NHS
South Devon and Torbay
Clinical Commissioning Group

South Devon and Torbay Clinical Commissioning Group

Strategic Plan 2014 - 2019

Excellent, joined up care for everyone.

Contents

Executive Summary

This is an update of our 2013-16 integrated plan. We have taken a fresh look at it because, one year on, we see a shifting landscape in health and care, with new national initiatives, new local ambitions and – importantly – a deeper understanding of what our communities want from us.

Our vision, to see excellent joined-up services for everyone, remains unchanged. And we stand by our determination to improve healthcare for our population while ensuring the long-term sustainability of our health and care services. But we are taking a longer view, up to 2019.

During the year, South Devon and Torbay Clinical Commissioning Group (CCG) and its partners in the health, care and voluntary sectors made a joint bid to become a pioneer site for integrated care. Out of 100 entries, we became one of 14 successful sites nationwide. This has given new impetus to our drive to join up services across the whole system, so that people can get the care and support they need, easily, wherever possible in one place, and without a struggle. This JoinedUp integration programme is a key part of our overall plan.

Over the last year we have visited towns and villages across our area, holding meetings to ask people what they most want from their community health and social care services, their mental health care, and services for people with learning disabilities. We have done this alongside our local Patient Participation Groups, local councillors and local people with a particular interest in health and care. Using the intelligence gained from this patient and public feedback, as well as the Joint Strategic Needs Assessment, we have set out our vision for the next five years and detailed priority work areas for the next two years. Involving patients and the public in key commissioning decisions is crucial, especially when we face the combined challenges of the overall economic situation and an increasingly elderly population with increasingly complex needs.

We have been working closely with our partners, in particular the Health and Wellbeing Boards of Torbay and Devon which provide local leadership in the delivery of a sustainable health and care system. The Health and Wellbeing Boards have been integral to the way this plan has been developed, ensuring that the priorities of all partner organisations are in step with one another. Through our community being awarded Pioneer status, and the national support which comes with this, we believe we can continue to build on this work to deliver the significant changes which are needed.

We know the next few years will be demanding, particularly as our budgets are recurrently over-committed, meaning we are spending more on healthcare than we've got available. We also understand our health and care system needs to change if we are to be able to deliver excellent services for future generations.

The people we have talked to have told us they value joined up care which provides care closer to home, continuity of care and access to services through a central contact point. We have also been told that care and treatment for mental health illnesses is an important component of overall well-being. We see new 'community hubs' being a central contact

point for overall wellbeing, providing a single point at which people can get what they need for prevention, self-care, social care, mental health and clinical services.

We see a new Integrated Care Organisation bringing together hospital and community services as the next major step towards achieving a joined up system. This will come about through South Devon Healthcare NHS Foundation Trust acquiring Torbay and Southern Devon Health and Care NHS Trust. The new integrated organisation will be able to deliver the scale of efficiency savings we all need to make sure services are sustainable for the future. A start in this direction is provided by the Better Care Fund (a single pooled budget to support health and social care services to work more closely together).

We will also work with our Public Health and Local Authority colleagues to promote prevention and personal responsibility, particularly relating to alcohol, smoking and healthy eating and lifestyles. It is vital that together we reduce health inequalities, and support people affected by disadvantage, unemployment and low incomes.

To be the best clinical commissioners we must keep our focus unremittingly on our patients and our population, and ensure the services we commission not only represent value for money but offer the best outcomes for each individual. We will continue to work towards and achieve the outcomes set out in the CCG Outcomes Indicator Set and the ambitions outlines in the 'Everyone Counts: Planning for Patients 2014/15 to 2018/19' guidance.

There will be some challenges along the way, but we believe we are in a strong position to achieve our vision, particularly given the dedication demonstrated by our staff. We look forward to taking the next steps towards delivering excellent, joined up care for everyone in South Devon and Torbay.

Dr Sam Barrell

Dr Derek Greatorex

1 About us

1.1 Who we are and what we do

South Devon and Torbay CCG is a Clinical Commissioning Group representing all of the local GP practices. Following authorisation on 1 April 2013, South Devon and Torbay CCG has become a formal NHS body responsible for buying and developing services for local patients.

We are led by senior GPs committed to putting the patient first, and we are among the few CCGs which have chosen to have a doctor as their leader rather than a manager. We are responsible for planning, designing and commissioning (buying) health services for our local population, working with partner organisations across a range of sectors to improve people's health, quality of life and wellbeing.

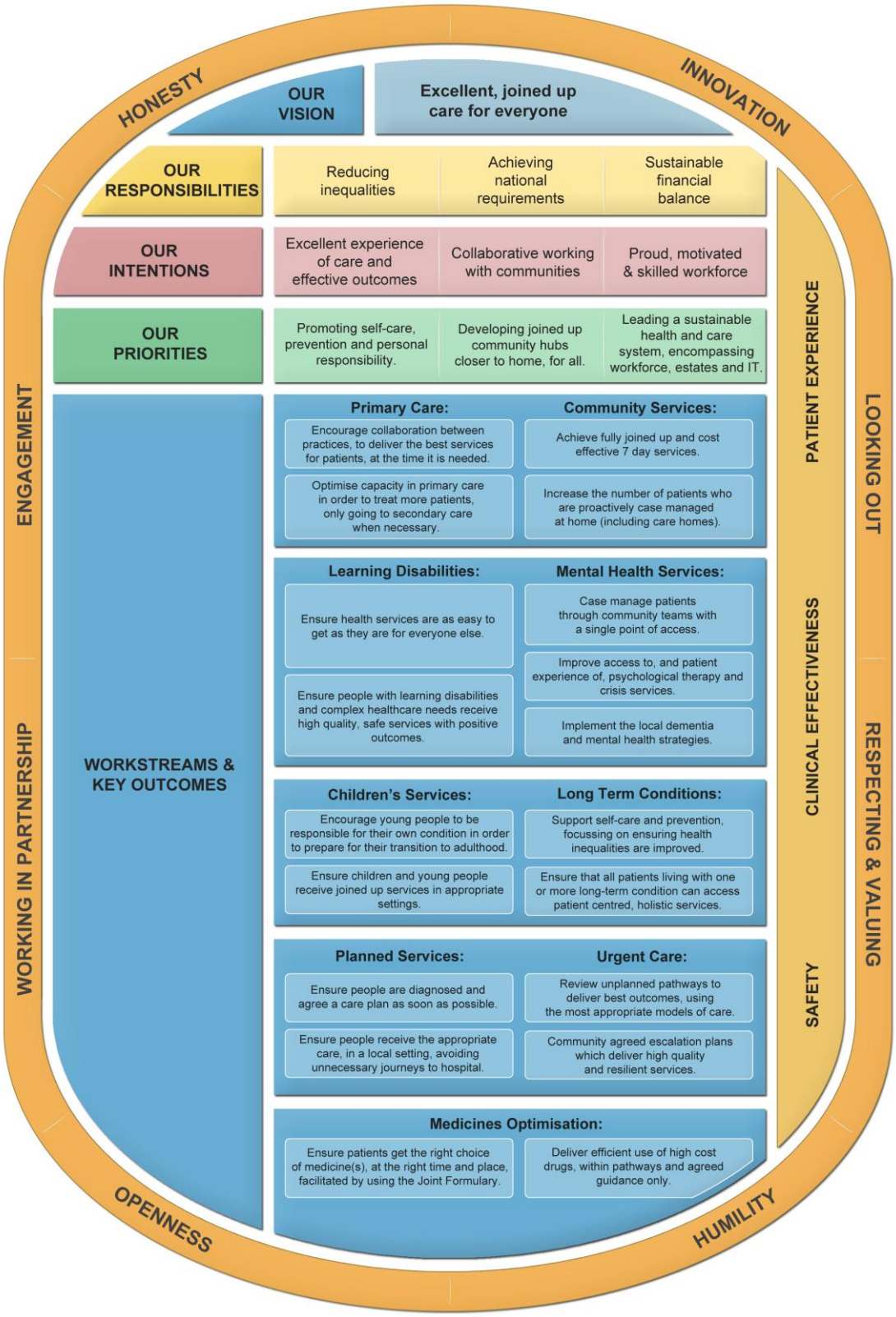
Locality Commissioning Groups

Our Governing Body has established a set of five groups known as the Locality Commissioning Groups (LCGs) – Coastal, Moor to Sea, Newton Abbot, Torquay and Paignton & Brixham. They are led by GPs and comprise representatives from the practices, including practice managers and patients. Through these groups, local commissioning can reflect local needs, which we know will be different in Widecombe-in-the-moor and Newton Abbot, and different again in Torquay.

The Locality Commissioning Groups will support the development of our CCG as a membership organisation, and enable local engagement with the public and GP member practices. Through them, local health needs, priorities and gaps in service provision are considered in the commissioning process. The localities are represented at the Clinical Commissioning Committee by their clinical and managerial leads. They are also responsible for the delivery, in partnership with other colleagues, of the Plan on a Page – our one-page summary of our overall plan.

1.2 Our Priorities – 'Plan on a Page'

So that we can develop and deliver our vision for the next five years we have needed to refresh our priorities which are informed through engagement with our stakeholders and through other information. The result can be seen in our 'Plan on a Page':



In order to develop the 'Plan on a Page' we have completed an extensive piece of information gathering and engagement, described as follows.

Qualitative:

During 2013/14, and carrying on into 2014/15, we have undertaken widespread engagement with many of our key stakeholders. We have held engagement events in each of our localities (on average one a fortnight) on community services and several engagement events on Mental Illness services and Learning Disability services.

The priorities of the Health & Wellbeing Boards of Torbay and Devon have informed our own priorities and we have asked all of our redesign boards, which sit across our nine work streams to feed back their views on our strategic direction and priorities over the next five years. These redesign boards have representation from our provider organisations, clinicians, public and local government,

In 2013/14 we introduced a system for collecting and analysing patient feedback and quality information from various different sources, including Patient Opinion, the Friends & Family test, local hospital surveys and feedback from professionals.

Quantitative:

During 2013/14 we developed the South Devon & Torbay Joint Strategic Needs Assessment (JSNA), by incorporating additional assessments of needs where we had identified gaps, for example in the areas of alcohol, mental health, carers, care homes and dementia. We have supplemented this with other intelligence and benchmarking from the NHS England Commissioning for Value Pack, CCG Outcomes Indicators, Dr Foster, Public Health England Profiles, NHS England Primary Care Tool and others.

Bringing the Plan together:

Qualitative and quantitative information was amalgamated and reviewed by our redesign boards, Clinical Commissioning Committee and Governing Body at several stages. This has resulted in the production of our 'Plan on a Page' which sets out our vision, responsibilities, intentions and commissioning priorities for our health community over the next five years. The work streams which will deliver the key outcomes sit underneath and underpin the delivery of our plan. Quality – good, safe services that mean a good experience for those using them - runs through all of our plans. Our values and behaviour are important to defining our organisation and how we will go about achieving our priorities. They encompass our whole plan.

1.3 What we have done so far

Improving Outcomes & Key Indicators

We have continued to improve outcomes for patients and to achieve well against the NHS Outcomes Framework indicators. In particular:

- We have statistically lower levels of mortality for cardiovascular disease.
- We have statistically lower levels of emergency admissions for chronic conditions that can be looked after in primary care, such as. asthma.
- We have good Patient Reported Outcomes Measures for elective procedures such as groin hernias and knee replacements.
- Friends & Family scores for acute hospital services are high.

We have also maintained or improved performance against the NHS Constitution Operational Standards. In particular:

- Referral to treatment waiting times continue to reduce
- Diagnostic waiting times continue to be achieved.
- All cancer waiting times indicators continue to be achieved.
- Accident & Emergency national waiting times continue to be achieved.

The proportion of people under adult mental health illness specialties on a Care Programme Approach who are followed-up within 7 days of discharge continues to be achieved.

Current year-to-date performance of all of the CCG's key measures, including the CCG Outcomes Framework and the Seven Ambitions, can be seen at Appendix 1.

Service Improvements

We have commissioned and led a number of service improvements this year, which have brought benefits to the quality and consistency of services across South Devon and Torbay.

In primary care, we have supported three 'access improvement' schemes to help increase capacity in primary care and these are now underway in 22 practices. They are Doctor First, Productive General Practice and Urgent Access in Primary Care. An assessment/comparison of their value has been undertaken. It is too early to be certain of the benefits these schemes have delivered, and they will be reviewed again in July 2014.

In the community, the Virtual Ward is established in all localities, ensuring close case management of those most at risk of being admitted to hospital. We are re-examining the risk stratification to reflect the top 0.5% of the CCG population (as opposed to practice population). Other developments in the Virtual Ward include the identification of patients further down the risk list to ensure coordinated access to services, the inclusion of targeted alcohol workers, and plans to include dementia link workers.

Our South Devon and Torbay health and care community has been successful in its bid to become a Pioneer site for integrated care. As one of 14 pioneer areas nationwide, we will

benefit from national and international support as we forge ahead with joined-up work across our whole community, to make a real difference for our population.

In urgent care, the 111 service has been implemented, in hours, under clinical leadership. The out-of-hours transfer to 111 is planned for March 2014, with the agreement of the local Urgent & Emergency Care Network. .

In Mental Health, we have been engaging people with lived experience of mental health problems and mental health staff in a major redesign of the service, focusing on caring for patients in primary care with support from joined-up mental health community teams. We are listening to what people want and implementing the changes as we go along – for instance, we will have piloted a crisis house in Torbay, as an alternative to inpatient admission, because that is what people have said they need.

The four-year strategy for psychological therapy and crisis service (including for children) is now approved.

The new Torbay dementia advisor service was formally launched on 3 September and is being provided by the Alzheimer's Society.

In planned care, patients being referred for suspected gastroenterology or colorectal cancer are now being pre-tested at their GP practice. This means they can then be booked straight into hospital for the appropriate test, therefore reducing their waiting time.

Financial Stability

This has been a difficult year in terms of budgets being continuously moved between the new commissioning organisations, and some unplanned overspends in some areas. . However, we have still been able to reduce our recurrent over-commitments in spending while maintaining headroom flexibility.

2 Our Community

2.1 Local Context

Our CCG extends from the South Devon coastline to the open moorland of Dartmoor (see Fig. 3). The CCG covers some 350 square miles and takes in a GP-registered population of around 288,000.

Our area proves a popular retirement destination, with a noticeably higher proportion of older people resident in the area (shown in the population pyramid overleaf). With this comes an impact on the health and social care services that need to be provided. This includes the management of complex and multiple long-term conditions, a higher number of injuries resulting from trips and falls, and the treatment of age-related diseases. We also need to balance this with ensuring the health and social care needs of the rest of the population are also met.

South Devon and Torbay is a popular tourist destination, attracting both day and longer-staying visitors. In the peak of the summer, there are estimated to be up to an extra 75,000 to 100,000 people visiting the area.

Fig 3. South Devon & Torbay CCG footprint, source: 2012/13 JSNA.

Using our JSNA enables us to understand our population and health needs in the forthcoming years.

2.1.1 Population

The area as magnet for people who are retiring can be seen in the population pyramid (see Fig. 4). The current average age in the South Devon and Torbay population is around 44.2 years, compared with an England average of around 39.5 years.

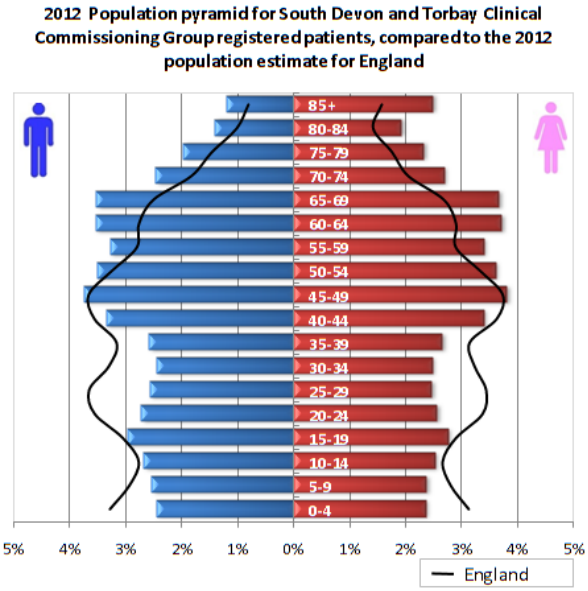


Fig. 4 Population Pyramid, source: 2012 GP registered list, 2011 interim subnational population projections (ONS)

The Office for National Statistics predicts a total population of around 300,000 registered with GPs in 2021 (see Fig. 5). Projections for the South Devon area show a noticeable increase in the over 85 population between 2012 and 2021.

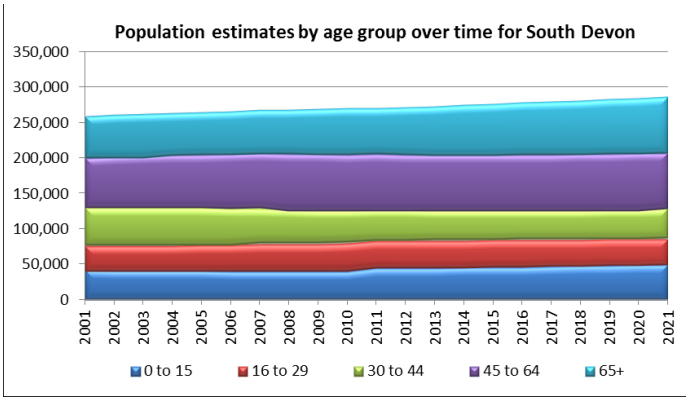


Fig. 5, Registered population projections, source: 2011 interim subnational population projections (ONS) modelled on 2010 LSOA population estimates (ONS), 2001 to 2009 Mid-Year Estimates, ONS.

2.1.2 Deprivation

Within the South Devon and Torbay area, there are pockets of severe deprivation, mainly in the urban areas such as Paignton and Torquay. The residents in these areas tend to experience noticeable inequalities, including lower life expectancy and higher rates of premature mortality. This is in part due to the higher prevalence of certain behaviours such as excess drinking and smoking. Other inequalities, including housing, employment and educational attainment also exist within these communities.

The areas in red in the following map (see Fig. 6) are among the top 10% most deprived in England, while areas in dark blue are within the 10% to 20% most deprived in England. In contrast, the yellow areas are among the least deprived in England.

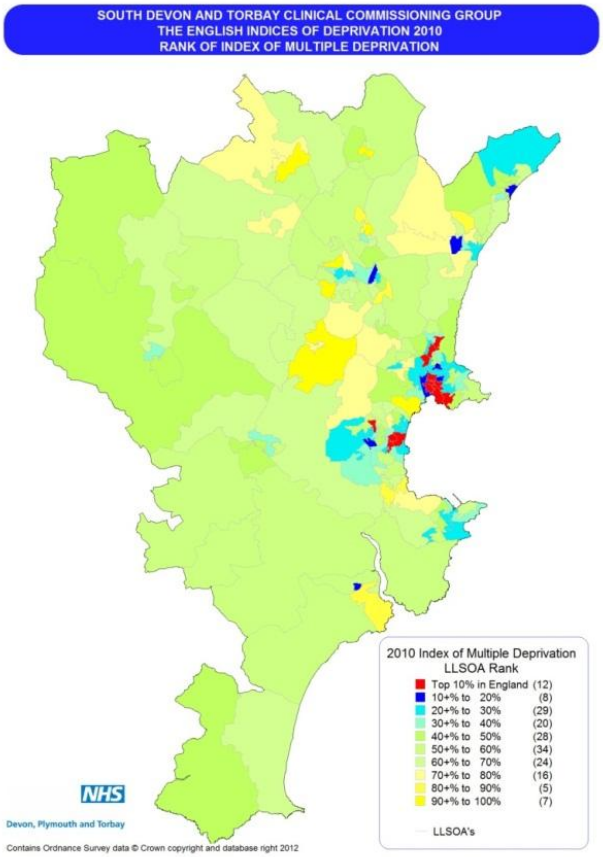


Fig. 6 2010 Index of multiple deprivation, source: Department for Communities and Local Government

2.1.3 Life Expectancy

Overall, life expectancy is high within the CCG area, with a large number of communities experiencing significantly higher life expectancy than the England average (see Fig. 7). However, there are pockets where life expectancy is significantly lower than the average; these are mostly communities within Newton Abbot, Paignton, Teignmouth and Torquay.

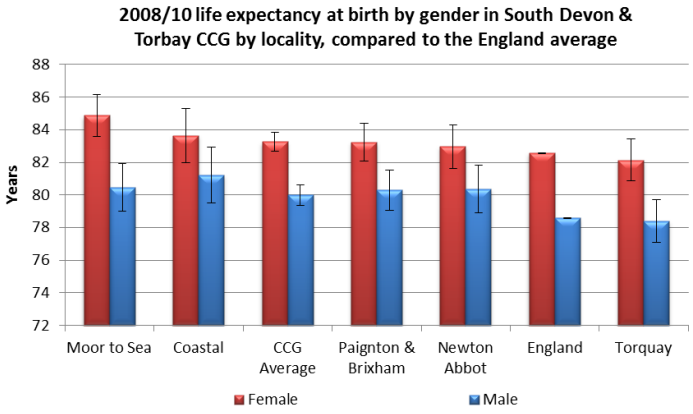


Fig. 7 Life Expectancy at Birth, source: PCMD, GP registered list, Information centre

There is a well-evidenced relationship between poorer communities (in terms of income) and poorer health outcomes. People in our more deprived communities do 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, in the more deprived communities there is a gap of some 17 years between the number of years people live, and the number of those years they live without a disability. Within the South Devon and Torbay CCG area, data suggests that females 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 in our least deprived communities.

2.2 Our Stakeholders and partners

The Public

Our most important stakeholders are the public, our patients and their carers. Our Localities have been working closely this year with our local Patient Participation Groups in each area. Through this joint working we have, as already set out, run a series of Locality Engagement events in every town and the surrounding villages, to seek the views of our local population on health and care services and how they would them designed to be fit for the future.

We have gathered a wealth of information and views from these events, and this has been combined with our Joint Strategic Needs Assessment to help us and our partners to describe our plan for services in the next five years.

Our Partners

Strong partnership working is vital to delivering good quality services and tackling the wider factors that determine or contribute to ill health.

Our CCG works with both Torbay Local Authority and Devon County Council, with community organisations, the voluntary sector, NHS England, our health and care provider organisations and neighbouring CCGs to achieve the improvements we want, and to address the wider inequalities in people's health.

As set out at 2.1, our JoinedUp Health and Care Cabinet has been involved in developing this approach and will continue to be a driving force across the community to ensure we can work as one to achieve the outcomes and goals we have set as our priorities.

Our CCG is actively engaged with the Health and Wellbeing Boards in Torbay and Devon, having a seat on each. This means we have been involved in the development of the health and wellbeing strategies and the boards' priority-setting for preventive health – helping ensure these dovetail with our own priorities. The boards enable a joined-up approach across the NHS, Adult Social Services and Children's Services to tackling the health needs of our local communities.

We continue to maintain the strong relationship we have with colleagues in Public Health, who have moved to the two local authorities. This relationship will aid the joint commissioning of services, and ensure we can benefit from the expertise of our public health colleagues through the 'Core Offer'.

The NHS here has a long tradition of engaging with and commissioning services from the community and voluntary sector. We have built positive relationships with community and voluntary sector leaders and their organisations, and recognise both their knowledge and skills, and the trust that the people who use their services have in them.

We also work with Healthwatch Devon and Healthwatch Torbay - the patient voice in health and social care. Patient Participation Groups are becoming more established, and our Locality Commissioning Groups are building relationships with them and other groups. At a local level, we are playing a part in neighbourhood planning and community partnerships.

We are working alongside NHS England and the Area Team for Devon Cornwall and the Isles of Scilly, particularly on primary care services, and with the Specialist Commissioning Group to ensure patients have access to more specialist services when they are needed.

2.3 Transforming the Care Delivery System

We believe services should be based on local communities and centred on the needs of individuals within those communities. We also believe that services should be built on the public's needs not organisational imperatives; this is a mantra as our Community Hubs take shape. Community Hubs will be centres of wellbeing where our population can receive co-ordinated support for prevention, self-care, social care, mental health and medical support from primary and community care. They will have strong links with community organisations.

We promote wellbeing and independence and will require all our providers of healthcare to move away from an institutional bed-based model of care to a delivery system that is flexible and responsive to the changing needs of our populations. We have been told, through our locality engagement events, that people want care closer to home with a single point of access to services. Over the next five years we will expect to see a reduction in inpatient beds. Three consecutive acuity audits have shown that with additional personal care services 30 - 40% of patients cared for in a community hospital bed could be at home.

The Integrated Care Organisation will provide acute, community and social care services, and through this we expect to see resources shift from inpatient beds to high quality, value-for-money care provided in people's homes. We expect to see a shift in the current workforce configuration to more community-based teams, delivering seven-days-a-week services.

We are working with the acute trust on detailed infrastructure (hospital estate and IT but also the location of services) and workforce plans. A joined-up workforce and integrated IT which enables multiple professionals to share patient records and treatment plans are vital in achieving a better quality of service for our patients in the most cost effective way. We are also working with providers of mental health services in our CCG to ensure that mental health professionals, as well as other agencies, are an integral part of our community based teams, to be co-ordinated through our community hubs.

3 Focused on Quality

A place at the centre for Quality

The NHS defines quality as effectiveness, safety and excellent patient experience. Quality, along with prevention, productivity and innovation, is key to the commissioning of sustainable services for our community. Quality is also a key driver for minimising health inequalities, promoting equality and diversity and raising the life chances and wellbeing of our population.

We expect quality to be central to all of our commissioned services, whoever provides them. As commissioners we have a duty to promote continually improving quality in primary care, and to enable the best, most effective use of secondary and tertiary (more specialist) care.

By ensuring that the quality of care is good, we will ensure that the outcomes for patients are the best. It means we check how patients feel about their treatment or care.

We will continue to include values based operating principles in our contracts. These will be reviewed and updated to ensure they include learning from the above named reports. The Operating Principles we will include cover:

- Healthcare associated infections
- Care and compassion – the 6 Cs
- Equality and diversity
- Safeguarding children and young people
- Safeguarding adults
- Placed people
- Nutrition and hydration
- Francis suite of recommendations
- Medicines' security and management
- Eliminating mixed sex accommodation

3.1 Safety

We will work over the next five years on projects that support providers to tackle issues of patient safety across the health community, through:

Improving Patient Safety

- Becoming active and innovative members of our local Patient Safety Improvement Collaborative, supporting both local and regional initiatives to improve care safety
- As part of our work to care for vulnerable and older people, working in partnership with acute and community providers and residential and nursing care homes on initiatives to prevent pressure ulceration.
- Supporting providers in primary, secondary and emergency care to care for children with possible septicaemia in a timely and effective way, using recognised best practice.
- Ensuring that the quality of care provided for vulnerable adults is closely monitored and that people with Learning Disabilities, autism, challenging behaviour and complex needs have their emotional, health and wellbeing needs met at all times.

- Enhancing our existing processes to ensure that we have robust systems in place to satisfy ourselves that commissioned providers are effectively recognising, reporting and learning from patient safety incidents and are implementing patient safety alerts in a timely way.
- Continuing to promote the use of the Safety Thermometer for an increasing number of providers, and report outcomes on the Integrated Quality and Performance dashboard.

Healthcare Associated Infections (HCAIs)

- Pursing the aspiration for zero tolerance of HCAIs, we will systematically review local objective setting across the organisations from which we commission services. This will include the review of surveillance data to monitor progress against nationally set trajectories for specific organisms and other agreed indicators.
- Continuing to work with providers and the public to reduce the incidence of Clostridium *difficile* and to ensure excellent antibiotic stewardship, as well as supporting the goal of zero tolerance to MRSA.
- Working with providers to raise awareness of and prevention strategies for E.Coli and MSSA.
- Being active members of the Health Protection sub-committee of the Health and Wellbeing Boards in Devon, Plymouth and Torbay and we will jointly chair a pan-Devon HCAI prevention group reporting to that sub-committee.

Early Warning and Quality Assurance

- Continuing to be members of and contribute to the Devon and Cornwall Quality Surveillance Group, informing NHS England, CQC and other agencies of identified risks or quality issues.
- Ensuring that all contract review meetings are focussed on the provision of high quality and safe, effective care.
- Working with providers of care in the community to develop a 'guild' or forum for the promotion of quality improvement in care, such as in care homes, nursing homes and domiciliary care provision.

Safeguarding

Ensuring that vulnerable people are safeguarded is a vital part of the role of the CCG. We will continue to maintain a focus on the safety of vulnerable adults, children and young people and will enhance our Safeguarding Adults team in 2014. We will commission services that promote and protect individual human rights, independence and well-being. We will secure assurance that any child, young person or adult thought to be at risk, stays safe. We will secure assurance that they are effectively safeguarded against abuse, neglect, discrimination, embarrassment, or poor, compassionless treatment. We want all patients to be treated with dignity and respect and to enjoy the best possible quality of life.

As a CCG we will gain assurance that the services we commission safeguard both adults and children. Statutory duties under sections 11 and 13 of the Children Act 2004 apply to CCGs and include the duties to safeguard and promote the welfare of children, and to have an active membership role in Local Safeguarding Children's Boards. It is known that for looked-after children, outcomes and access to healthcare are often worse than for other children and the CCG has a duty to work with local authorities to provide support and services to children in need, which we will do by:

- Continuing to work in active partnership with two local authorities through Safeguarding Children Boards and Local Safeguarding Adult Boards and we will contribute to multi-agency agendas such as the Multi-Agency Public Protection (MAPPA); Multi Agency Risk Assessment Conferences (MARAC) and the Domestic Violence and Prevent agenda
- Working with neighbouring commissioners to develop a supporting 'Health Forum' as a health focussed sub group of the LSCBs in Devon, Plymouth and Torbay (the CCGs will co-chair)
- Chairing the multi–agency adult safeguarding investigations and meetings and ensure that all relevant health providers work together to produce Serious Case Reviews, Investigations or Independent management reviews.
- Focussing on a proactive approach to commissioning and contracting of individual placements. Contracts will include the Safeguarding Operating principles and we will run in depth reviews of safeguarding processes for all providers.
- Ensuring that the voice of individuals is heard.
- Continuing to support the development of the 'Frequent Users' joint partnership which will identify individuals who are high users of services and who may be at risk, or in need of safeguarding.
- Designing ways to ensure that people who live and work in South Devon and Torbay know what signs and indicators of abuse to look out for and who to contact for advice.
- Supporting national initiatives that safeguard vulnerable people including:
    - The PREVENT agenda
    - Preventing child sexual exploitation
    - Preventing female genital mutilation
    - Combating sexual violence
    - Combating domestic abuse
- Developing and monitoring the dissemination and evaluation of outcomes of all domestic homicide reviews, serious case review action plans and Serious Incident investigations (SIRIs).
- Providing training, support and supervision for named professionals across the health community.

Higher standards – Safer Care

Winterbourne Review

We will work with the Devon and Torbay Health and Wellbeing Boards and with providers to ensure the recommendations made in 'Transforming Care: A national response to Winterbourne View Hospital' are implemented. We will ensure a dramatic reduction in hospital placements for people with learning disabilities and autism, and people in NHS-funded care who have a mental health condition or challenging behaviours.

The Francis Report - Quality Drivers

The Francis Report is arguably the most influential publication in recent years on the state and quality of care in the NHS. As well as reporting on the substandard provision of care in Mid Staffordshire, the report examined the role of commissioners in the failings of patient care. Our CCG is determined to learn from the failings in Mid Staffordshire and will continue to ensure that the many

recommendations of the Francis report are progressed. We will work with providers to ensure that these and other recommendations from the reports by Berwick and Keogh are acted upon where relevant by all providers of care. We will focus particularly on quality and safety issues for frail, elderly people and for children with possible septicaemia.

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3.2 Patient Experience

Over the past year we have worked on listening, responding and improving care by using insights gained from patient feedback. We are determined over the next five years to glean more from patients and their families about their experiences, to influence our commissioning decision making and to continue our work on improving the quality of services. Over the next five years we will:

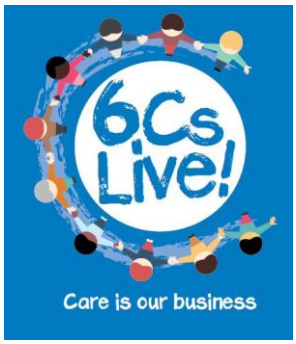
Complaints and concerns

- Take complaints management back in-house and develop resource within the CCG to respond effectively to complaints, concerns and other feedback from patients.
- Acknowledge when mistakes happen, apologising, explaining what went wrong and putting things right quickly and effectively.
- Publish on our website the types of complaints and concerns received by our organisation, and what we have done in response.

Gathering experience from people who use our services

- Promote, support and monitor the widespread use of the Friends and Family Test (FFT), and develop ways of using this to monitor the quality of commissioned pathways. The FFT will feature on our integrated Quality and Performance Dashboard and will be reported to our Governing Body.
- Work with providers to ensure that the most vulnerable people, whether young or old, are able to provide us with feedback and insight.
- Continue to improve and promote the use of the Yellow Card Scheme which is an electronic system in place for GPs to report to the CCG any quality issues or concerns they and their patients have identified in all care settings. We plan to roll out the scheme to other healthcare professionals.
- Develop an e-newsletter to provide feedback to people who have used the Yellow Card Scheme (or could be encouraged to).
- Form stronger relationships with Healthwatch Devon and Healthwatch Torbay to ensure that what they learn from members of the community is heard by the CCG.

Compassion in Practice



We are committed fully to the vision of the 6 Cs – we believe that kindness, care and compassion are vital to quality care. We recognise that the elderly patient is particularly vulnerable and should be treated at all times, by all staff, with respect, with dignity and with kindness, big and small.

We have put an Operating Principle within all contracts and we will evaluate the progress all providers have made every year, with an in-depth multi provider review. We are supporting the local Compassion in Practice Actions implementation plan by working with partners and the local Area Team. By supporting these plans we will:

- Help people to stay independent, maximising wellbeing and improving their health outcomes
- Work with people to ensure a positive experience of care is provided
- Ensure providers deliver high quality care that has positive health impacts
- Support the development of strong local leadership
- Ensure that there are the right staff with the right skills in the right place to deliver the best quality care and patient experience.

Staff satisfaction

There is good evidence to show that satisfied, motivated and happy staff will deliver better care and outcomes for patients. Over the next five years we will:

- Put a new Operating Principle in contracts that ensures providers listen to the experience of their staff and promote a positive staff experience,
- Benchmark providers staff satisfaction levels and report results in our integrated Quality and Performance Dashboard, and address any low levels at contract review, supporting the provider on an improvement trajectory,
- Promote the use of the Staff Friends and Family test to help us consider the quality of services.

3.3 Clinical Effectiveness

Quality Dashboard

Our CCG will continue to develop the integrated Quality and Performance dashboard. One of the key roles of commissioners is to specify the quality standards to be achieved for individual services by developing quality dashboards incorporating measures of clinical outcome, patient experience and service effectiveness and efficiency. These will enable commissioners and the public to see and understand any variation, and also any evidence of actions being taken where improvements are identified as being required.

NICE Quality Standards

The Health and Social Care Act 2012 set out a new role for the National Institute for Health and Care Excellence (NICE) in producing quality standards for health and social care. These will be published in addition to the clinical guidelines that NICE also provides, which describe best practice for an entire clinical pathway. The quality standards provide sentinel markers which are statements of what high quality care and services will look like. Over 20 have already been published and it

is expected that up to 180 will be available by 2017. Our CCG plans for health improvement by using the various metrics, measures and benchmarking outcomes that are provided by NICE quality standards, and the CCG Outcomes Indicator Set that NICE standards feed into.

NICE Technology Appraisals

We will continue the arrangement with Northern, Eastern and Western Devon CCG to provide strategic level clinical effectiveness leadership and work to include horizon scanning, impact analysis of published guidance indicating local relevance, local impact and costing assumptions for our CCG, as well as dissemination of published guidelines.

4 Commissioning Priorities

4.1 Overview

As set out in our Plan on a Page and developed in conjunction with our stakeholders, through our engagement events, and with our partners, the following high-level commissioning priorities have been agreed for the next five years:

- **Promoting self-care, prevention and personal responsibility.**
- **Developing joined-up patient-centred community hubs (including mental health), closer to home.**
- **Leading a sustainable health and care system, encompassing workforce, estates and IT.**

A description of how we will achieve these high-level priorities, in each of our work streams: prevention, primary care, community, urgent care, mental health, long-term conditions, learning disability, planned care, medicines, joint commissioning and children's services, and in the context of a flat-cash environment, is described in detail, along with the key outcomes and indictors we will use to measure success, in section 4.2

In conjunction with these ambitions and in line with he 'Everyone Counts: Planning for Patients 2014/14 to 2018/19' planning guidance, we will be working towards achieving improvements in the following seven ambitions and three key measures:

- **Additional Years of Life**
- **Quality of Life for people with Long-term Conditions**
- **Eliminating avoidable deaths in hospital**
- **Positive experience of care outside hospital**
- **Positive experience of hospital care**
- **Avoiding hospital through Integrated Care**
- **Older people living independently**

- **Reducing health inequalities**
- **Improving health (via prevention)**
- **Parity of esteem**

A description of how these ambitions and the CCG Outcomes Indicators will be delivered through our work streams is at Appendices X & X. It will be the responsibility of the Quality Committee and the Clinical Commissioning Committee (through its redesign boards) to monitor progress against these indicators, which will form a core part of the Integrated Quality & Performance Dashboard (along with other key indicators from the CCG Outcomes Framework and NHS Constitution).

4.2 Work streams & key outcomes

Following the engagement process and defining the three high-level commissioning priorities the Redesigns Boards were asked to define their strategic vision for their services over the next five years, based on information packs containing the relevant qualitative and quantitative information, and in particular what they will achieve over the next two years to work towards delivering the three commissioning priorities. They are described as follows:

4.2.1 Prevention

What we know

We are recurrently overcommitted on our healthcare spending at this time. We know from the JSNA that we already have a higher than average number of older people. We know that in some of our localities we have pockets of severe deprivation, and significantly higher than average rates of harmful alcohol use and smoking. We also know that, if nothing changes, with future population projections and people living longer but with more complex needs, we will not be able to afford the healthcare that our population will need. A vital way to preserve our health and care system for future generations is for people to change their behaviour and take more responsibility for their own wellbeing.

The strategic vision for the services in five years' time

There has been a further shift in the work to prevent ill health with increased integration and a focus on prevention within all of our partners' plans. This has enabled health promotion work to have greater scope and reach. Identifying and addressing lifestyle issues are integral to the work of front-line workers.

This is particularly the case with mental health where resilience is key to both on-going mental ill-health but also to physical health. The resilience of the community and community cohesion is seen as equally important as individual resilience and this is addressed within our plans.

A programme of work will be delivered with key Council-led departments to promote health and consider wellbeing as an important outcome.

What will change in the next 2 years?

Work stream Priorities 2014/15 – 2015/16	What will success look like?	Outcome Measure
Whole systems lifestyle work	• Joined up offer around lifestyles agreed and being delivered in initial key areas of alcohol and smoking. • This is supported by a programme of innovative social marketing.	• Increase in health checks, especially in certain defined groups. • Reduction in alcohol related hospital admissions. • Reduction in smoking-related disease and admissions. • Reduction in smoking in pregnancy.
Work with Children and Young people	• Integrated approach to health promotion and early intervention agreed, with a focus on the early years and on teenagers.	• Increase in breast-feeding rates. • Improvement in school readiness. • Decrease in teenage pregnancy levels. • Decrease in smoking rates.
Work on the determinants of Health	• Agreed process to embed consideration of health and well-being outcomes in plans as they develop.	• Reduction in health inequalities.
Mental Health resilience	• Integrated programme of work agreed across public, private and voluntary and community sectors to build individual	• Reduction in self-harm.

Work stream Priorities 2014/15 – 2015/16	What will success look like?	Outcome Measure
	and community resilience.	

Key Outcomes

As well as the key outcome measures the following indicators in the 2014/15 CCG Outcomes Indicator Set will be addressed through this work stream:

- Potential years of life lost from causes considered amenable to healthcare: adults, children and young people (NHS OF 1a i & ii)
- Antenatal assessment < 13 weeks
- Maternal smoking at delivery
- Breastfeeding prevalence at 6-8 weeks

4.2.2 Primary Care

What we know

The 'case for change' in primary care was made widely in 2013 including nationally in the "Call to Action" by NHS England and it has emerged as a key theme from our Locality engagement events. There is both a recognition of primary care services facing increasing pressure and the desire of general practice to transform services to meet challenges including:

- An ageing population, co-morbidity and increasing patient expectations which have all resulted in large increase in consultation especially for older patients.
- An increasing pressure on NHS financial resources, which will intensify from 2015/16.
- A perception of growing dissatisfaction with access, although nationally 76% of patients rate their overall experience of making an appointment as good – however, there is significant variation by CCG and across practices.
- Inequalities in access and quality, including national variation in GPs and nurses per head of population.
- Workforce pressures including recruitment and retention problems for GPs and practice nurses.

Most recently, NHS England has expressed a desire to 'co-commission' primary care with CCGs to bring commissioning back closer to practices and ensure that services commissioned meet local needs. Locally, this is moving forward quickly with proposals for a Devon and Cornwall local variation to the Quality and Outcomes Framework (QOF) from January 2014. This will be followed by other local changes designed to ensure that the services commissioned from primary care reflect local needs and issues.

The role of general practice in the urgent and emergency care system features heavily in the report by Sir Bruce Keogh into urgent and emergency care, placing an emphasis on prompt access to GP services through the 111 telephone service, seven day services and more rapid response to patient concerns through the use of telephone consultation.

The strategic vision for the services in five years' time

There will be greater collaboration between practices which are sustainable in the long-term and provide consistently high quality services. Some services that were previously provided in hospital will be available locally and community services will be attached to smaller numbers of practices. There will be fully-functioning GP practice provider networks across the CCG, within the same areas as our localities. They will deliver cost-effective primary medical services and a wider range of services, while still being accessible for local contact. A wide range of these services will be available from primary care seven days a week, 8am to 8pm.

There will be increased capacity in primary care, including more GPs and nurses being trained. Workforce plans will include clear and realistic projections for the numbers of GPs and practice nurses needed. Practice nurses will have a greater role and contribution, improving access to services for patients with urgent and long term conditions. Community pharmacy will be increasingly used for urgent minor complaints, as part of an integrated urgent and emergency care system, reducing the pressure on general practice and A&E.

What will change in the next 2 years?

Work stream Priorities 2014/15 – 2015/16	What will success look like?	Outcome Measure
Provide support to practices to collaborate on the provision of primary medical services *and* additional services for which they may become providers and reduce the barriers to providing joined up care, with practices able to provide services to others patients, utilising clinical shared records.	• Agreement on financial support in place. • Barriers to providing care to other practices patients removed, including access to shared records.	• Improved accessibility and patient satisfaction.
Support collaboration between practices to provide 7 day services, to avoid A&E attendance and admissions.	• GP medical services are available across a locality 7 days a week, 8-8, utilising a range of provision opportunities. • Primary care estate improves, with fewer purpose built sites, and with capacity for additional services.	• Reduction in A&E attendances.
Continually optimise access to primary care, including all practices offering non face to face forms of consultation.	• All practices offer telephone consultations or other alternatives including e-mail, Skype etc within set ring back and contact times.	• Improved patient satisfaction.
Working alongside acute and community specialists, optimise care for patients in residential and nursing homes, including care plans and pro-active follow up.	• Improved quality of life for care home residents.	• Reduction in avoidable admissions from care homes.

Key Outcomes

As well as the key outcome measures the following indicators in the 2014/15 CCG Outcomes Indicator Set will be addressed through this work stream:

- Patient experience of GP out of hours services (NHS OF 4a ii)
- Patient experience of GP services (NHS OF 4a i)
- Access to GP services (NHS OF 4.4i)

4.2.3 Community Services

What we know

The over 85 population is expected to increase from 3.9% in 2012 to 4.8% in 2021 in South Devon & Torbay, more than the national average. Older people, on average, cost the most per head for hospital care, given the complex set of chronic conditions that can be seen. From our Joint Strategic Needs Assessment we can see the rates of unplanned hospitalisation for chronic conditions that can often be managed in primary care. These are highest in the Torquay locality. We need to identify and work with these patients to ensure they are being managed without the need for secondary care. The number of people with co-morbidities is expected to rise by a third in the next ten years. To address this we need to develop care plans that treat the person as a whole, not by each condition they have.

Fewer people fit neatly into the defined disease pathways, but rather need complex case-management of multiple health, social and mental health needs, with case management by a key worker with support from specialist advice. This model of care requires much larger, more complex teams which are centred around an individual. Feedback from our extensive locality engagement process tells us that people would like better communication, including a single point of access, co-ordination, education about self-care and prevention, better accessibility, reliability and consistency of services.

Over the last ten years a growing body of national and international evidence has emerged, that links poorer outcomes, including a higher risk of death, for patients admitted to hospital at the weekend. The lack of availability of community-based services such as primary care and social care, and reduced co-ordination between services, contribute to this risk. Length of stay in hospital is another indicator as to whether the wider health and social care system is organised effectively - matching capacity to demand and supporting the flow of patients along their pathway. These systems are less good at weekends. Similarly, at weekends, important collaboration and multi-disciplinary planning between the hospital, community health services and social care becomes increasingly difficult, with a negative impact on re-admission rates.

In 2014/15 £1.1 billion is being made available to Local Authorities to support health and social care services to work more closely together in local areas. By 2015/16 the Better Care Fund (BCF) will be a single pooled budget of £3.8 billion. NHS England and the Local Government Association's aim is for a health and social care system that is truly seamless so that people receive the right care, at the right time in the right place. As part of the process for accessing BCF funding, CCGs and local authorities will have to demonstrate that they are meeting a number of national conditions. These include seven day health and social care services to support patients being discharged and to prevent unnecessary admissions at weekends.

There are 220 care homes in our CCG, home to around 3900 older people, although these numbers are falling as more people are cared for in their own homes. Care home residents make up 1% of our population, but 6% of our emergency admissions, and these admissions cost around £4 million a year, making this a focus area for our CCG.

The strategic vision for the services in five years' time

We will see a continued roll out of six/seven day services across key community services, as identified in 2014/15 and through ongoing evaluation, with fully joined-up services across health and care providing continuity of care and support seven days a week.

Community hubs will be a focal point in each of the localities, operating according to the needs of each community. Key partners will be fully engaged with the hubs: the primary care network, social care, the Integrated Care Organisation, the voluntary sector, mental health, and the hospice, as well as the people within each community. The development of the hubs will be informed by continual engagement.

We will see a continued reduction in the number of older people placed in long-term care, and a continued reduction in the number of avoidable emergency admissions from care homes. Each person in a care home will have dedicated support from a GP practice linked to the home, and every patient admitted to a care home will be offered a Treatment Escalation Plan where appropriate, to ensure their end of life care preferences are discussed and recorded.

What will change in the next 2 years?

Work stream Priorities 2014/15 – 2015/16	What will success look like?	Outcome Measure
Full evaluation of the effectiveness of weekend working, leading to the roll-out of 6-7 day services.	• Completion of nursing review to determine skill mix for integrated service. • Key community services to enable 6-7 day delivery are identified, tested and costed by end 14/15. • Identified key community services operating at least 6 days a week by end 15/16.	• Reduced pressures in the system on Mondays and Fridays e.g. more bed availability and fewer delayed discharges.
Development of Community Hubs, with our Pioneer Partners, based on Single Point of Access.	• Two community hubs in place in 14/15, a further three in 15/16.	• Reduction in emergency admissions and long-term placements. • Reduction in inequalities. • Increase in people feeling supported to manage their conditions.
Build on existing work with care homes to provide training, education and proactive care from GPs within Localities..	• All homes to have link GP practice(s) covering the majority of their patients with dedicated support by end 15/16.	• Reduction in emergency admissions from care homes.

4.2.4 Unplanned Care

What we know

Our locality engagement events have told us that patients want better access to urgent care, locally where appropriate. The numbers of people using hospital-based unplanned care services is rising each year and demand for A&E and minor injury unit services has been increasing for over a decade. We need to reduce unnecessary A&E attendances and admissions to hospital to ensure that health and social care resources are put to best use.

Emergency admissions in South Devon and Torbay are generally lower than expected (source: Dr Foster), even though we have seen a sharp rise in line with national trends throughout 2012. Emergency admissions for injuries and poisonings (relating to both prescribed medication and recreational drug use) are markedly higher than we would expect for our population and significantly higher in the over 75 age group. Fracture of the neck of femur (hip) and lower limbs are also significantly higher than we might expect.

The strategic vision for the services in five years' time

People with urgent but non-life threatening needs will be provided with highly responsive, effective and personalised services, outside hospital wherever possible. These services should where possible be configured to deliver care on a consistent seven day a week basis as close to people's homes as possible, minimising disruption and inconvenience for patients and their families. For those people who encounter serious or life threatening situations we must ensure they are treated in centres with the best possible expertise, in the most suitable facilities, so as to maximise the likelihood of an optimal recovery. By doing this we expect to relieve reliance and therefore pressures on our hospital and bed-based emergency services.

What will change in the next 2 years?

Work stream Priorities 2014/15 – 2015/16	What will success look like?	Outcome Measure
Review unplanned pathways, particularly for vulnerable patient cohorts, identifying and addressing change opportunities, being mindful of delivering outcome rather than model.	• Some services will be provided over seven days in hospital and community. • The redesign of MIU services, ensuring consistency of services across units. • An evidence based public awareness campaign which diverts patients away from A&E as appropriate. • Adapted pathways to reflect greater reliance on originating clinician.	• Reduction in emergency admissions. • Reduction in A&E attendances.
Develop escalation plans which are agreed by all members of the Urgent and Emergency Care Network as reflecting the optimal system deliverable and deemed realistic in terms of expectations, processes and protocols.	• Signed escalation plans. • The development of the Emergency Department team, in line with the Keogh review recommendations.	• Continued achievement of the relevant operating standards e.g. 4hr wait.

Key Outcomes

As well as the key outcome measures the following indicators in the 2014/15 CCG Outcomes Indicator Set will be addressed through this work stream:

- Hip fracture: incidence
- Emergency admissions for acute conditions that should not usually require hospital admission (NHS OF 3a)
- Emergency readmissions within 30 days of discharge from hospital (NHS OF 3b)
- Hip fracture: formal hip fracture programme, timely surgery, and multifactorial risk assessment
- Emergency admissions for alcohol related liver disease
- Alcohol admissions and readmissions

4.2.5 Long Term Conditions

What we know

At our locality engagement events people told us that they want to have a single point of access for all their health and social care, as they often have more than one issue they need support with. In England, 15.4 million people (over a quarter of the population) have a long term condition, and an increasing number of these have multiple conditions (the number with three or more is expected to increase from 1.9 million in 2008 to 2.9 million in 2018). People with long-term conditions use a significant proportion of health care services (50% of all GP appointments and 70% of days spent in hospital beds), and their care absorbs 70% of hospital and primary care budgets in England.

Our CCG has a higher proportion of older people compared with the national average. This proportion is expected to increase over the coming years. An ageing population places increased demand on both health and social care services. A greater number of people are expected to suffer from multiple long-term conditions such as dementia, hypertension, chronic obstructive pulmonary disease and diabetes.

The strategic vision for the services in five years' time

Patients will be offered an individualised approach to self-care, and benefit from support to manage their condition alongside their dedicated health and social care team. Programmes such as cardiac rehabilitation and pulmonary rehabilitation will support patients to self-care alongside more generic programmes that focus on the overall health and wellbeing of patients and are linked seamlessly with health care services, through a single point of access. Patients will feel more confident to self-manage and take responsibility for their own health care, but will also be fully supported to access healthcare advice when required.

All patients can expect to be treated in line with national standards, with enhanced levels of preventive services and initiatives targeted at where they are most needed. Patients can expect to achieve the same outcomes and access to services, wherever they live. Specific work will focus on improving cancer survival where the CCG appears to be an outlier.

Patients identified via a frailty/multi morbidity register will be offered access to an enhanced level of community based services as close to their home as possible. Services will put the patient at the centre of the pathway of care, providing a holistic approach to the management of their condition(s) and access to a service which provides specialist support in an outreach environment. Access for patients should be in a domiciliary setting when necessary but we will also provide support in an inpatient and outpatient setting. Signposting to other supporting services will be made available to patients.

What will change in the next 2 years?

Work stream Priorities 2014/15 – 2015/16	What will success look like?	Outcome Measure
To develop a frailty index to identify patients that will benefit from enhanced multi-morbidity management.	• Service will be in place to support these patients (in 1 Locality). • All practices in the CCG are able to identify patients suitable for a frailty register.	
To develop a supported self-care service which works in collaboration with other services to support people to proactively take a role in the management of their condition.	• By end 15/16 all patients who would benefit from self-care interventions are offered them. • There will be an increase in the proportion of primary care health professionals who have received training in self-care techniques and support.	
To ensure that all Long Term Condition services (including Cancer) across health and social care provide cost effective high quality services and health promotion, which deliver better than average survival rates.	• Complete systematic review of all mortality rates for Long Term Conditions to understand priority areas. • Complete review of all commissioned services to ensure that all KPI's and Outcome indicators are met.	• Continued achievement of the relevant CCG Outcomes Indicators.

Key Outcomes

As well as the key outcome measures the following indicators in the 2014/15 CCG Outcomes Indicator Set will be addressed through this work stream:

- Health-related quality of life for people with long-term conditions (NHS OF 2)
- People feeling supported to manage their condition (NHS OF 2.1)
- People with COPD & Medical Research Council Dyspnoea scale ≤3 referred to pulmonary rehabilitation programme
- People with diabetes who have received nine care processes
- People with diabetes diagnosed less than one year referred to structured education
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) (NHS OF 2.3.i)
- Complications associated with diabetes including emergency admission for diabetic ketoacidosis and lower limb amputation
- Under 75 mortality from cardiovascular disease (NHS OF 1.1)
- Cardiac rehabilitation completion
- Myocardial infarction, stroke & stage 5 kidney disease in people with diabetes
- Mortality within 30 days of hospital admission for stroke
- Under 75 mortality from cancer (NHS OF 1.4)
- One year survival from all cancers (NHS OF 1.4i)
- One year survival from breast, lung & colorectal cancers (NHS OF 1.4 iii)
- Cancer: diagnosis via emergency routes
- Cancer: record of stage at diagnosis
- Cancer: early detection
- Lung cancer; record of stage at diagnosis
- Breast cancer: mortality

- People who have had a stroke who are admitted to an acute stroke unit within four hours of arrival to hospitality
- People who have had a stroke who receive thrombolysis following an acute stroke
- People who have had a stroke who are discharged from hospital with a joint health and social care plan
- People who have had a stroke who receive a follow-up assessment between 4-8 months after initial admission
- People who have had a stroke who spend 90% of more of their stay on an acute stroke unit
- Proportion of patients recovering to their previous level of mobility or walking ability (NHS OF 3.5 i and ii)
- Bereaved carers views on the quality of care in the last 3 months of life NHS OF 4.6)
- Health-related quality of life for carers (NHS OF 1.4)

4.2.6 Mental Health

What we know

At our mental health engagement events, people have told us that mental health illness is a major contributing factor to overall wellbeing. They have told us they mental illness to be seen as just as important as physical illness and they want accessible services which they can access when they need them, not months after they were needed.

The Government's '*No Health without Mental Health – A cross-governmental mental health outcomes strategy for people of all age'* – sets out the vision to improve outcomes for people who use mental health services and to promote positive mental health and wellbeing among the whole population.

Mental health problems are common across all sectors of society. It is estimated that in any one year approximately one British adult in four experiences at least one diagnosable mental health disorder.

Dementia is a key area of concern for our CCG, particularly given that projections show the local population, already older than most other areas nationally, is likely to continue to age. The prevalence of people with dementia in South Devon and Torbay is currently approximately 5,000 and is projected to increase to 10,000 by 2021.

The strategic vision for the services in five years' time

In five years' time we will have delivered Parity of Esteem for mental health in our CCG area. Mental health and wellbeing will be embedded in all aspects of the delivery of health and social care, through our Community Hubs and a single point of access. We will be working to a model of health and social care that is based on individual need. There will be one route into accessing support for health and social care need, and all those requiring support for their mental health will have a personalised care plan that reflects their needs and preferences and agreed decisions.

What will change in the next 2 years?

Work stream Priorities 2014/15 – 2015/16	What will success look like?	Outcome Measure
Implement and further develop community based crisis interventions.	• More people will have timely access to support for a mental health crisis through community hubs and a single point of access.	• Reduction in acute and secondary mental health inpatient admissions.
Enhanced access to and choice of psychological interventions to those over the age of 65.	• Access to peer-support/ befriending services. • Choice of psychological intervention in place, accessible through a single point of access.	• Increase in the number of people accessing psychological interventions (10% of the total). • No-one waiting more than 18weeks by end of 14/15. • Reduction in self-harm and suicide rates for this age group. • Reduction of acute psychiatric functional mental health admissions and re-admissions.
Enhance perinatal mental health service to include all pregnant women.	• Peer Support and mutual aid services will be available.	• Improved user and carer experience.
Deliver a redesigned Urgent and Inpatient Care Pathway including Psychiatric Intensive Care.	• A redesigned acute pathway which includes crisis support services in the community.	• Reduced number of people accessing secondary care in-patient psychiatric services. • Reduction in the use of out of area placements and psychiatric intensive care units.
To develop and implement a comprehensive personality disorder pathway.	• An agreed multi-agency comprehensive personality disorder pathway including access to specialist advise to community teams and primary care. • Access to a range of services, through a single point of access, providing choice to secondary and primary care services.	• Appropriate and timely access to specialist advice services. • Reduction in lengths of stay. • Repatriation and reduction of numbers requiring out of area treatments.
Enhanced access to & outcomes from a more comprehensive psychiatric liaison service.	• 7 day a week (14 hour day) service. • A whole system approached to enable the community to access specialist support. • Multi-agency care plans for 'frequent A&E attenders'.	• Reduction in admissions from A&E to hospital in patients with associated mental health problems. • Reduction in readmissions. • Total reduced length of stay for people with a secondary diagnosis of dementia in acute/community hospitals.
To increase the number of people receiving a timely diagnosis of dementia.	• Timely diagnosis of dementia. • People with dementia prescribed anti-psychotic medication, where appropriate.	• More than 66% of number of people estimated to have dementia will have a timely diagnosis of dementia by end 14/15.
Delivering Parity of Esteem including the provision of physical health checks for people with serious mental illness, ensuring physical health is not overlooked.	• Annual physical health checks will be offered to all.	• 100% of those accessing primary and secondary services with a serious mental health problem will have at least an annual physical health check and be offered

Work stream Priorities 2014/15 – 2015/16	What will success look like?	Outcome Measure
		appropriate health and well-being support.
To work in partnership with public health to refresh the suicide prevention strategy and action plan.	• Refreshed suicide prevention strategy and action plan.	• Reduction in self-harm and suicide rates for South Devon & Torbay

Key Outcomes

As well as the key outcome measures the following indicators in the 2014/15 CCG Outcomes Indicator Set will be addressed through this work stream:

- People with severe mental illness who have received a list of physical checks
- Access to community mental health services by people from BME groups
- Access to psychological therapy services by people from BME groups
- Recovery following talking therapies (all ages and older than 65)
- Health-related quality of life for people with a long-term mental health condition
- Estimated diagnosis rate for people with dementia NHS OF measure in development.
- People with dementia prescribed anti-psychotic medication
- Mental health readmissions within 30 days of discharge
- Proportion of adults in contact with secondary mental health services in paid employment

4.2.7 Planned Care

What we know

Benchmarking data shows the CCG to be an outlier in terms of our spending on hip fractures and musculoskeletal conditions (MSK), as per the Commissioning for Value pack. This is also reflected in the Standardised Admission Rate (SAR) data (source: Dr Foster) which shows high SARs for orthopaedics, dermatology, rheumatology, gynaecology, breast surgery and colorectal surgery. We are also experiencing higher than expected GP referral rates for MSK conditions, dermatology, 2-week-wait Cancer pathways, urology and neurology. Public health profiles identify that our CCG is an outlier for incidence of malignant melanoma, while best practice tells us that there are opportunities to commission new models of care for dermatology, as well as ophthalmology and ear care.

Patient feedback through the patient advice service, PALS, and Patient Opinion suggests there is scope to review the process for appointment handling and booking to ensure that people receive a choice of appointment at a time that is convenient to them. To that end, a review of referral management models and processes will be conducted in 14/15 and 15/16.

The strategic vision for the services in five years' time

People will be treated in the most appropriate local setting for musculoskeletal, dermatology, ear care and ophthalmology conditions via integrated, tiered models of care, which may be primary, community or acute based and will aim to avoid unnecessary journey's to hospital. These services will have been commissioned to meet the needs of the local population, based on best practice guidance and will be cost-effective.

Referrals will be managed in a co-ordinated, cost-effective way enabling use of e-referral and promoting patient choice, allowing people to be diagnosed and to agree a care plan.

We will continue to explore how self-management and shared decision-making can be utilised in relation to planned care to support people to manage their health effectively.

What will change in the next 2 years?

Work stream Priorities 2014/15 – 2015/16	What will success look like?	Outcome Measure
Review the whole Musculoskeletal pathway, looking at prevention and self-care, shared decision-making, patient experience, waiting times and current and future population needs. Reviewing current services/ contracts and implementing changes to commissioning intentions where required.	• People are able to make informed, shared- decisions about their care informed by individual care plans that take a holistic approach to MSK health. Services work in an integrated way, with people receiving the appropriate level of intervention in the right setting, minimising reliance on secondary care. • Physiotherapy programmes for all appropriate patients prior to surgical intervention	• Improved concordance with pathways. • Reduction in patient-led surgery cancellations. • Increase in physiotherapy activity. • Reduction in orthopaedic referrals. • 18 week RTT achieved for Orthopaedics.
Review commissioning intentions for referral management to enable the CCG to deliver its responsibilities with regard to the 'Choice Framework' and to put the necessary systems in	• The health community has agreed a model of referral management which is fit for the future and cost effective.	• Patients report a high degree of satisfaction in the booking process.

Work stream Priorities 2014/15 – 2015/16	What will success look like?	Outcome Measure
place to offer and support choice and enable patients to book appointments. Working with localities to minimise referral variation and put in place solutions to support referrers to do this.	• Providers are complaint with the Choose and Book operating principle and are managing capacity appropriately.	• Referral variation is minimised.
Implement tiered models of care for dermatology in 14/15 and ear care in 15/16, to minimise reliance on secondary care and to enable self-management and delivery of intermediate services in the community.	• Care is delivered in the most appropriate setting, minimising reliance on secondary care. People are able to access services in a convenient, timely way and are encouraged to self-manage where appropriate.	• Reduction in secondary care referrals • Acute providers are achieving 18 weeks RTT.

Key Outcomes

As well as the key outcome measures the following indicators in the 2014/15 CCG Outcomes Indicator Set will be addressed through this work stream:

- Increased health gain as assessed by patients for elective procedures; a) hip replacement b) knee replacement c) groin hernia d) varicose veins
- Under 75 mortality from liver disease (NHS OF 1.3)

4.2.8 Children's Services

What we know

Transition for young people into adult services has been recognised as an area for improvement. Children with more complex care needs are surviving and living into adulthood longer than before.

Analysis from the Joint Strategic Needs Assessment of preventable health conditions in maternity and early years indicates concern both about smoking in pregnancy, which is linked with increased risk of cot death and complex medical conditions, and about lower breastfeeding rates among the localities of Torquay, Paignton & Brixham and Newton Abbot. The Child Poverty Commission in 2013 also provided a number of findings and recommendations for focus.

There have been increased pressures on Children's and Adolescents' Mental Health Services recently, most notably an increase of 25% in referrals into the services. At the same time, the service is also trying to sustain and improve primary mental health services to meet demands at an early intervention level. There have been difficulties across the peninsula in accessing 'tier four' beds which puts further pressure on local resources in trying to manage and safeguard complex and vulnerable children and young people in the community.

Referral data shows hospital admissions in young people for unintentional and deliberate injuries have been linked to longer-term health issues, including mental health. Across South Devon and Torbay, the rate of admissions is highest in the Torquay locality.

The number of unplanned hospitalisations for asthma and diabetes in the under 19s has initially reduced in 2013/14 compared to the previous year, while unplanned admissions for epilepsy appear to remain similar. Child poverty estimates in our CCG suggest between 20-25% of children under 16 living in the Torquay and Paignton and Brixham localities are living in child poverty, higher than national estimates and approximately 5% higher than other localities in our CCG. Child poverty can have a significant impact on the health of children and families, including on their emotional and mental health, and can lead to admissions to hospital and increased safeguarding concerns, as well as having an impact on life chances. The government's troubled families initiative has been led by local authorities in recognition of the growing needs of local communities.

The strategic vision for the services in five years' time

There will be increased integration of services for children and young people where pooled or aligned budgets will be explored and multi-agency care pathways will be owned by all. There will be a reduction in the number of hospital admissions/ attendances for children and young people with complex care needs, supported by a redesigned community nursing service which is equitable across South Devon and Torbay. The Children and Adolescents Mental Health Services assertive outreach service will also be preventing a significant percentage of tier four placements. Access to primary mental health care will improve and we will jointly work to provide an environment where a significant number of children and young people can be brought back to this area, to in-house foster placements.

What will change in the next 2 years?

Work stream Priorities 2014/15 – 2015/16	What will success look like?	Outcome Measure
To consider autism as a whole life pathway and commission a new Autistic Spectrum Condition service in line with the specification.	• New pathway in place based on NICE guidance. • Full evaluation of staff training needs will be complete.	• No backlog for patients waiting for the Autistic Spectrum Condition service.
Review existing services including the Paediatric Community Nursing, Therapies and Complex care services. Any major changes to service to be implemented as part of the contracts.	• There will be consistent, equitable and accessible services across South Devon & Torbay. • Improved foster care placements in Torbay, with access to psychological therapies and functional families therapies.	• Reduction in number of hospital attendances/ admissions for children. • Increase in the number of Children & Young People repatriated by the Local Authority to in-house foster care placements.
Introduction of Special Educational Needs and Disability Education Healthcare Plans. Also, consider the implications around transitions for this cohort and the extended age range to 25.	• Providers have staff educated in transitions planning and trained to undertake Education Healthcare Plans.	• 100% of statements converted to EHC Plans by end 2017. • Low numbers of new EHC plans contested.
Agree a Mental Health model for Children & Young People and an Emotional Health and Wellbeing Strategy for Devon and Torbay.	• Mental Health model for Children & Young People agreed and an Emotional Health and Wellbeing Strategy signed off by all parties. • Assertive outreach service up and running.	• Increase in number of assertive outreach referrals. • Improvements in tier 2 access and waiting times.

Key Outcomes

As well as the key outcome measures the following indicators in the 2014/15 CCG Outcomes Indicator Set will be addressed through this work stream:

- Emergency admissions for children with lower respiratory tract infections (NHS OF 3.2)
- Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (NHS OF 2.3.ii)

4.2.9 Learning Disabilities

What we know

In South Devon and Torbay there are likely to be more than 2,640 people with a learning disability while only 920 are likely to be known to the service. We need to be aware that not all people who have a learning disability are in contact with services that will keep them healthy, safe and able to live better lives.

The findings of the confidential inquiry into premature deaths of people with learning disabilities in England showed that 37% of the deaths in people with a learning disability were considered avoidable. Compared with the general population, men with a learning disability died on average 13 years earlier, while women with a learning disability died 20 years earlier.

The most common reasons for premature deaths were problems with investigating and assessing the cause of illness and delays or problems with treatment.

As a result of Winterbourne View Transforming Care One Year On *Department of Health update* it is clear that progress has been made in achieving the Concordat commitments.

The strategic vision for the services in five years' time

We will have reviewed all learning disability provision to ensure mainstream care is provided. We will have a learning disability service that is resourced to treat people with health needs at the earliest possible stage by providing support and intervention in primary care and as close to home as possible.

What will change in the next 2 years?

Work stream Priorities 2014/15 – 2015/16	What will success look like?	Outcome Measure
Review of community, specialist and Crisis Learning Disability provision – identified gaps for provision.	• By end 15/16 implement recommendations of review to ensure equitable care across all services.	
Contract with providers to deliver employment opportunities for people with disability and 'lived experience'.	• By end 15/16 review and evaluate existing contracts and ensure appropriate performance management systems exist.	• Increase in number of people with who are gaining employment and are financially independent.
Young people with learning disabilities to be identified as part of the placed people dashboard. Packages understood and transition arrangements and future packages known. Ensuring that contractual and financial risks are known and mitigated.	• Seamless person-centred transition to adult services, multi-agency involvement, and service user and family engagement at all stages.	

4.2.10 Medicines' Optimisation

What we know

Medicines' optimisation ensures that patients get the right choice of medicine, at the right time. By focusing on patients and their experiences, the goal is to help patients improve their outcomes. Ultimately medicines optimisation can help encourage patients to take responsibility and control over their treatment.

The Royal Pharmaceutical Society suggests four guiding principles for medicines' optimisation that will help all healthcare professionals to support patients to get the best outcomes from their medicines use:

- Aim to understand the patient experience
- Evidence based choice of medicines
- Ensure medicines are used as safely as possible
- Make medicines optimisation part of routine practice

The strategic vision for the services in five years' time

Safe and cost-effective use of medication will continue to be our primary goal. Over a five year period we envisage an expanding role for technology to support this.

Our vision for an electronic prescription and medication administration system (ePMA) for our hospitals that provides convenience, safety and optimal medication management for patients and prescribers alike will be realised within this period. We will continue to develop this system to provide maximum safety and benefit for patients while fully supporting all prescribers across South Devon and Torbay. It will also provide contemporaneous access to the patient's medication record to any appropriate healthcare worker, in any situation, at any time, allowing medicines' reconciliation at the interfaces of care, and helping to facilitate the vision of joined-up care for patients South Devon and Torbay.

The resources at our disposal to maximise medicines' optimisation rely largely upon the skills of those who support prescribing and the administration of medicines. This includes all prescribers, pharmacists and those who administer medicines, both patients and carers alike. These skills need to be developed and deployed in an integrated fashion. The pharmacists' profession has for a long time been undervalued, but as an integrated team we believe they can offer a substantial resource to the whole health and care community.

To achieve the best possible care and outcomes for patients while delivering value for money for the NHS. We will achieve this by working closely with doctors, nurses, pharmacists, the public and other stakeholders in the health and social care community.

Patients will understand their therapeutic options and know why they are taking a medicine, when to take their medicine, and how to take a medicine. Patients will routinely ask their community pharmacist for a Medicines Use Review (MUR) and patients will request that their community pharmacist discuss their new medicines with them. Patient safety will be improved due to significantly improved medicines' transfer.

What will change in the next 2 years?

Work stream Priorities 2014/15 – 2015/16	What will success look like?	Outcome Measure
Ensuring appropriate resources to support evidence based prescribing as defined by the joint formulary.	• Implementation and monitoring of formulary compliance and the implementation of practice specific action plans. • Maintained effective relationships with GPs and developed working relationships with other providers.	
To utilise a wide range of tools and opportunities to understand, control and influence growth in non-payment by results drugs prescribing.	• Implement agreed work plan with stakeholders, including plan for Secondary Care Tariff Excluded Drugs.	• Prescribing spend within budget • Reduced spend on Secondary Care Tariff Excluded Drugs.
Wider engagement to maximise the medicines optimisation agenda.	• Implement action plan with localities for care home support in collaboration with social care. • Joined-up pharmaceutical care across care pathways including better integration with Community Pharmacy. • Healthwatch and patients involvement.	

4.3 Joint Commissioning

Our CCG works closely with other commissioning organisations to ensure that patient services are joined up and deliver the best value for our population. We have a history of successful integrated commissioning between our CCG and the local authority, including Public Health. We will further develop these arrangements with the opportunities for pooled budgets under the 'Better Care Fund'. In considering efficiencies in our resources we have agreed with partners a number of key strategies setting out the needs of the populations that we serve. As mentioned in section 5.3.1 we will be working with NHS England to co-commission primary care, which will ensure more integrated services locally.

Some of the areas which require us to work closely with our partners and our strategies for these areas are as follows:

Carers

We know from the 2011 census that there are 33,392 people (of whom 886 are under 18) in the CCG area who provide unpaid care and are therefore carers.

In the next five years integrated and personalised services will be provided to meet the needs of carers to support them in their caring role and enable them to have a life of their own alongside their caring role. Carers will be supported so that they are not forced into financial hardship by their caring role. They will be supported to stay mentally and physically well and treated with dignity. Services for young carers will support them to learn, develop and thrive and to enjoy positive childhoods.

Working with our local authority partners we have set out, in the refreshed Devon Carers Strategy and Torbay Measure-Up Strategy, a key commitment to improve the approach of all commissioned services to carers. A number of common key outcomes have been agreed as follows:

- An increase in the numbers of carers identified through primary care and hospital discharge and supported to access appropriate services for their needs and those they care for.
- Improved availability and take up of health and wellbeing checks for carers across the CCG area.
- Partnership working to ensure young carers have the opportunity to have a proper assessment of their needs for support and that their health and wellbeing is protected.
- A focus on prevention and what works in supporting carers through evaluation and an evidence base from best practice locally and nationally.

Alcohol

Our Joint Strategic Needs Assessment tells us we have a high rate of emergency admissions which are alcohol related, particularly in the Torquay and Paignton areas. We are working with our providers and local authorities to agree a strategy for tackling the wider

contributing factors affecting alcohol use among the population and access to acute and treatment services.

Alcohol remains of concern and continues to be a priority given the levels of alcohol-related admissions to hospital. In 2012/13 the provisional figures indicate a rate of 2,226 per 100,000 population. The overwhelming numbers of alcohol-related admissions are 'alcohol-attributable' (approximately 75% in 2011, source LAPE), which is most commonly associated with 'increasing risk' drinking rather than dependent drinking. A review of high impact changes has been undertaken, which shows Torbay has implemented but has not witnessed the positive results achieved by other areas. External help has been sought from Public Health England to review data collection and interpretation.

In the next five years we will have services in place which are meeting needs effectively to minimise the risks, harm and costs caused by alcohol to individuals, families and communities across the CCG footprint. We will achieve this by working closely with local authorities and other stakeholders in terms of using data intelligence to target resource and commission evidence-based interventions, as well as creating an environment which supports the responsible use of alcohol and reduces the rate of people using acute services.

In the next two years we will be working with our partners to achieve the following:

- Individuals identified within primary care are provided with brief advice to self-manage their alcohol intake (hazardous and harmful drinking) with clear referral to appropriate alcohol treatment options where appropriate.
- Embedded pathways focused on referrals from primary care (including health checks) to lifestyle support.
- Targeted services will provide a follow up to those completing intervention to provide an evidence base of effectiveness.
- Improved identification and responses to those within the criminal justice, probation and social care settings.

Continuing health care and complex care

Individuals with continuing health care needs are some of our most vulnerable people. They have complex health care needs which need to be managed in an appropriate setting, whether that is packages of care in their own home or in a care home. There is increasing demand on the continuing health care team to meet the levels of current claims while also addressing retrospective claims. Initial work has begun in assessing retrospective cases but the process in clearing these is likely to take in excess of twelve months.

We recognise that individuals with complex health care needs may not always be able to be cared for in their local area due to the nature of their condition and the availability of specialist providers. Therefore, our CCG through our commissioning arrangements with local providers will ensure that the decision-making and contracts for placements and care packages are based on quality and the ability to be responsive and effective in meeting outcomes set for the individual.

In the next two years we will work with our partners to achieve the following:

- Retrospective cases will have been assessed and decisions communicated to claimants.

- Personalisation will encourage and support people to take a different approach to control and decision making in their care and health outcomes through the use of personal health budgets.

Military veterans

An estimated 11% of the population in the South West are veterans. The transition from a military culture to living as a civilian can be a challenging experience for personnel leaving services. A number of issues facing veterans, reservists and Armed Forces families will include: psychological wellbeing, securing a job and stability, housing, financial and legal difficulty, social activity, and relationship satisfaction. We know that alcohol remains of concern and continues to be a priority given the levels of alcohol-related admissions to hospital. The overwhelming numbers of alcohol-related admissions are alcohol-attributable, which is most commonly associated with 'increasing risk' drinking rather than dependent drinking. External help has been sought from Public Health England to review data collection and interpretation to inform our strategy.

We are fully committed to delivering on our responsibilities in the NHS Mandate. In addition to having a lead GP and Local Authority lead working closely with dedicated managerial support, we are already working closely with neighbouring CCGs on a range of Armed Forces, community and veteran related initiatives.

In five years' time we would expect our veteran and Armed Forces community to feel their health and social care services are coordinated, appropriate, and well sign-posted and to ensure the commissioning of services, particularly in their design and delivery, is centred around the 'whole person' and their needs. The 'whole person' includes the individual and the family and spans the dimensions of health, housing, employment, education and welfare (H2E2W).

In the next 2 years we will see improvements in:
- primary care and clinical awareness.
- an associated integration of informed Armed Forces community issues between health and social care.
- Improved cross-service and cross-CCG/Local Authority evidence base through the JSNA process.
- Better understanding of the local requirements for the transition support to all those leaving the services - both routine leavers and the wounded, injured and sick, and their respective families.

Specialist Services

To follow – NHSE

4.4 Key Risks

We are committed to a risk management strategy that minimises risks through a comprehensive system of internal controls while providing maximum potential for flexibility, innovation and best practice as we seek to achieve our priorities.

The aim of our risk management process is to provide a systematic and consistent framework through which our priorities are pursued. This involves identifying risks, threats and opportunities for achieving these objectives and taking steps to mitigate the risks and threats. An integrated approach will be taken so that lessons learned in one area of risk can be quickly spread to another area of risk.

Some of the specific risks currently highlighted are as follows:

Overall our ambulance service provider delivers a high quality service with good response times. However, over the last year our provider has achieved 72% against the new Red 1 target, which requires 75% of ambulances to respond within eight minutes to presenting conditions that may be immediately life threatening. For our local area our provider has achieved 79.5%. However, this is a particularly challenging target for the provider, which covers a very large, geographically-dispersed area from Cornwall & the Isles of Scilly to South Gloucestershire. To ensure this target is achieved in 2014/15 we have asked our provider to produce an action plan and recovery trajectory, which will show delivery of the target next year through a combination of advanced triage and additional defibrillators.

We have a very stretching target for reducing the incidence of Clostridium difficile next year. We plan to tackle this by focusing on prevention and working closely with our local providers and local authority (for more detail see section 3.1).

Referral to treatment times are improving and the number of patients waiting over 18 weeks has reduced since the beginning of 2013/14. However, we are managing a complex set of interdependencies relating to market supply, demand and technological advances, which mean this will need close monitoring into 2014/15. This will be undertaken through our contract review meetings with our providers (see section 5.3).

The creation of the Better Care Fund (BCF) will create a pooled fund for joint use by NHS and Local Authority commissioners. The monies to create this pooled fund are already being spent on existing, joined up services in the community. In order to mitigate any destabilisation in these services the plan for the use of this pooled fund will be agreed by the Health and Wellbeing Boards in Torbay and Devon.

5 How We Deliver

5.1 Financial Planning

National Context

Commissioning organisations in the NHS typically receive both recurrent (ongoing) and non-recurrent (one-off) funding. Commissioning a clinical service which lasts for longer than one year would always ideally be kept at or below recurrent funding levels. Maintaining the quality of ongoing services at or below recurrent funding levels is a measure of the financial health of a commissioning organisation.

The national operating framework, 'Everyone Counts: Planning for Patients 2014/15 – 2018/19', sets out a number of financial requirements for commissioning organisations to achieve, both at the beginning and the end of the financial year. This is done in order to make sure that all local health and care services are sustainable and that each local health organisation plays its part in managing the national NHS budget.

The planning requirements for the CCG financial plan are that it has to:

- Achieve a minimum 1% underspend against allocated recurrent resources at outturn in 2014/15 (and currently assumes this remains the same for each year of the plan),
- At outturn have available 1.5% recurrent resources for 2014/15, (although these can be committed non-recurrently throughout the year) then 1% for each of the plan thereafter,
- At plan stage set aside a 1.5% contingency for 2014/15 (including 1% for transformation), then 0.5% for each year of the plan thereafter.

The percentages are calculated on the recurrent baseline resources allocated to CCGs (excluding the CCG's running cost allowance).

Where a commissioner achieves these additional requirements, and is in recurrent financial balance, recurrent growth funding in subsequent financial years should be available in its entirety for investment across the range of commissioned services.

Regional and Area Teams of NHS England will routinely review the compliance of the CCG plans with this framework.

In 2014/15 NHS England has approved the introduction of a new allocations formula which will establish the appropriate, or target, level of funding for each CCG. This target will affect how growth funding is allocated to CCGs. For CCGs that are above their target this means they will receive a relatively lower level of growth funding than CCGs below their target allocation. At present, all CCGs will receive a minimum level of funding which represents growth in real terms (allowing for inflation). NHS England has confirmed two year allocations up to 2015/16.

Local Context

In 2013/14 our CCG began the year with a plan which was compliant with the 2013/14 Operating Framework, but the CCG's budgets were at that point recurrently over-committed. This was offset with available non-recurrent funds. This led our CCG to approve a financial strategy for three years intended to redress this historic over-commitment in spending.

During 2013/14 additional services, in the main specialised, were transferred from the CCG to NHS England with the attached financial resource. This has resulted in an overall worsening in the recurrent over-commitment of the CCG in 2013/14.

The revised target allocations formula calculated that the CCG's current level of funding was 11.59% above its target level. This means we will receive the lowest growth level for a CCG, although still a real terms increase in funding overall. This will be 2.14% in 2014/15 and 1.70% in 2015/16.

The July 2013 Spending Review confirmed the reduction of CCG and NHS England running cost allowances (10% nationally in 2015/16) as well as the creation of the Better Care Fund (BCF). BCF will create a pooled fund for joint use by NHS and Local Authority commissioners. The plan for the use of this pooled fund will be agreed by the Health and Wellbeing Boards in Torbay and Devon. The fund will begin in 2015/16 and the CCG will receive additional resources of £7.1million (previously budgets managed by NHS England) to create the fund which will total £20.8million. The monies to create this pooled fund are already being spent on existing, joined up services in the community.

The acquisition process for Torbay & Southern Devon Health & Care NHS Trust by South Devon Healthcare NHS Foundation Trust is expected to conclude in Summer 2014 following the announcement by the NHS Trust Development Authority of the Foundation Trust's preferred bidder status in Autumn 2013 and subject to approval of the Integrated Business Plan (IBP) by Monitor and respective organisations Boards. The new Integrated Care Organisation will be a significant and key element in the future reshaping of services in South Devon and Torbay and as part of the CCG's overall JoinedUp pioneer programme for integrated care.

5 year Financial Plan

	13/14			14/15			15/16		
	£000 Rec	£000 Non-rec	£000 Total	£000 Rec	£000 Non-rec	£000 Total	£000 Rec	£000 Non-rec	£000 Total
Total Resources	**371,092**	**10,126**	**381,218**	**379,473**	**5,583**	**385,056**	**388,046**	**3,729**	**391,775**
Healthcare Providers									
Current Services	280,726		280,726	280,726		280,726	280,726		280,726
New Services	1,434		1,434	1,624		1,624	2,169		2,169
Uncommitted				500		500	500		500
Primary Care									
Prescribing	47,400		47,400	48,585		48,585	49,800		49,800
Other	5,552		5,552	5,552		5,552	5,552		5,552
Continuing Healthcare & IPP	24,330		24,330	25,547		25,547	26,824		26,824
Reablement	688		688	688		688	688		688
Running Costs	6,717		6,717	6,717		6,717	6,717		6,717
Reserves:									
Contingency		1,844	1,844		1,864	1,864		1,907	1,907
Headroom	7,376	(1,895)	5,481	7,457		7,457	7,629		7,629
Other	(6,819)	8,282	1,463	(1,652)	3,719	2,067	3,627	1,822	5,449
Underspend	3,688	1,895	5,583	3,729		3,729	3,814		3,814
Total Applications	**371,092**	**10,126**	**381,218**	**379,473**	**5,583**	**385,056**	**388,046**	**3,729**	**391,775**

Financial Allocations

The CCG has been allocated funding for the next two financial years based on its recurrent resource position of £367.013million at Month 8 of 2013/14. This allocation covers the purchase of healthcare and related services and is set out in the table below:

	14/15	**15/16**
Recurrent Resource	£367.013m	£374.867m
Differential Growth applied at	2.14%	1.7%
Resource Limit Including Growth	£374.867m	£381.240m

In addition, the plan assumes that growth is applied each year beyond 2015/16 to 2018/19, ie, 1.7%.

Separate allocations cover funding in respect of running costs and the implementation of an element of the Better Care Fund.

The allocation for running costs in 2013/14 was £6.72million, equating to £25 per head of population and we are anticipating further guidance regarding to this shortly and notification of the actual allowance for each of the next two financial years. At present plans are consistent with a planned reduction of the required 10% in 2015/16.

The additional allocation for the Better Care Fund is notified as £7.097m effective from 2015/16.

Planning Assumptions

The main points to note with regard to the assumptions contained within the 5 year financial plan are:

- Planned spending on the CCG's current main healthcare provider services will remain at the same level as planned in 2013/14, except where organisations can demonstrate that by spending more than this savings will be made for other healthcare providers, and that this can be agreed with those organisations,
- Planned spending on the CCG's other services will be reviewed and where appropriate will be renegotiated with any reductions in spending used in support of this plan,
- Planned spending in respect of placed people will increase by 5%,
- Planned spending for primary care (predominantly GP) prescribing will rise by 1%,
- Planned developments in services agreed in 2013/14 will proceed,
- A recurrent reserve of £250,000 will be set aside to fund unplanned service developments identified in 2014/15,
- Remaining growth funding will be allocated to fund those existing services which give rise to the CCG's recurrent level of over-spending.

A summary of the revised CCG plan for 2014/15 and 2015/16, along with the CCG's reserve position in each year, is set out in the tables below:

	13/14 (Revised)			14/15 Plan			15/16 Plan		
	£000 Rec	£000 Non-rec	£000 Total	£000 Rec	£000 Non-rec	£000 Total	£000 Rec	£000 Non-rec	£000 Total
Total Resources	**371,911**	**11,622**	**383,533**	**379,706**	**5,583**	**385,289**	**392,416**	**3,749**	**396,165**
Healthcare Providers									
Current Services	281,131	6,399	287,530	280,166	3,300	283,466	268,987	3,300	272,287
New Services/Commitments				905		905	950		950
Uncommitted				350		350	850		850
Primary Care									
Prescribing	46,829	191	47,020	47,802		47,802	48,281		48,281
Other	7,166	140	7,306	7,257		7,257	7,257		7,257
Continuing Healthcare & IPP	24,294	160	24,455	26,717		26,717	28,053		28,053
Better Care Fund (ITF)	1,023	186	1,210	2,519		2,519	20,795		20,795
Running Costs	6,720		6,720	6,661		6,661	5,943		5,943
Reserves:									
Contingency (0.5%)/Call to Action (1%)		1,844	1,844		5,623	5,623		1,942	1,942
Headroom (1.5%)	7,375	(5,195)	2,180	5,623	(3,300)	2,323	3,883	(3,300)	583
Other (Funding Gap/Flexibility)	(6,314)	6,000	(314)	(2,044)	(40)	(2,084)	3,533	1,808	5,340
Underspend	3,687	1,896	5,583	3,749		3,749	3,884		3,884
Total Applications	**371,911**	**11,622**	**383,533**	**379,706**	**5,583**	**385,290**	**392,416**	**3,749**	**396,165**

	13/14			14/15			15/16		
	£000 Rec	£000 Non-rec	£000 Total	£000 Rec	£000 Non-rec	£000 Total	£000 Rec	£000 Non-rec	£000 Total
Reserves:									
Contingency (0.5%)/Call to Action (1%)		1,844	1,844		5,623	5,623		1,942	1,942
Headroom (1.5%)	7,375	(5,195)	2,180	5,623	(3,300)	2,323	3,883	(3,300)	583
Other (Funding Gap/Flexibility)	(6,314)	6,000	(314)	(2,044)	(40)	(2,084)	3,533	1,808	5,340
Total	**1,061**	**2,649**	**3,710**	**3,579**	**2,283**	**5,862**	**7,416**	**449**	**7,865**
Remaining			**3,710**			**5,862**			**7,865**
Percentage of Baseline			0.97%			1.52%			1.99%

Appendix X shows the CCGs five year financial plan.

Financial Management

The plan is dependent on the ongoing evaluation and mitigation of three broad financial risks through 2014/15, namely:

- The emerging liability for retrospective 'continuing healthcare' claims as well as the current level of spending on existing and new cases
- Funding provider contracts into 2014/15 and managing in-year financial risk
- Managing budget movements arising out of continued changes in commissioner responsibility.

In 2015/16 these financial risks will likely continue (though on-going transfers of budget to align new commissioning responsibilities should by then be minimal) but will also include the risk of managing within the reduced running cost allowance and agreeing the use of the Better Care Fund in a way which is consistent with this five year plan.

Currently, the plan makes no assumption about the achievement of Quality Premium payments and would represent additional resources to those set out above.

Implications

Following years of growth in NHS budgets, the requirement for healthcare providers to manage current services, accommodate growth, and deliver other service developments within a limited growth environment will be a marked change from the norm for some. It will be likely to require sustainable levels of unprecedented cost reduction and efficiency savings in providers.

Any over-spending against budgets in 2014/15 and 2015/16 would need to be funded from non-recurrent headroom or contingency reserves.

In order to deliver recurrent balance in a sustainable way the CCG (and the wider health community) will need to adopt very consistent, clear, and early communications; this will build on the approach taken in agreeing contracts for 2013/14.

The impact of these decisions is consistent with the planning assumptions in the Integrated Care Organisation Integrated Business Plan however the risk sharing agreement which

describes what happens across a range of alternative planning scenarios has yet to be agreed. The implications of the risk sharing agreement will need to be understood and accepted by each respective organisation's governing body.

5.2 Procurement

Our role as a CCG is to secure services that meet the health needs of our population, delivering best quality to patients and value to taxpayers, within the available financial envelope. We are responsible for making appropriate and effective decisions relating to the procurement of clinical services based on the principles of transparency, proportionality, non-discrimination and equality of treatment. Our statutory functions include to uphold the right to choice (NHS Constitution) and to decide how best to use competition in accordance with:

- EU Procurement Directives, implemented into UK law by The Public Contracts Regulations 2006
- NHS (Procurement, Patient Choice and Competition) Regulations 2013 made under Section 75 of the Health and Social Care Act 2012 and subsequent guidance from NHS England (due early 2014) and substantive and enforcement guidance from Monitor (December 2013)

Our CCG is committed to the development of innovative and integrated local and regional solutions, and recognises procurement is a key enabler to stimulating the healthcare market. Procurement and the work leading to a possible approach to market is an integral part of our commissioning cycle and incorporate our duties to engage and consult.

The function of procurement is embedded within the structure of the CCG with additional specialist support received from South West Commissioning Support which helps to deliver training, support on specific projects and provides proven knowledge and experience from across the procurement network that could not be achieved as a CCG alone.

Procurement as part of the overall commissioning cycle continually evolves and the CCG maintains a database of all clinical service contracts. The database is continuously updated in accordance with review of existing contracts, delivery of new services as identified through this Plan, emerging priorities including nationally mandated procurements and completed, on-going or potential procurements.

Our current procurement considerations includes the development of the self-care agenda , where appropriate of the continuation of the national Any Qualified Provider programme, re-procurement of the GP and dental out of hours service and the delivery of homecare services for oxygen and enteral feed. Where appropriate, these services and others will be considered in conjunction with other NHS commissioning organisations. We advertise opportunities for providing healthcare services on the Department of Health website, 'Supply2Health'.

Our CCG has developed a procurement strategy which provides further detail on how we meet our legal obligations for procurement and in accordance with our Constitution. It is available from our website.

5.3 Outcomes & Performance Management

5.3.1 Performance Management of our Providers

We hold regular monthly/bi-monthly Contract Review Meetings with all of our main providers, which cover quality, performance, finance and service development. We also have frequent technical meetings with providers covering particular topics when required. We encourage a mature and transparent relationship where issues are openly discussed and we work with our providers to develop the best outcome for the community and our patients.

5.3.2 Internal Business Planning and Performance

To support planning within our CCG we have established a Business Planning and Performance (BPP) group. The group is responsible for timetabling and delivering the annual business cycle. BPP also has responsibility for the internal performance management of delivery against our commissioning priorities as described in the Plan on a Page. As a result the group are also responsible for reviewing existing and new services for quality and value for money and recommending (dis)investments to the Clinical Commissioning Committee.

BPP provides a forum for discussing and moving forward the business of the CCG, on a medium-term basis. It includes clinical representation and the representation of senior managers covering all aspects of commissioning, finance, contracting, performance, quality, engagement and public health. This broad membership ensures that the appropriate due diligence is given to all service reviews. It also ensures the necessary links are made within the CCG to ensure potential service changes are well understood from all perspectives and can be implemented as soon as is appropriate, without unnecessary delays.

BPP is a recognised process with our main providers and links into the established provider and commissioner meeting structures including the Redesign Boards and Contract Review Meetings.

5.3.3 Measuring Success

We will measure progress against our commissioning priorities and the CCG Outcomes Framework at the monthly BPP meetings. This will be supported by our Business Manager, who is responsible for ensuring BPP is cited on all current activities and progress against delivery. Key Performance Indicators will be monitored via a web-based dashboard which will inform BPP, the Clinical Commissioning Committee and the rest of the organisation on progress with regard to finance, activity, outcomes, and local trajectories.

5.4 Information Technology

It is important that Information Technology (IT) and other infrastructure is used as an enabler, supporting our strategic and operational aims and the objectives of the wider health and care community. This includes using existing and new technologies with information-sharing protocols and agreements to underpin the need and ambition to provide access to

care records and other important information - supporting safe care provision in different settings. A joint Information Communication and Technology (ICT) Strategy has been developed by the health care community that derives from the proposed clinical models of care, and provides a clear vision for the future. The strategy intends to deliver:

- **Joined-up care** by delivering ICT that supports the integration of primary, community, acute and social care services and thereby places the patient at the centre of a ”web of care”.
- **Safe, effective and high quality care** by providing ICT that supports professionals to deliver care at the right time and in the right place.
- **A sustainable health and care system** by using ICT to enable service provision that is value for money and sustainable.
- **Well-managed services** by supporting operational and strategic management through the provision of the information needed to ensure services are high quality, safe, sustainable and value for money.
- **Innovation** by assisting research and continuous improvement.

The delivery of these ICT objectives will depend on five core features.

- Interoperability
- Best of breed systems
- Mobile working (agile) technology
- Transformed business and performance information
- Contemporaneous use

There is overwhelming evidence that excellence in healthcare informatics improves patient care. Modern healthcare is increasingly complex, and ICT is at the heart of this complexity. However in many cases ICT is not integrated, and any “integrated” patient record is paper-based and difficult to share. These inadequacies drive a need for better ICT. For example, order communications technology reduces form filling by clinicians and automates audit trails from request to result. Electronic prescribing will reconcile medicines, reduce errors and save time re-writing paper drug charts. Electronic clinical notes and letters will eliminate the need for bulky paper records and help information sharing between GP practices and across providers. Links to clinical decision support (CDSS) systems will bring focus to decision making and guide best practice. CDSS will reduce errors and provide alerts according to defined rules. This is represented by the diagram below:

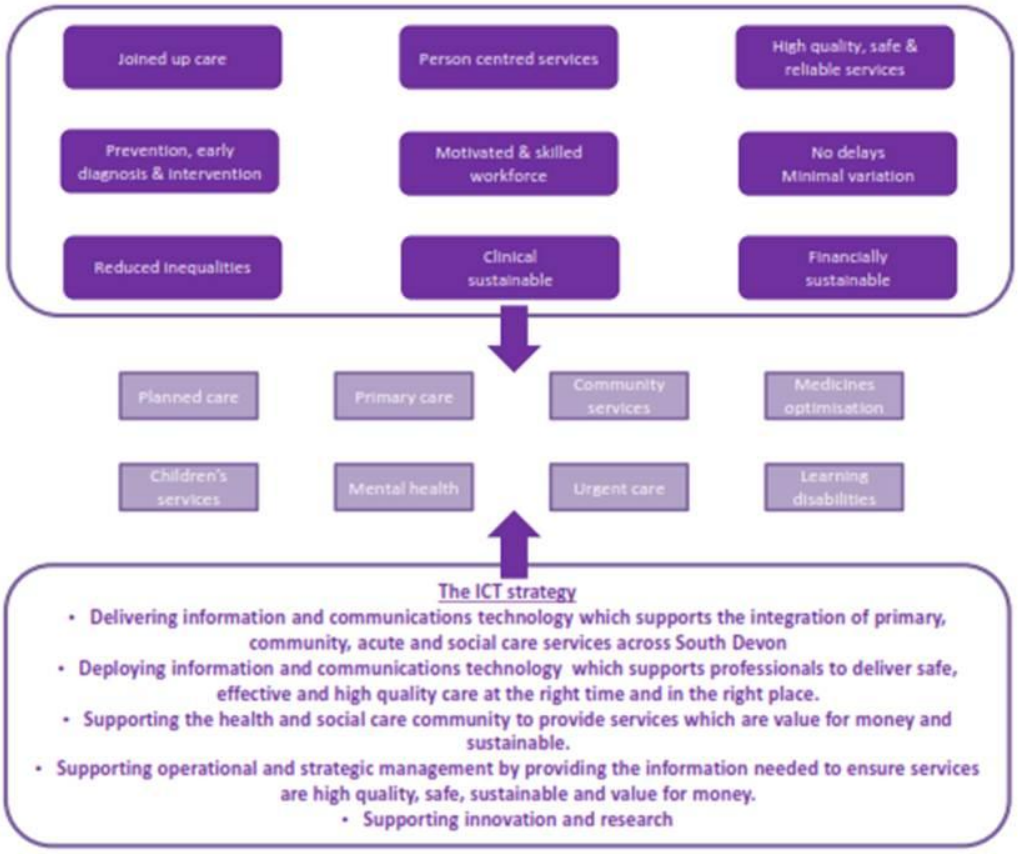


Figure 4 The link between the health and care community's objectives and the ICT strategy

5.5 Innovation

The Department of Health report 'Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS' sets out a delivery agenda for spreading innovation at pace and scale throughout the NHS. The spread of innovative approaches will be vital in transforming patient services, improving quality and supporting delivery of our Plan.

We are putting in place tools that will allow us to measure the impact of any changes we make as we make them. We have developed a community-wide strategy for innovation and agreed a defined budget for investing in innovative ideas. Our developing pathway for innovation will provide an open and transparent process which will allow us, as a community, to respond quickly to opportunities and capture the views of our service users during the development of an idea. Should we fail, we will learn from our mistakes and share that learning.

We continue to build on our already strong links with industry partners to capture their skills and expertise to help us achieve our goals.

Technology to improve care and patient experience

We will improve access to our services through greater use of technology. We will, where appropriate, offer our patients greater choice in using their preferred methods of contact, providing greater access to alternatives to face-to-face, phone and paper correspondence such as, email, video contact, online correspondence and instant messaging.

Sustainability

Sustainability is about getting the right balance between 'Economic Sustainability', 'Social Sustainability' and 'Environmental Sustainability'. For our CCG it is also about how we deliver care, how we create a healthier population and how we can afford to deliver care in the future.

In line with our Sustainable Development Management Plan objectives we will continue to focus on the 6 key areas of Travel, Procurement, Facilities Management, Workforce, Community Engagement and Buildings. We have made good progress in our first year, achieving a considerable reduction in our travel activity and will continue to actively work with local partners to develop sustainable transport options within the CCG area.

5.6 Strategic communications

Our CCG uses strategic communications to help it achieve the priorities and objectives set out in this plan, through stakeholder engagement. The communications work plan focuses on enabling two-way dialogue and collaborative working with staff, patients, carers, partners and local communities. It promotes joined up working throughout the health and care community and beyond, supporting the JoinedUp (integration pioneer) programme, and setting out to keep local communities fully engaged in the CCG's work. To this end, our website is being redeveloped and will provide more comprehensive and more easily-accessible information, including clear detail about local statutory, third sector and voluntary services available in local areas. A strong social media presence has been established. A programme of stakeholder engagement has been put in place, and we now play our part in a broad range of partnership groups. The relationship with community organisations has changed so that we work as equal partners.

GP Engagement

Our CCG being the sum of our 37 member GP practices, wel work to ensure we retain the goodwill, ideas and input of our constituent members. Engagement is facilitated through the five localities, and communications will increasingly be tailored to reflect the priorities, needs, community strengths and demography of each locality. A Council of Members, which adopted the CCG Constitution, is held at regular intervals, offering GPs a forum in which to exchange ideas and to network, in addition to focussing on CCG commissioning priorities. GPs are updated weekly through a concise newsletter.

Population Engagement

The design of our organisation places an independent Strategic Patient Involvement Group (SPIG) as one of our key consultative bodies. Bringing together the many sectors upon whose hard work and goodwill we depend for our feedback and intelligence, this is a strategic group which is now developing effectively and extending its expertise and influence

into our redesign processes. Our Non-Executive Director for Patient and Public Involvement regularly attends SPIG and reports to the Governing Body on key points. A programme of inclusive engagement has also been developed, including of more vulnerable or disadvantaged groups or those in the 'Inclusion Health' groups such as people who are homeless, have limited social networks or are long-term unemployed.

5.7 Organisational Design & Workforce

Organisational Design

The organisational model now in place has worked well since we launched as an independent organisation in April 2013. It is designed to support our vision of a clinically-led commissioning service, backed up by a capable and motivated workforce and informed by the views, experience and opinions of the public.

It comprises two elements: firstly, the structural considerations of delivery, decision-making and organisational governance and assurance, and secondly, the development of our people alongside a plan for the future. We are committed to making sure these elements are closely managed alongside one another; where one part of the system is changed, the whole system is affected.

Element 1: The architecture of our CCG

The structural diagram (see Fig. 2) below shows our key organisational relationships. The top right hand section describes the statutory CCG committees, while top left outlines the external bodies with whom we work to maintain excellent relationships. In October 2013 we learned that we had been selected as one of 14 national Pioneer sites to achieve full integration of care services. Our JoinedUp Cabinet provides the collaborative basis for ensuring that change is planned over the next five years to achieve this ambitious aim. The bottom left and right hand sides of the structure describe clinical commissioning, through redesign (on the right) and locality-led commissioning (on the left). A Clinical Commissioning Committee brings together the practice-led commissioning intentions of the localities with the improvement and innovation outputs of the redesign groups, thus ensuring cohesion with the planning intentions of the organisation. 2014 may see some changes in the balance of planning across locality and redesign.

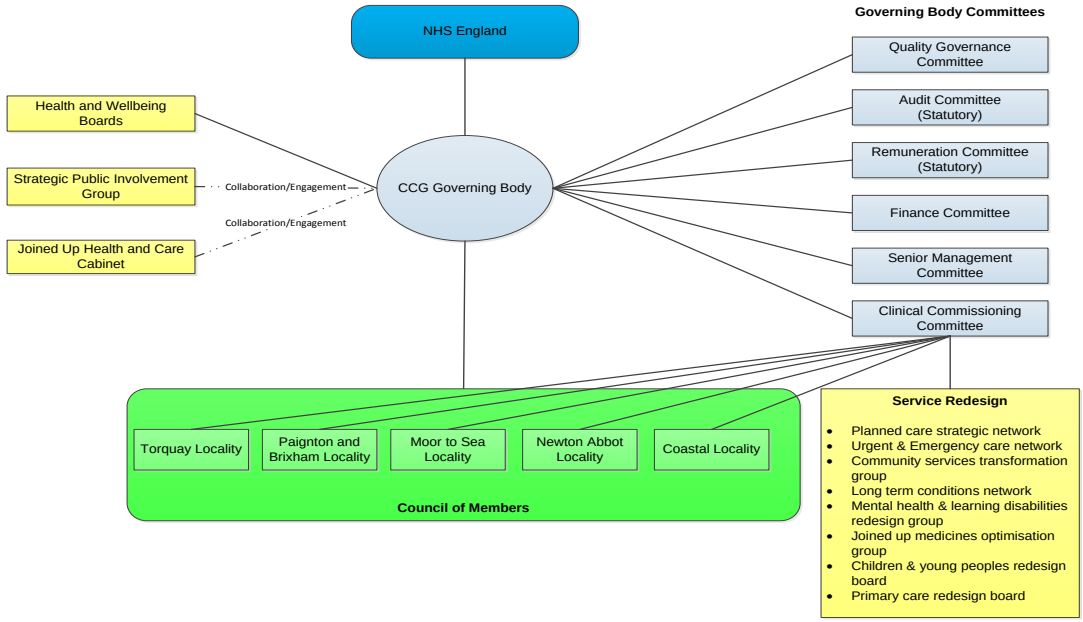


Fig. 2 Key organisational relationship

Element 2: Clinical Development

Our CCG enjoys wide clinical leadership as demonstrated by the appointment of seven GPs to our Governing Body. This includes a chief clinical officer and a clinical chair, each with 100% support from our constituent practices. All GP leaders on our Governing Body have a management portfolio as well as a clear understanding of their corporate and strategic responsibilities. Our Governing Body continues to take a highly self-reflective approach to performance both in terms of outputs ('what we achieved') and team ('how we achieve it').

Workforce

Due to its geographical constraints, size, and the nature of its vision, our CCG has chosen to construct a management structure which will enable it to directly control and deliver optimal commissioning. While the structures are lean (with a focus on clinical delivery rather than business support), they have been scrupulously tested against the required financial targets and allocations. The focus of the workforce is on commissioning, supported by key functional services such as corporate governance, finance, performance reporting, organisation development, communications and engagement and quality. Where economies of scale can be achieved through outsourcing, this has been negotiated and is described in section 5.8.

Future workforce development will need to focus on the delivery of integrated care through the Pioneer programme. From a CCG perspective, we anticipate that this will take the form of rigorous skills analysis over the next five years, to ensure that we have a management structure which can understand, design, lead and control the required changes in commissioning and providing within the context of the NHS reforms. We expect that our CCG workforce will become more focused on:

- Business improvement and innovation.
- New opportunities on the landscape for procurement and contracting where this improves patient care and streamlines efficiency.

- Encouraging flexibility of practice across the clinical workforce from early years education right through to existing practice.

Distributed Leadership and Clinical Partnerships

In accordance with our vision, we have continued to develop a distributed model of leadership throughout the CCG. We have appointed (through selection) healthcare professionals and GPs to lead redesign, innovation, education, quality improvement, patient safety and other key work streams in support of excellent commissioning. Some 50 GPs are now involved throughout the organisation. Clinical leaders work alongside a manager who supports their work, ensures delivery and thus enables the release of clinical leadership. In addition, we are working to ensure that our Locality clinical leads have the skills required to lead their communities in the construction of 'Community Hubs'.

5.8 Commissioning Support Arrangements

Our CCG has entered into an agreement with South West Commissioning Support for them to provide all procurement services and sustainability expert advice and support. We are currently entering into an agreement for them to provide data management and integration services from 1st April 2014.

It has also been agreed that Northern, Eastern and Western Devon CCG will host a Collaborative Business Service (CBS), which will provide support to the localities within the NEW Devon CCG and also to our CCG. These services generally fall into one of the following categories:

- Referral management via the Devon Access and Referral Team (DART)
- Clinical effectiveness and medicines optimisation support
- Specialist business intelligence functions
- Information security

There are other areas of commissioning support that will be provided via shared service arrangements with South Devon Healthcare NHS Foundation Trust and Torbay & Southern Devon Health and Care NHS Trust via Service Level Agreements. These are:

- IT (including GPIT services)
- Data warehousing
- HR services
- Occupational Health

All commissioning support arrangements and requirements will be kept under review and will be further tested.