduce the long lists of quality

requirements within the contract schedules.

For each OP, we agree with the provider a few discrete 'proxy indicators' of compliance with the principles. We also let the providers know that should other lines of enquiry suggest a need, (for example when patients and carers are telling us there are issues of poor care) we would ask for broader evidence of compliance with a particular Principle. We would then initiate a more in-depth look at the area of quality in question, working with the provider to determine if action was needed to improve against the principles.

The Operating Principles agreed to date include:

- Dignity Privacy and Respect (incorporating Care and Compassion)
- Equality and Diversity (incorporating compliance with the Equality Act)
- Serious Incidents Requiring Investigation (SIRI's)
- Nutrition and Hydration
- Medicines Security and Management
- Safeguarding Adults
- Safeguarding Children
- Eliminating Mixed Sex Accommodation
- Care Home and Intermediate Care Quality Assurance

The Quality Team, working with clinical commissioning leads, contracting and commissioning managerial colleagues, and with providers, will build on these principles during 2012-13 and plan to add the following:

- Pressure Ulcer prevention
- Record Keeping Best Practice
- Improving the health of mothers, babies and children
- Principles of Self Care
- Using Patient and Carer feedback to inform improvements in care quality
- Public Health messages – making every contact count
- Quality of Life – making sure to treat the whole person

As soon as robust communications are in place with patient groups in the localities, we plan to consult with communities about what they would like to see as future OPs, so we are sure that not only are the public influencing decision making around commissioning decisions, but also deciding what is important to monitor with respect to quality assurance.

This suite of Operating Principles will support the work of NHS Commissioning Board,

by reducing duplication of key quality indicators, and ensuring locally driven quality initiatives are developed, embedded and assessed within the health community, through joint working initiatives and an integrated community wide focus on quality improvement.

Transparency and accountability

Transparency and accountability to the Public continues to a highly important driver within NHS Policy and this will need to be reflected in our relationships with stakeholders, patients and their carers, and the wider communities we serve. The availability and transparency of information is key to ensuring patients and the public are able to exercise informed choice in the services they receive and help drive improvement.

During 2012/13 and on into 2013/14 we will continue to focus on improving access to information for the Public and in particular access to information regarding the quality and safety of services to inform choice. We will expand the information available to patients on the performance of services and will further develop integrated information sharing between services where this improves the quality of care provided. We will tell patients what has been said to us through MICC about patient experience and we will publish detail of the actions that have been taken as a result of that feedback.

We will give patients better access to their health records in-line with national recommendations and information governance regulations and will publish local information. In due course, the CCG will publishes all the relevant quality and performance data in respect of the services we commission so that our patients can be increasingly well informed and better able to make their care and treatment choices.

In addition, a Duty of Candour will be included in contracts to require providers to be open and transparent in admitting any mistakes.

Safeguarding

Safeguarding systems will continue to be strengthened in 2012/13 with a need to ensure that Primary Care is prepared for the requirements under Care Quality Commission (CQC) registration and that the new commissioning system has the appropriate arrangements in place to safeguard individuals and families.

The Cluster will continue to work in partnership with local authorities through Safeguarding Children Boards (LSCBs) and Local Safeguarding Adult Boards (LSABs) to ensure that the needs of the most vulnerable are safeguarded. There will be a focus on a proactive approach to commissioning and contracting of individual placements, and strengthened quality assurance mechanisms for placements in and out of the County.

The CCG will have clinical leads for both Safeguarding Children and Safeguarding Adults to ensure that the Governing Body has a firm grasp of the issues facing vulnerable adults and children in healthcare. The clinical leads will work with Safeguarding leads within the Quality team, and there will be a robust strategy for Safeguarding both adults and children so that the CCG is able to carry out its statutory duties to keep people from harm in healthcare. This is being developed jointly with the other CCGs in Devon to ensure compatibility of processes, and to prevent the formation of gaps between services.

In depth Quality Reviews by Condition

NICE are now publishing Quality Standards and it is anticipated that there will be up to 150 of these developed in the next 4-5 years. The CCG has started looking at these standards within the Clinical Pathways Groups (CPGs), led by the Clinical Effectiveness lead in the Quality Team. The Quality Standards are a set of specific, concise statements and associated measures setting out aspirational, but achievable, markers of high quality, cost effective patient care, covering the treatment and prevention of different conditions and diseases.

Quality Standards will be reflected in the new Commissioning Outcomes Framework (COF) being developed by the NHS Commissioning Board and are designed partly to help commissioners to be confident that they are purchasing high quality and cost effective services.

The CCG will continue to be at the forefront of measuring outcomes and indicators in relation to quality of care and to drive local improvements in quality and outcomes for patients through the work of the CPGs, and using the COF (in due course), the NICE Quality Standards and other measures to demonstrate progress to both the NHS Commissioning Board, and the wider public and stakeholders.

6. Structure and governance

The Shadow arrangements

In February 2012 the Joint Boards of South Devon Shadow CCG and Baywide Shadow CCG voted to form one Shadow Governing Body which would hold the transitional responsibilities (including overseeing the Scheme of Delegation from Devon Cluster to the Shadow CCG). Full delegation was enabled in April 2012.

Risk management and assurance frameworks are currently held by the Cluster Board of Devon, Torbay and Plymouth. It is anticipated that this will transfer to the Shadow Torbay and South Devon CCG, through a clearly defined Scheme of Delegation, by October 2012 (in shadow form) and by April 2013 in fully Authorised form.

The accountability agreement for the Shadow CCG is as follows, and conforms with the draft 'Governance Arrangements for the Torbay and South Devon Clinical Commissioning Group (Version 1.0) produce by the Devon Cluster.

This agreement details the following three principles for managing the delegated authority from the Cluster to the Shadow CCG:

- It is based on the maximum possible delegation of delegable functions and responsibilities from the Cluster to the Shadow CCG on 1 April 2012, with specified exceptions. The Shadow CCG will also fulfil the Professional Executive Committee (PEC) statutory duties for the population served by the CCG.

- The Shadow CCG operating model supports the principle that the management functions and responsibilities delegated to the CCG Shadow Governing Body will be delivered through its shadow and interim management structure, alongside a detailed plan of Practice engagement and organisation development, which will clearly detail both the clinical and financial decision-making flows to be developed within the Shadow CCG. The Scheme of delegation would allow the Shadow CCG to operate with high levels of

autonomy and authority i.e. strategy, decision making, delivery, allocation and management of resource takes place at the locality level, with the CCG Shadow Governing Body receiving assurance on the performance and delivery of agreed outcome-based delivery plans.

- The Shadow CCG will provide appropriate assurance to the Cluster Board that the functions and responsibilities delegated to it are being delivered.

As a sub-committee of Devon Cluster Board, the Shadow CCG will provide assurance on its performance management arrangements through regular reporting. In addition, the following roles have been agreed as accountable roles on the Shadow CCG Governing Body during transition:

- Cluster CEO to hold the position of Shadow Accountable Officer on the Shadow Governing Body
- Cluster Director of Finance to hold the position of Shadow Chief Finance Officer on the Shadow Governing Body
- Cluster Director of Nursing to hold the position of Shadow Board Nurse on the Shadow Governing Body
- Nominated Non- Executive Director (NED) of the Cluster Board to hold the position of Shadow NED on the Shadow Governing Body (this latter post to specifically create the assurance link between Shadow Governing Body and Cluster Audit Committee)

Performance management is further strengthened by the creation of a Senior Management Team (SMT) within the Shadow CCG, which is staffed by the Heads of Department and Chaired by the Joint Clinical Chairs of the Shadow CCG and the Shadow Managing Director of Transition and Commissioning. A 'Terms of Reference' for this committee have been approved by the Shadow Governing Body, and by the Cluster. An open invitation to all Cluster executives has been extended for attendance at this Committee, which has a specified level of delegation from its Shadow Governing Body as regards strategic and operational planning.

The Organisation Development (OD) Plan

The emerging guidance around the governance of Clinical Commissioning Groups (CCGs) suggests that the creation of responsive and accountable structures will depend upon the development of both transactional and transformational processes required to discharge their duties. The latter will comprise financial controls, stewardship of resource and the effective commissioning of services which are clearly matched to the needs of its population.

The CCG will be accountable to the NHS Commissioning Board (for statutory duties), to the local community for their ability to commissioning high-quality services, and also have oversight from the Local Authority.

The emerging organisation development plan will be predicated on the CCG's ability to:

- Focus on the organisation's purpose and on outcomes for the population of Torbay and South Devon,
- Perform effectively in clearly defined roles and functions,
- Define and promote values for the whole organisation, and demonstrate values of good governance through behaviour,

- Take informed, transparent decisions and manage risk,
- Develop the capacity and capability of the Governing Body to become effective,
- Engage stakeholders and make accountability visible and real.

In addition, the emerging OD plan commits the new organisation to creating structures which support the commissioning of excellent services, and which drives both clinical leadership and staff development towards attainment of its vision which (after significant consultation) is presented here:

South Devon and Torbay CCG: commissioning excellent, joined-up care for everyone. Fresh, innovative and population-focused – we are led by doctors, by healthcare professionals and by the views of our local people. Small enough to respond: big enough to deliver.

The following OD objectives have been agreed by the Shadow Governing Body and are the backbone of our development towards Authorisation:

- Creation of a statutory Constitution with Practice, public and patient/user engagement. Key to this is evidence that all of our constituent parts understand and own what is required of this method of engagement
- Finalisation and consultation on proposed final structures
- HR process to align current management structures with future needs
- Governance: Due Diligence and the creation of key governance documents to support a transparent and accountable system of assurance and risk management
- Policy development and endorsement
- Stakeholder analysis: internal and external
- Strong communications plan which clearly translates our vision into practice
- Clear and visible links to transformation plans
- A credible plan for staff development
- A credible plan for clinical leadership development, and in particular the creation and nurture of a talent management system for the future
- Board development – both in the creation of our new Governing Body and in sustaining its competence into the future

The process of Authorisation

The Shadow CCG is confirmed as a Second Wave CCG and is currently using the framework presented in the 'Draft Guide for Applicants' dated June 2012 as well as the standards presented in the Declarations of Compliance for the CCG. The latter comprise our duties relating to:

- Research
- Procurement
- Choice and shared decision-making
- Equality
- Education and Training
- Sustainability

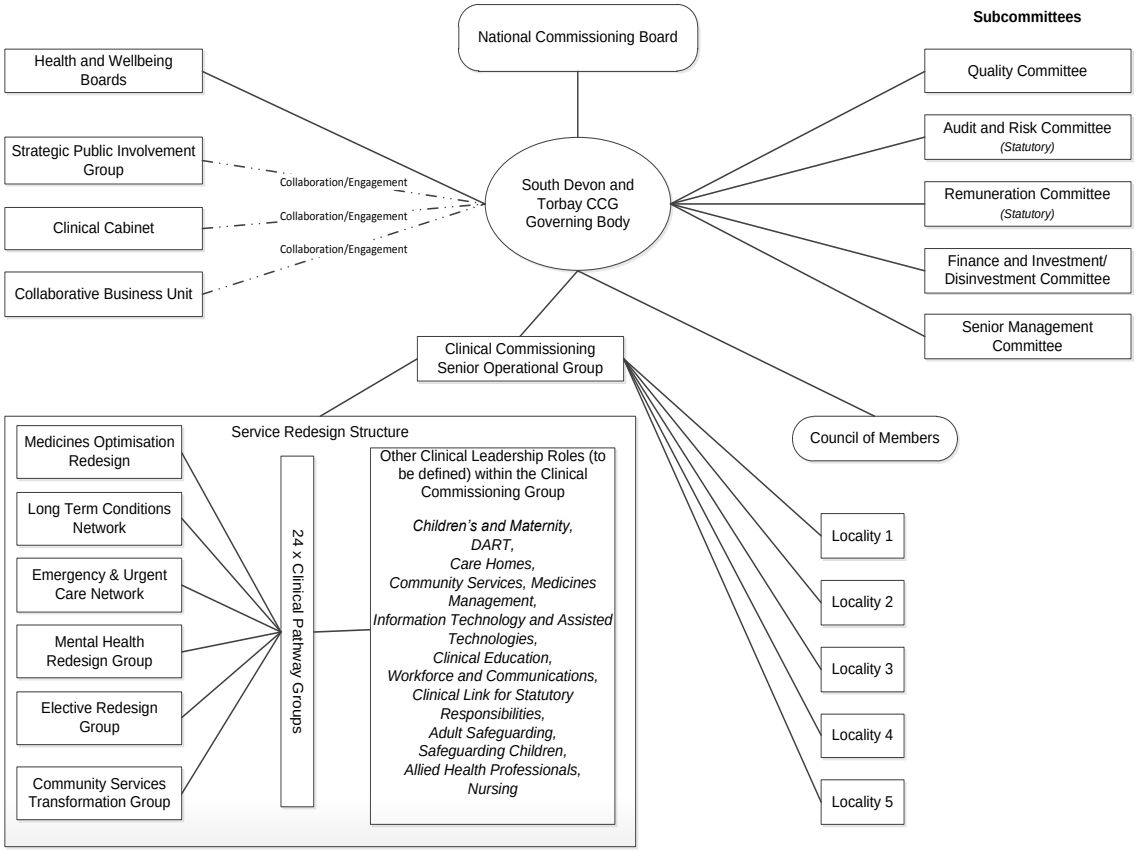
- Innovation
- Commissioning Support

Creation of the Governing Body

In accordance with national guidance, our plans to create and establish a Governing Body of officers (who will remain designate until April 2013) are well-developed and have strong support from our constituent Practices. This body will be in place by the end of August 2012. Members include:

- The appointment of a Clinical Accountable Officer through national selection and local Practice mandate
- The appointment of a Clinical Chair, through national selection and local Practice mandate
- The appointment of a Chief Finance Officer post – national selection
- The appointment of a Chief Operating Officer post – local selection
- The creation of a further five clinical (GP) Board-level roles through local selection: in consultation with Devon LMC
- The recruitment of a Board Nurse and Senior Clinician, appointed on a non-executive and part-time basis to the CCG
- The recruitment of two lay members, one responsible for patient involvement, and the other for finance and governance
- Creation of statutory governance committees (Audit and Remuneration)
- The establishment of a number of other functional and collaborative committees within the CCG
- The creation of a Council of Members, comprising commissioning management and clinical leads from all Practices. This body will ensure engagement, and hold our Governing Body to account on behalf of constituent Practices

Added clinical value through leadership is embedded throughout the CCG and is represented in the emerging model, below:



7. Finance Planning & Investments

Planning Parameters

2012/13 is the second year of the current Comprehensive Spending Review (CSR) which covers the four year period 2011/12 to 2014/15. The review confirmed that despite a background of reductions in public spending, NHS spending in England would rise in real terms by 0.1% per annum during this time.

The CSR also identified the need for the NHS to make efficiency improvements of circa £20bn over the same period in order to cope with the increased pressures it will face from technological advances in drugs and other treatments, demographics and other structural changes.

In particular, the CSR signalled the establishment of a £200m cancer drugs fund, increased numbers of health visitors, an additional £1bn to be invested in social care and an anticipated £0.5bn of cost pressure from other Government departments.

The CCG has set its financial plans for 2012/13, and its medium term financial plan to 2014/15 to reflect its assessment of the local impact of these national expectations.

2012/13 will be the last year that allocations will be made to PCTs. 2012/13 allocations see a 2.8% growth in recurrent allocations for local PCTs within the Devon Cluster plus a share of £150m for Reablement. Taking the funding for Reablement with the growth in recurrent resources, overall resources increase by 3.0% for all PCTs.

In 2012/13 the Devon Cluster will delegate authority for the management of commissioning budgets as well as the responsibility for investment decisions to the CCG. Table **X** below outlines the indicative growth funding, and indicative total resources available for the CCG, given current PCT allocations.

Public Health commissioning budgets will transfer to the Local Authorities from April 2013. Allocations are unknown at present although indicative estimates suggest a reduction in current budgets within Torbay and growth in Devon albeit over a period for pace of change.

Table X: CCG Indicative Allocations and Growth in Funding 2012/13

CCG	2012/13 Recurrent Allocation £000	Recurrent Growth £000	Recurrent Growth %	Recurrent Growth Incl. Reablement Funding £000	Recurrent Growth Incl. Reablement Funding %
South Devon & Torbay CCG			2.8%		3.0%

The indicative CCG budget is given in detail at **Appendix X** and sets out:

- Opening budget for 2012/13,
- A summary of the source and applications of new resources for 2012/13,
- A summary of the efficiency requirements for 2012/13,
- The Provisional CCG QIPP plan for 2012/13 .

Budgets have been delegated to the CCG as a sub-committee of the Cluster Board and in line with the framework and governance set out in **Appendix X**. This framework was formally adopted by the CCG Governing Body in June.

Planning Requirements: National and Local

The CCG is required to achieve a surplus of 1% or £xm across the PCTs within the Cluster. The CCG has increased its planned surplus to x% or £xm in recognition of the differential starting points of the PCTs in Devon and the need to achieve financial targets across the Cluster in 12/13. Table **X** below sets out the planned surplus.

Table X: CCG Planned Surplus

CCG	2012/13 Delegated Budget £000	2012/13 Planned Surplus £000	2012/13 Planned Surplus %
South Devon & Torbay CCG			

It is anticipated, and part of medium term planning assumptions, that surpluses achieved in 2012/13 will be made available to future commissioning organisations to deliver services to their populations

The CCG must plan for 2% of its revenue allocation to be available recurrently to fund the non-recurrent cost of change. The CCGs financial plans are compliant with this requirement. The sums set aside are held at the Cluster and are set out in table **X** below. Funding from Headroom can only be used on non-recurrent costs, and requires the approval of both the Cluster Board and NHS South of England before funding can be released.

Table X: CCG Headroom

CCG	2012/13 Headroom Funding £000	2012/13 Headroom Committed £000	2012/13 Headroom Uncommitted £000
South Devon & Torbay CCG			

In reaching 12/13 contract agreement with NHS providers headroom has been accessed in line with the approval process set out above. This is set out in Table X above.

Investment Priorities

Given recent lower acute sector secondary care activity growth levels than in previous years the priority will be to ensure that services are maintained and the underlying growth in the demand for healthcare services managed whilst ensuring quality improves.

In addition there are a number of priority areas of investment:

- Reablement,
- Improving access to mental health services (including dementia),
- Support for carers,
- Implementing the 111 service,
- Implementing HART services,
- Expanding health visitor services.

Investment plans are set out in detail in **Appendix X**.

The CCG has developed a transparent and rational approach to investment decisions which is fundamentally clinically led. The Business Development and Performance process is set out in **Appendix X**. This is same function which controls the performance management of QIPP delivery.

Inflationary costs

Table X below outlines the key inflationary assumptions included within the 2012/13 plan.

Table X: Inflationary and Volume Growth Assumptions

Spend Area	Assumption	Rationale
NHS Secondary Care Contracts	-1.8% (2.2% inflation less 4% Efficiency)	As indicated within national operating framework. Actual impact of changes
Primary Care Prescribing	4.5% (8.5% less 4% Efficiency – Covering both price and volume change)	As per recent trends
Primary Care Contracts	0.5%	As indicated in national contract awards
Continuing Healthcare	10% (covering both price and volume)	As per recent trends
Drugs and Devices excluded from Tariff	10-15% (Volume, provider specific)	As per recent trends
Volume increases in	1% by value	As per underlying

Secondary Care Contracts		Demographic changes
CQUIN	An increase from 1.5% to 2.5% of contract value	As per National Operating Framework

QIPP Requirements

To be able to afford to increase the surplus, the underlying inflationary pressures and the cost of new investment, the local health system has to become more efficient. This forms the CCG's Quality, Innovation, Productivity, and Prevention (or QIPP) challenge for 2012/13.

The CCG's QIPP requirement is **£Xm** in addition to the 4% cash releasing efficiency savings (CRES) pass-ported to providers of **£Xm**.

In addition, QIPP schemes equating to £5.7m recurrently were planned in 12/13 for South Devon Healthcare NHS Foundation Trust and is in addition to the Trust's required 4% CRES efficiency saving. These have been mitigated by £2.2m in reaching contract sign-off with the Trust.

There remains a clear requirement to achieve recurrent reductions in the current cost of commissioned services.

The QIPP plans are built around five themes (detailed in **Appendix X**):

- Intelligent referral (elective care),
- Cost effective, non-admitted care pathways (elective care),
- Proactive case management (non-elective care),
- Robust alternatives to admission (non-elective care).
- Secondary Care Drugs & Devices

The achievement of QIPP at South Devon Healthcare NHS Foundation Trust is the principle risk facing the local health community in 2012/13 and beyond.

Running Cost Requirements

The financial plan includes a planned reduction in running costs of **£Xk**. It is important to manage this reduction to ensure the minimum impact on the public purse whilst also ensuring that the CCG retains the operational capacity to deliver the commissioning requirements for 2012/13 and prepare for the new commissioning infrastructure from 1st April 2013.
In 2013/14 the CCG will be expected to manage its running costs within an overall limit of £25 per head of population. Current plans are consistent with this requirement and take account of the expected transfer of overhead to support commissioned services moving to the National Commissioning Board, Local Authorities, and other organisations.

Financial Management

The CCG has been actively leading the in-year risk assessment and financial management across the range of its activities as well as contributing to the financial plan for 12/13 with the Devon Cluster. The CCG has been fully involved in negotiating the parameters and operation

of the Cluster's financial framework in regard to the CCG's delegated responsibilities in 12/13. This understanding, of and commitment to, a transparent approach to financial management in 12/13 will allow the CCG to continue to build on its track record of managing within delegated budgets, regular reporting, achieving financial targets, and providing a credible approach to achieving the QIPP challenge ahead of 13/14.

The Clinical Commissioning Group is the co-ordinating commissioner of South Devon Healthcare NHS Foundation Trust (3 associate commissioners), South West Ambulance Services NHS Foundation Trust (6 associate commissioners), and Torbay & Southern Devon Health & Care NHS Trust (2 associate commissioners).

In addition, the CCG is an associate commissioner to other significant NHS contracts with Devon Partnership NHS Trust, Royal Devon & Exeter NHS Foundation Trust, and Plymouth Hospitals NHS Trust, and the Specialised Commissioning Group.

In agreeing the 2012/13 contracts the CCG led the negotiation process with the Trusts and successfully agreed all contracts within expected timescales and budgets.

The approach taken to contracts has been to agree financial envelopes on 11-12 outturn adjusted for drugs and devices growth. Contracts are largely 'block' and variances from contract are limited. This contract arrangement will provide for a substantially 'de-risked' year in 12-13 from the financial perspective which is important ahead of CCG authorisation. It is also felt more able to support the delivery of QIPP as it incentivises Commissioners and Trusts to focus on removing system cost rather than negotiating solutions around reducing Commissioner spend and Trust income respectively. This arrangement has required the use of headroom and other non-recurrent funding and it is increasingly important in 12-13 that progress is made in delivering the QIPP programme so that negotiation for 13-14 begins with a lower contract value than in 12-13. It is acknowledged that maintaining a reliance on non-recurrent funding for recurrent spending is not a sustainable position in the medium term.

The CCG has used the opportunity provided by the DH contract transition assurance process to assess the adequacy of its contract governance across the range of commissioned healthcare. This has led to the establishment of a contract risk register which is used to identify where improvement is necessary and manage this process.

The performance, quality, and financial aspects of contracts are managed through Performance & Contract meetings held regularly with providers.

2013/14 Commissioning Intentions

Further progress is needed in the recurrent delivery of QIPP.

Workforce plans, activity plans, and finance plans need to be integrated.

The CCG will live within its £25 per head running cost allocation.

Contracts will be agreed in a way which seeks to mitigate risk while maximising the opportunity for system wide cost restructuring and efficiency.

In agreement with the Health & Wellbeing Boards provide a focus of commissioning activity on shared priority service areas.

Activity, Workforce, and Finance – QIPP (Integrated Approach)

How we will do this? Activity increasing ↑ Workforce staying the same → Finance getting worse ↓?

Business Planning

Over the last year much effort has been made to implement a rigorous process for signing-off business cases. This has involved setting-up monthly performance review meetings, whereby commissioning leads can present their QIPP plans for expert review by finance, commissioning, performance and information leads, before they are finalised ready for Board approval.

We have also begun to design and implement standard templates for business cases which include detail on service change, benefit for the patient, key performance indicators to demonstrate success and financial benefits. Financial benefits are worked-up in conjunction with information and finance specialists who have a sound knowledge and understanding of how services are contracted and paid for. Decisions for investment can then be made on an informed basis.