South Devon and Torbay
Clinical Commissioning Group

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Integrated Plan 2013 - 2016

Excellent, joined up care for everyone.

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7.4. Performance Management

Foreword

This plan sets out the priorities and outcomes that the South Devon and Torbay Clinical Commissioning Group (SD&T CCG) will be working with partners to achieve in the next three years, so that we improve healthcare for our population and ensure the long-term sustainability of our local health and care services.

2013/14 will be the first year of the clinical commissioning group – and the first time that commissioning has been led by healthcare professionals. It will be a crucial year, in which maximising quality improvements, while maintaining financial stability, will be the focus.

Involving patients and the public to improve key commissioning decisions around services is very important to us. We will make the best use of patients' experience in respect of the care they receive, by using the intelligence gained from patient and public feedback to influence decision-making and ensure that the right care is commissioned for the local population.

We will be supported by the national reforms which will help to devolve decision-making to patients and clinicians, with Health and Wellbeing Boards providing local leadership to deliver quality improvements. The Health & Wellbeing Boards of Torbay and Devon have been integral to developing this plan and bringing together the alignment of priorities, across partner organisations, for the benefit of our communities.

We know the next few years will be demanding. The quality and productivity challenge has already moved into its third year and the requirement for us to meet our financial efficiency commitments continues. However, significant progress has already been made and we are confident the relationships we have built and the plans we are developing with partner organisations will allow us to make further steps towards delivering excellent, joined-up care for everyone in South Devon and Torbay.

Within South Devon and Torbay we have a vision of a clinically joined-up system, building on the successes that we have seen through our clinical pathway groups, our integrated health and social care teams and joint commissioning arrangements. We believe that seamless care pathways and care packages will give patients higher-quality care, in a more cost-effective manner. We see the acquisition of our local provider of community services, Torbay & Southern Devon Health and Care NHS Trust, as the next major step towards achieving a clinically joined-up system which can deliver the scale of efficiency savings needed to provide the services which will be required by our future population.

To be the best clinical commissioners we must keep our focus unremittingly on our patients and our population, and we must ensure that the services we commission not only represent value for money but offer the best outcomes for each individual. We will take responsibility for using commissioning budgets to deliver high-quality, responsive and safe services for our patients.

Partnership working with local authorities, providers of health services and other organisations will be essential in ensuring all our plans fit together, and that further progress is made in providing joined-up care between services. We will work closely with them to promote innovation and ensure there is a continued high level of services offered to patients and the people who use our services.

Through our previous primary care trusts, we have a strong track record of delivery and in 2012/13 we made good progress in improving quality, meeting financial and performance targets, and working with GPs and partners to prepare for reform of commissioning structures. The next few years will be challenging but we are in a strong position to deliver our priorities, alongside the operational standards and outcome measures set out within the NHS Constitution and the "Everyone Counts" framework. The dedication that our staff have already demonstrated will be key in ensuring we continue to commission the best possible health and care for the people of South Devon and Torbay.

Dr Sam Barrell

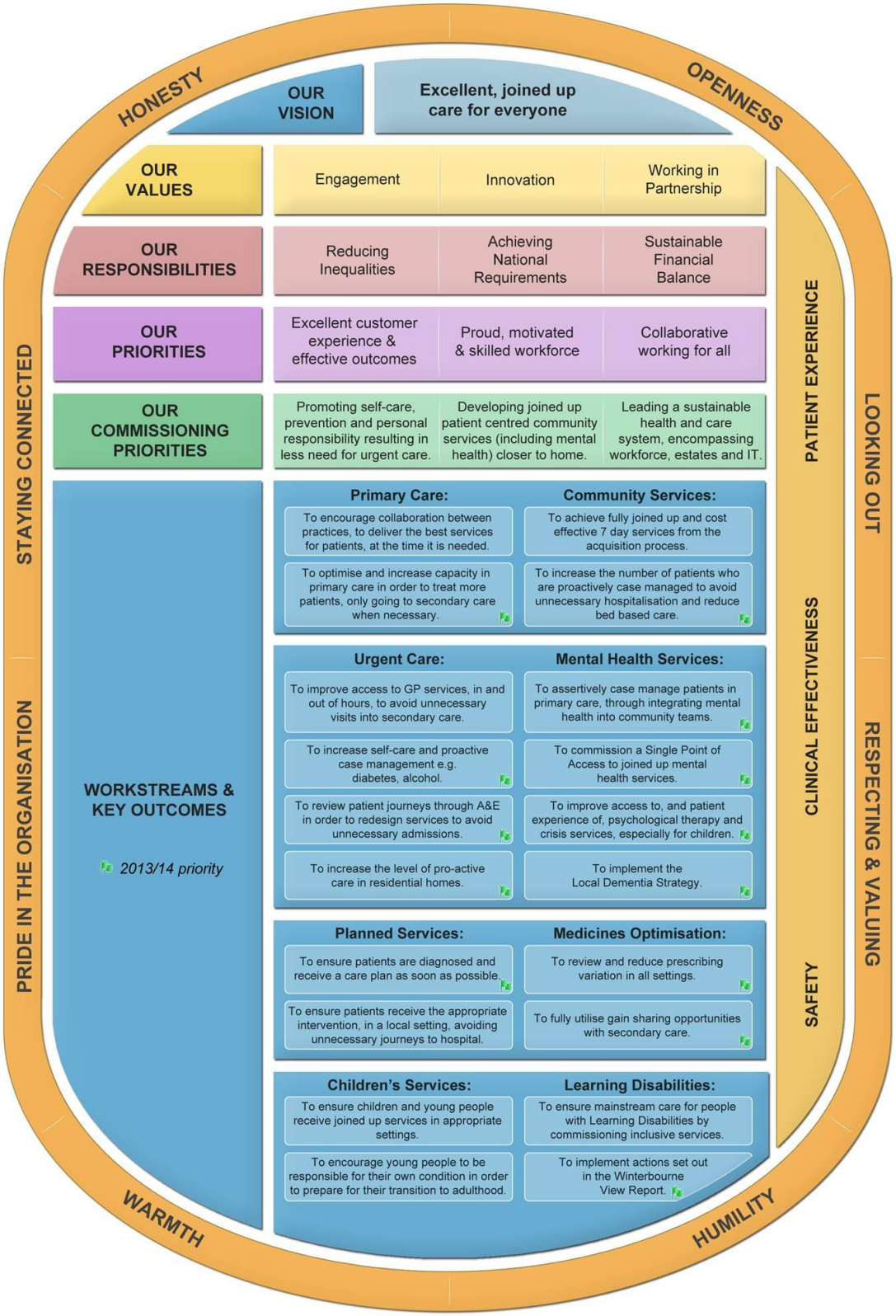
Dr Derek Greatorex

1 Our Priorities- 'Plan on a Page'

In order to develop a set of priorities which are evidence-based and informed by all parts of the system, we have completed an extensive piece of information gathering and consultation.

This has involved developing the first South Devon & Torbay Joint Strategic Needs Assessment (JSNA), which covers parts of two local authority areas, as a starting point. (See Appendix 1 for how this has informed the plan). We have added other intelligence with benchmarking from the CCG Outcomes Benchmarking support pack from the NHS Commissioning Board, NHS comparators and others. The priorities of the Health & Wellbeing Boards of Torbay and Devon and the Joined-Up Clinical Cabinet (the local group comprising clinicians and board members from all local providers, commissioners and local authorities), have informed our priorities and the work streams which sit below them. We have used this information to inform discussions at the Governing Body, which have been further worked up with clinicians and localities.

The 'Plan on a Page' sets out our vision for local services, our responsibilities, our corporate priorities and our commissioning priorities, with the work streams which will deliver the key outcomes to achieve those priorities. The 'Plan on a Page' reflects our statutory duties and fully covers the CCG Outcomes Indicators (see Appendix 2 for mapping). Quality is at the heart of everything we do, and as such 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.


HONESTY
OPENNESS
STAYING CONNECTED
LOOKING OUT
PRIDE IN THE ORGANISATION
RESPECTING & VALUING
WARMTH
HUMILITY
PATIENT EXPERIENCE
CLINICAL EFFECTIVENESS
SAFETY
OUR VISION
Excellent, joined up care for everyone
OUR VALUES
Engagement
Innovation
Working in Partnership
OUR RESPONSIBILITIES
Reducing Inequalities
Achieving National Requirements
Sustainable Financial Balance
OUR PRIORITIES
Excellent customer experience & effective outcomes
Proud, motivated & skilled workforce
Collaborative working for all
OUR COMMISSIONING PRIORITIES
Promoting self-care, prevention and personal responsibility resulting in less need for urgent care.
Developing joined up patient centred community services (including mental health) closer to home.
Leading a sustainable health and care system, encompassing workforce, estates and IT.
WORKSTREAMS & KEY OUTCOMES
2013/14 priority
Primary Care:
To encourage collaboration between practices, to deliver the best services for patients, at the time it is needed.
To optimise and increase capacity in primary care in order to treat more patients, only going to secondary care when necessary.
Community Services:
To achieve fully joined up and cost effective 7 day services from the acquisition process.
To increase the number of patients who are proactively case managed to avoid unnecessary hospitalisation and reduce bed based care.
Urgent Care:
To improve access to GP services, in and out of hours, to avoid unnecessary visits into secondary care.
To increase self-care and proactive case management e.g. diabetes, alcohol.
To review patient journeys through A&E in order to redesign services to avoid unnecessary admissions.
To increase the level of pro-active care in residential homes.
Mental Health Services:
To assertively case manage patients in primary care, through integrating mental health into community teams.
To commission a Single Point of Access to joined up mental health services.
To improve access to, and patient experience of, psychological therapy and crisis services, especially for children.
To implement the Local Dementia Strategy.
Planned Services:
To ensure patients are diagnosed and receive a care plan as soon as possible.
To ensure patients receive the appropriate intervention, in a local setting, avoiding unnecessary journeys to hospital.
Medicines Optimisation:
To review and reduce prescribing variation in all settings.
To fully utilise gain sharing opportunities with secondary care.
Children's Services:
To ensure children and young people receive joined up services in appropriate settings.
To encourage young people to be responsible for their own condition in order to prepare for their transition to adulthood.
Learning Disabilities:
To ensure mainstream care for people with Learning Disabilities by commissioning inclusive services.
To implement actions set out in the Winterbourne View Report.

2.1 Organisational Design

The organisational model now in place for South Devon and Torbay CCG results from a consultative process undertaken throughout transition. It has been carefully crafted 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 our population.

We designed our new organisation based on a systems-thinking model, and were complimented on this during our authorisation process. 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 which we will forge excellent relationships. One of these is the Joined-Up Cabinet: the over-arching strategic body comprising top leaders from the local healthcare environment, who meet to support their common aim of achieving true local integration. 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 corporate planning intentions of the organisation.

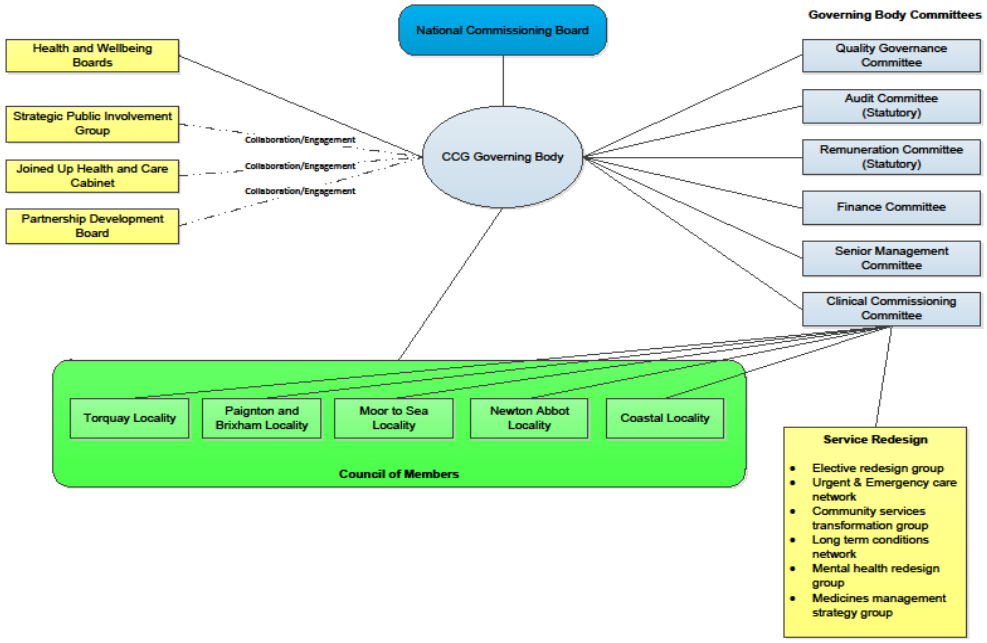


Fig. 2 Key organisational relationship

As required by statute, the Governing Body sits at the centre of the organisation and the key reporting arrangements, financial controls and systems of delegation

are in place and have been fully ratified by all of our practices through sign-off of our constitution.

Element 2: Clinical Development

Our CCG enjoys excellence of clinical leadership as demonstrated by the appointment (through a highly selective process) of seven GPs to its 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. A programme of development for the Governing Body is in place, and includes a highly self-reflective approach to performance both in terms of outputs ('what we achieved') and team ('how we achieve it'). The Governing Body is committed to retaining this approach to development for the foreseeable future.

2.2 Service Improvements

We have commissioned and led a vast number of service improvements this year, which have improved the consistency of services across the two areas of South Devon and Torbay.

Among them, the virtual ward – a list of patients being actively case managed by a multidisciplinary team - was introduced in South Devon in late 2010. We are continuing to work to maximise the benefits of integrated working between general practice and the wider community teams, and introduced the same model to Torbay in 2012. When the full data for virtual ward patients for 2011/12 was analysed, South Devon was shown to have the most successful virtual wards in Devon, with the highest virtual-bed occupancy, the highest proportion of high-risk patients being case managed, and with the most significant reduction in hospital admissions for that cohort of patients. In 2012, we won the Vision Award for Best Integrated Care Model, as well as the NHS Alliance Acorn Award for Best Example of Integrated Care. The model has also been chosen by The King's Fund as one of five demonstrator sites to study the care co-ordination of people with complex needs.

During 2012 we extended our intermediate care service from Torbay into South Devon. Intermediate care provides the local community with an alternative to hospital admission or long-term care and enables patients to be discharged from hospital more quickly by providing health and social care support. Patients may be cared for in their own homes or in short-term placements in nursing or residential homes. The intermediate care service also seeks to enable the rehabilitation of patients to allow them to regain their independence as quickly as possible.

We are piloting a single point of access for health and social care services in South Devon to see how best to introduce this system, already used highly successfully in Torbay. The single point of access helps GPs arrange the right care for urgent and non-urgent referrals, helping to prevent avoidable hospital admissions and more effectively manage long-term conditions in the community.

'Just In Case' bags are our locally adapted version of a national initiative, which is about anticipating the problems people can experience at the end of their life and ensuring sufficient supplies of medication are available in their home before they

are needed. This makes it easier for patients who so choose to remain in their homes at the end stage of their lives. They have been in use in Devon since 2011 and we have now brought them into use in Torbay.

We have been working with our secondary care colleagues and our care home providers to improve the quality of life of patients in care homes, reducing the numbers of hospital admissions. Nurses from the medical admissions team now offer training and support to nurses in the nursing homes to enable them to give acute nursing treatments, such as intravenous treatments and blood transfusions. In residential homes the team itself delivers the acute nursing treatments, enabling patients to remain in the home rather than go to hospital.

2.3 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.
- Emergency admissions for chronic conditions that can be looked after in primary care, e.g. asthma, are low compared with in other CCGs and have decreased this year as well.
- We continue to have statistically better patient experience of GP services, both in and out of hours.
- Patient experience of acute services continues to be very good.

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

- Referral to treatment and diagnostic waiting times are continuing to reduce this year. However, there are still some longer waits in orthopaedics which continue to be addressed.
- Cancer waiting times indicators continue to be achieved.
- Accident & Emergency national waiting times continue to be achieved.
- The venous thromboembolism trajectory has been achieved and performance is being maintained.
- The indicator for time spent on a stroke ward continues to be achieved.

Current year to date performance of some of these key measures can be seen below:

Secondary Care

Latest	Measure	PREV YTD	CURR YTD	Target YTD	Variance	YTD Trend
Apr-Nov '12	Diagnostic tests longer > 6wks (SDHFT)	1.8%	1.27%	1.0%	0.27%	
Nov '12	18 wk RTT - admitted (SDHFT)	92.8%	92.7%	90.0%	2.7%	
Nov '12	18 wk RTT - non-admitted (SDHFT)	97.2%	95.1%	95.0%	0.1%	
Nov '12	18 wk RTT -incomplete (SDHFT)	N/A	93.6%	92.0%	1.6%	
Nov '12	Outpatients Waiting List @ SDHFT	8,600	9,173	8,600	6.7%	
Nov '12	Inpatients Waiting List @ SDHFT	2,523	3,250	2,523	28.8%	
Nov '12	On the day elective cancelled operations	1.0%	1.2%	0.8%	0.4%	
Apr-Nov '12	Mixed sex accommodation breaches	0	1	0	1	
Apr-Oct '12	Cancer 2 Week Waits (aggregate) (SDHFT)	97.3%	96.7%	93.0%	3.7%	
Apr-Oct '12	Cancer 31 Day Waits (SDHFT)	97.6%	98.0%	96.0%	2.0%	
Apr-Oct '12	Cancer 62 Day Waits (aggregate) (SDHFT)	88.8%	88.1%	85.0%	3.1%	
Apr-Dec '12	A&E 4 hour wait performance (SDHFT)	98.2%	96.5%	98.0%	-1.5%	
Apr-Nov '12	Stroke - 90% stay on stroke ward (SDHFT)	90.8%	80.3%	80.0%	0.3%	
Apr-Dec '12	Ambulance Cat A8 (TCT)	90.9%	89.7%	75.0%	14.7%	
Apr-Dec '12	Ambulance Cat A19 (TCT)	99.5%	99.7%	95.0%	4.7%	
Apr-Dec '12	Ambulance Handovers <15mins	83.5%	72.9%	94.0%	-21.1%	
Apr-Dec '12	Ambulance Handovers <30mins	98.6%	96.5%	100.0%	-3.5%	

3.1 Local Context

Our CCG extends from the South Devon coastline to the open moorland of Dartmoor (see Fig. 3). The CCG covers some 310 square miles and takes in a GP-registered population of around 284,500.

Our picturesque area proves a popular retirement destination, with a noticeably higher proportion of older people resident in the area (shown in the population pyramid overleaf). We welcome and embrace this, at the same time as recognising the impact on the health and social care services that need to be provided. This includes the management of 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.

3.1.1 Population

The area's popularity as a retirement destination can be observed 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.

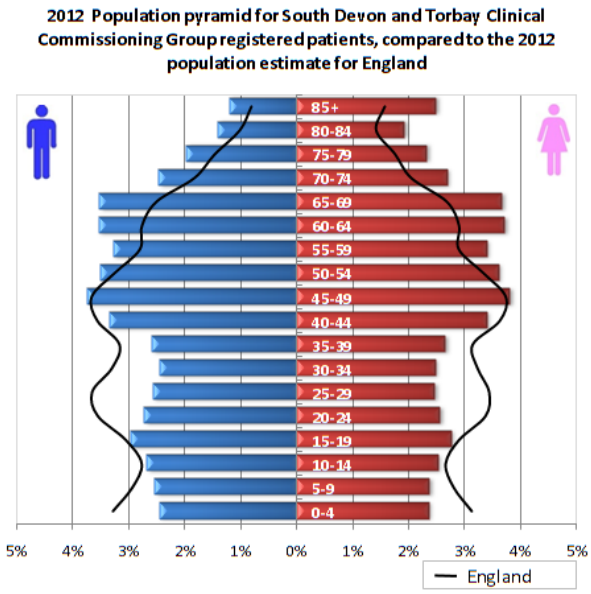


Fig. 4 Population Pyramid, Source: 2012 GP registered list, 2011 interim subnational population projections (ONS)

There is predicted to be a total registered population of around 300,000 in 2021 (see Fig. 5). The population projections for the South Devon area show a noticeable increase in the over 85 population between 2012 and 2021.

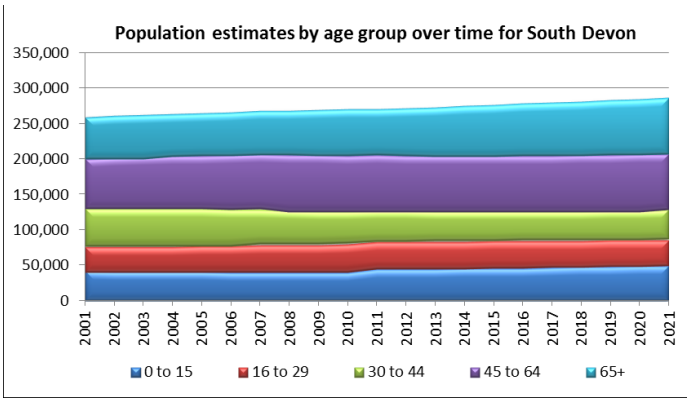


Fig. 5, Registered population projections, Source: 2011 interim subnational population projections (ONS) modelled on 2010 LSOA population estimates (ONS), 2001 to 2009 Mid-Year Estimates, ONS.

3.1.2 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 behaviour 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.

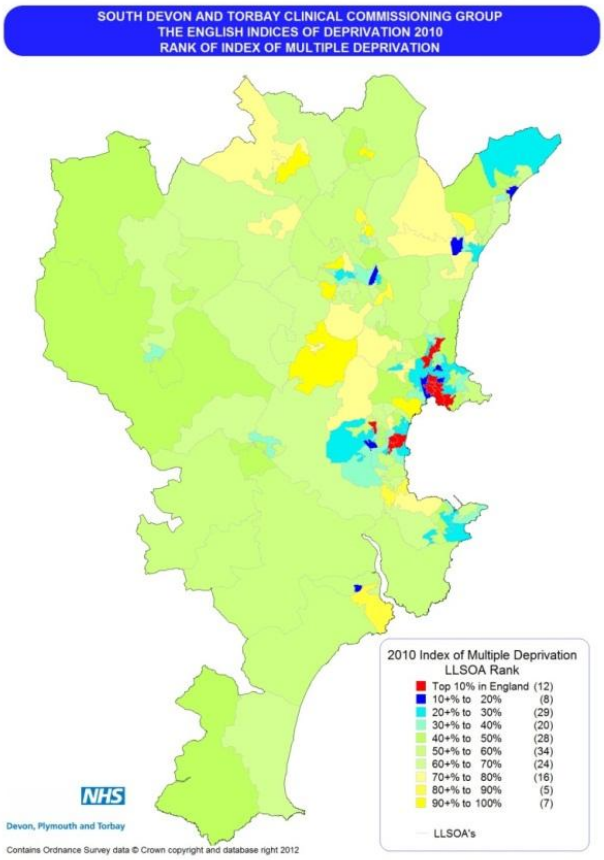


Fig. 6 2010 Index of multiple deprivation, Source: Department for Communities and Local Government

3.1.3 Life Expectancy

Overall, life expectancy is generally 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 England average; these are communities within larger areas such as Newton Abbot, Paignton, Teignmouth and Torquay.

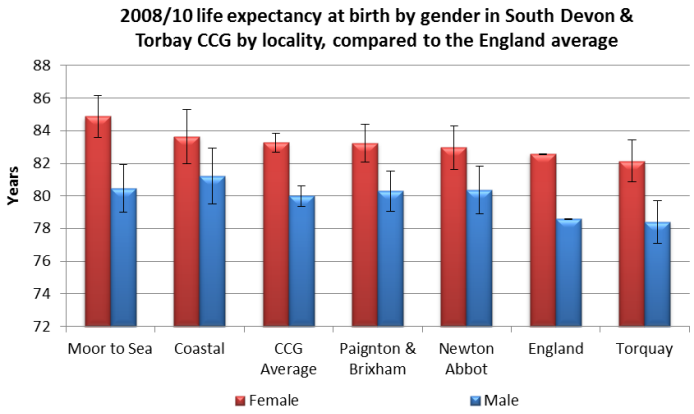


Fig. 7 Life Expectancy at Birth, Source: Source: PCMD, GP registered list, Information centre

There is a well-evidenced relationship between poorer communities (in terms of income) and poorer health outcomes such as life expectancy. People in our more deprived communities 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 the least deprived communities in South Devon and Torbay.

3.2 Locality Commissioning Groups

Our Governing Body has established a set of five groups known as the Locality Commissioning Groups (LCGs). They comprise representatives from the practices: GPs, practice managers and patients. Through these groups, local commissioning can reflect local needs.

The purpose of the Locality Commissioning Groups is to support the development of our CCG as a membership organisation, enable commissioning at a locality level, and to enable local engagement with GP member practices. Through them, local health needs, priorities and gaps in service provision are considered in the commissioning process. Each locality has developed its own commissioning plan, (see Appendix 3) and these have helped to define the priorities and work streams described in this plan. 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 locality plans.

3.3 Our Stakeholders and partners

Strong partnership working will be vital if we are to deliver good quality services and tackle the wider factors that determine or contribute to ill health.

Our CCG is committed to working with our partners in both Torbay Local Authority and Devon County Council, with community organisations, the NHS Commissioning Board, our providers and neighbouring CCGs to achieve improvements across the whole health economy and to address the wider inequalities that exist in people's health.

As set out at 2.1, our Joined Up 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.

Through our membership of the NEW Devon CCG Partnerships Commissioning Programme Board and the Torbay Partnership Commissioning Board we can consider a joint approach to commissioning for key specific population groups, reducing duplication and making the most effective use of our resources and capacity.

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 will be maintaining 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 in South Devon and Torbay has a long tradition of engaging with and commissioning services from the community and voluntary sector. We have built positive relationships with 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 will also work with Healthwatch Devon and Healthwatch Torbay, the new organisations that will act as the patient voice in health and social care. Patient Participation Groups are becoming well established in many areas, and our locality commissioning groups will build relationships with them and other groups across their local communities. At a local level, we will play a part in neighbourhood planning groups and community partnerships.

The CCG will work alongside the NHS Commissioning Board Area Team for Devon and Cornwall, particularly on primary care services, and with the Specialist Commissioning Group to ensure patients have access to more specialist services when they are needed.

Local Professional Networks will also be an integral part of the NHS Commissioning Board. Local Professional Networks for dentistry, optometry, and pharmacy will be built into the Commissioning Board Area Team, providing local intelligence and expertise for the local commissioning infrastructure.

3.4 Transforming the Care Delivery System

Our vision is to have joined up care for all. We believe that services should be based on populations in local communities, the obvious starting point being the communities served by GP practices. We also believe that services should be built on patient needs not organisational imperatives.

We wish to promote well-being and independence and will require all providers 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. Over the next three years we will expect to see a reduction in inpatient beds in line with the evidence we have already collected. We have undertaken 3 consecutive Acuity Audits that all clearly state that with additional personal care services 30 - 40% of patients cared for in a community hospital bed could be at home.

Our local provider of community services, Torbay & Southern Devon Health and Care NHS Trust has decided against becoming a standalone Foundation Trust. As such, in 2013/14 they will need to be acquired by another organisation. The process of acquisition, which will be overseen by the NHS Trust Development Authority, the Co-operation and Competition Panel, and Monitor, is expected to conclude during 2013/14. Commissioners will have a key input in approving the acquisition integrated business plan (IBP) in May; this will include CCGs, NCB Area Team, and Local Authority commissioners.

The CCG view this as the major underpinning opportunity to realise our vision of joined up, patient centred, community based services. South Devon Healthcare Foundation NHS Trust are the sole bidder in the acquisition process. We are working closely with the Trust to ensure their Outline Business Case is completely aligned to this commissioning plan.

We are working with the Trust on detailed infrastructure (hospital estate and IT but also the location of services) and workforce plans however these will not be available as part of the acquisition IBP although it is intended to give a broad direction of travel describing a refocusing on more community based services - resulting in a reduction in acute outpatient attendances, which are better configured geographically closer to patients homes.

Through the acquisition and into 20014/15 we expect to see a transfer of resources from inpatient beds to care provided in person's homes. To deliver this we would expect to see a shift in the current workforce configuration to more community based teams, delivering 7 day a week services. For example, the diabetes nurses which work as an integrated team across the acute and community, which we plan to deliver in other specialties e.g. epilepsy and heart failure.

The CCG is keen to support a model that realises this change. This does require the production of detailed infrastructure and workforce plans which describe the redesigned health and social care system and which describes a system capable of responding to higher demand, but at the same or reduced cost (in real terms). Further work to specify detailed infrastructure and workforce plans will therefore continue in 2013/14.

3.5 Key Risks

We are committed to a risk management strategy that minimises risks to all our stakeholders 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:

Although the NHS locally has a good track record in delivering the key operational standards and outcome indicators, we recognise that the next few years in particular will be challenging. We know that we have an increasingly elderly population and so far during 2012/13 we have seen a 6% increase in emergency admissions from the previous year. National Standardised Admission Rates (Dr Foster) show that we have a lower than expected emergency admission rate, which means we will have to go further than before and further than other CCGs have gone in order to reduce this (actions described in section 5).

Waiting times overall for planned and emergency care are very good locally but we still have some patients waiting too long for orthopaedic operations. During 2014/15 we plan to meet the NHS Constitution requirement of ensuring no patient, except where there is a medical reason, has to wait beyond 18 weeks for a planned operation. In order to achieve this as soon as possible, we have asked South Devon Healthcare NHS Foundation Trust for a detailed trajectory and activity plan, which makes use of capacity available at both public and private sector providers.

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 4.1.2).

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

Our CCG constitution upholds all the values and pledges made in the NHS Constitution. By actively seeking and listening to patient and carer feedback, putting in place robust governance arrangements for assuring the quality of care given by our providers and by contract monitoring, we will be able to provide on-going assurance of quality of care, and take action where care is found to be in need of improvement.

We consider that building a new relationship with patients and local communities is key to establishing our CCG as a real advocate of high quality care on behalf of all our communities. Supporting the improvement of quality where we identify poor care, and rewarding good quality where that is evidenced will be at the heart of our work and we will focus on ensuring the best possible outcomes for all of our population.

The Francis report on the failings at the Mid Staffordshire NHS Foundation Trust has implications for the entire health service and this includes commissioning activities and quality and safety assurance. We are digesting the learning and recommendations in the report and will work with the NHS Commissioning Board to ensure that any new enhanced quality standards are applied locally by all of our commissioned providers. We will work with our providers to determine how we can offer support if poor, unsafe or sub-standard services are identified, with a view to rapidly and sustainably improving quality and safety. We will also be active members of the Quality Surveillance Committee, working with our local commissioning partners to share information and find ways to best tackle poor quality care for our patients.

We very much welcome the Chief Nursing Officer's 'Compassion in Practice' document, outlining the need for a focus on "the 6 Cs" – compassion, courage, communication, competency, care (quality/safety) and commitment. We have already built an operating principle into our contracts with providers, specifically focused on care and compassion, dignity and respect. We will be reviewing this operating principle to ensure that it is fully aligned to the 6Cs, and that we work with our providers and listen to patients and their families, to ensure that we can identify where care is not being provided to these high standards.

One dimension of the NHS Outcomes Framework covers the commissioning and provision of safe, harm-free care. We will continue to hold central the principle of caring for people safely and will monitor the delivery of harm-free care in all our providers. To do this we will use the NHS Safety Thermometer and other processes we have in place, including the monitoring of all Serious Incidents and the reporting rates of patient safety incidents. We will work closely with our providers to ensure that they apply the Duty of Candour when incidents occur, and that they demonstrate learning from incidents and events where near misses or actual harm has occurred.

The NHS Outcomes Framework shifts the focus from measuring processes to measuring outcomes for patients. The Framework covers the following areas:

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

Fig. 8 The Five Domains

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

The Four Equality Delivery System Goals are:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and included staff; and
- Inclusive leadership at all levels.

4.1 Safety

4.1.1 Safeguarding

Provision of high-quality, safe services is the organising principle of the NHS and we need to assure ourselves 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. This includes 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.

We will work in active partnership with local authorities through Safeguarding Children Boards and Local Safeguarding Adult Boards to ensure that the needs of the most vulnerable are safeguarded. There will be a focus on a proactive approach to commissioning and contracting of individual placements, and strengthened quality assurance mechanisms for placements in and out of the county.

We have clinical leads for both safeguarding children and safeguarding adults to ensure that the Governing Body has a firm grasp of the issues facing vulnerable adults and children in healthcare. There will be a robust strategy for safeguarding adults and children so we are able to carry out our statutory duties to keep people from harm in healthcare. This is being developed jointly with the other CCG in Devon to ensure compatibility of processes, and to prevent gaps between services.

As with all areas of quality and patient safety, we will work to ensure that the voice of individuals is heard. We will actively seek to listen to the experiences of people who have been through the safeguarding processes, and use their experiences to feed into the Safeguarding Adults and Children's Boards.

4.1.2 Healthcare Associated Infections

Reducing healthcare-associated infections is high on our CCG's safety and quality agenda and we will ensure we lead the local health community in concerted efforts to reduce them. We do not accept that these infections are an inevitable part of or an acceptable risk related to health or social care. We will support providers, while holding them to account for their performance with regards to surveillance of infections and the implementation and sustained improvement of infection control practices and procedures.

Our CCG will lead the local health and social care community in developing a refreshed and joint action plan to reduce the incidence of Clostridium difficile and MRSA bacteraemia. A health community management plan is being developed, and will be monitored by the CCG Quality Committee. Root cause analysis is undertaken for all notified Clostridium Difficile cases and we will ensure that incidents are thoroughly investigated and lessons learned. Our CCG has a named clinical lead, an infection control lead and a managerial lead who will work with the local Director of Infection Prevention and Control to ensure maximum understanding of why the incidence of infection occurred.

Our CCG has a very challenging objective set for the incidence of Clostridium Difficile for the year ahead which will require a multi-faceted approach to ensuring reduction of cases. The plan will focus on prevention, and will include working with GPs to monitor antibiotic prescribing and to ensure that local prescribing of antibiotics and proton pump inhibitors appropriate. Our CCG will also work with the local authority to raise public awareness and to ensure that patients and the wider public know about the preventive measures they can take to protect themselves or the people they care for from becoming vulnerable to infection.

We will work with neighbouring CCGs to ensure a shared approach to learning from incidents and we will also include within all contracts an operating principle for healthcare-associated infections that sets out provider obligations and quality requirements.

4.2 Effectiveness

4.2.1 Quality Governance

As part of the clinical governance arrangements there is a Quality sub-committee to the CCG Governing Body. This is chaired by the Governing Body lead for patient safety and quality. The committee has an annual work plan to receive annual reports about quality issues such as safeguarding, healthcare-associated infections, equality and diversity, information governance, patient safety, implementation of quality standards from the National Institute for Health and

Clinical Excellence and other topics. The committee receives assurances and any escalated issues or risks identified by the commissioning quality improvement and patient safety group (CQIPS). Minutes from the Quality Committee are received by the Governing Body every month, accompanied by a chair's report.

CQIPS receives risk-based reports on various aspects of quality, such as complaints and concerns, infection control, safeguarding adults and children, medicines management, patient safety and clinical effectiveness. The Committee is chaired by the safeguarding lead and minutes from the meeting are received by the Quality Committee. Commissioning leads have membership of both the Quality Committee and CQIPS, to ensure that issues of quality and safety are picked up by those responsible for commissioning care pathways.

The Governing Body also receives a monthly quality report, which covers national, regional and local quality issues, as well as provider quality assurance information. This document, combined with the performance data presented to the Governing Body, provides the CCG with a holistic view of the state of quality in the locality, and will alert them to risks that need addressing or any national issues that require action or translation locally.

Our CCG has instigated a child health and safeguarding group, chaired by the clinical lead for safeguarding children and maternity. The group's remit is to have oversight over child protection and safeguarding issues and duties under Section 11 and 13, as well as to ensure that the CCG has a focus on commissioning the best, high quality care for all children. This group reports into the Quality Committee and will be responsible for monitoring safeguarding children action plans.

The quality team and the various contract leads work together to ensure that regular quality review meetings take place with all providers, seeking on-going assurance of good quality care and with a focus on the experience of people who use the services, either as patients or as carers. Evidence from patients and care professionals that indicates care is below expected standards will prompt an enquiry and follow-up, and we will work to support providers to improve their care standards. From April 2013, all quality review meetings will be part of the regular performance and contracting meetings with providers; this will promote the integration of quality issues into the performance and finance agenda so that quality is always considered when commissioning decisions are made.

4.2.2 Quality Assurance in Primary Care

Improving the quality of primary care is one of the statutory functions of the CCG and we will be working with the NHS Commissioning Board Area Team to improve the quality of services and develop a primary care development strategy. The quality of primary care across the CCG is generally good but it is important to ensure that this is monitored and that supportive development to improve quality continues. The quality of primary medical services will be reported on quarterly to the commissioning for quality and patient safety (CQUIPs) committee and any risks will be escalated to the Governing Body via the Quality Committee.

4.2.3 NICE Quality Standards

National Institute for Health and Clinical Excellence (NICE) quality standards are a set of specific, concise statements and associated measures setting out

aspirational but achievable markers of high-quality, cost-effective patient care, covering the treatment and prevention of different conditions and diseases.

We will ensure that Clinical Pathway Groups consider relevant NICE quality standards as part of their quality impact assessment.

We will continue to drive the measurement of outcomes and indicators in relation to quality of care and to drive local improvements in quality and outcomes for patients. This will be done through the work of the Clinical Pathway Groups and by using the Commissioning Outcomes Framework, the NICE quality standards and other measures to demonstrate progress to the NHS Commissioning Board, the wider public and stakeholders.

"GPs are very important – they know my medical history and can assess the need for treatment or referral quickly."

"The preventative work done by the GP practice is invaluable."

What would you change?
"A single contact point that could direct you to the most appropriate place"

4.2.4 Values-based Operating Principles

In addition to the quality requirement set out in the NHS Contract with providers, we have developed a suite of values-based operating principles that are embedded in the major contracts and which we plan to include in smaller contracts in the future. These operating principles, jointly developed with providers, set out commissioning intentions and provider requirements against a set of quality issues, which all align to the quality domains and the NHS Outcomes Framework.

The operating principles provide a means of gaining assurance from our providers that they are meeting the quality requirements central to each operating principle. There are currently 10 operating principles covering a range of areas including: privacy, dignity and respect, healthcare acquired infections, safeguarding adults and children, medicines management, and nutrition and hydration. A programme of in-depth reviews for gaining assurance against the operating principles is included in the Quality Committee work plan.

The operating principles agreed so far can be seen at Appendix 4.

4.3 Patient Experience

4.3.1 Using Feedback from Patients and the wider community

We will ensure we are:

- **Listening** – making it easy to give feedback, providing good information about providing feedback or making a complaint, getting complaints-handling right first time and ensuring people's rights under the NHS Constitution are met.
- **Responding** – able to handle the complaint at the level it requires, support people when they make complaints and ensure they are not disadvantaged by raising their concerns; mediate when issues can't be resolved; investigate concerns or cause concerns to be investigated.
- **Improving** – by using the intelligence gained from patient and public feedback to influence commissioning decision-making or to change the way the CCG or its processes works, by providing training for CCG staff and members as a result of such intelligence and in handling complaints

Additionally, there are systems and processes in place for monitoring and acting on feedback received through less formal channels. Patients and their families or carers, and indeed other people who witness poor care, need to be able to raise concerns quickly and easily.

What is learned from such feedback will inform an overall picture of the quality of care and of patient safety, where all our information is joined together. This way, early warning of risks to patient safety or a failing provider can be spotted and the appropriate commissioning actions taken.

The processes for receiving and acting on complaints and concerns raised is part of our wider focus on patient experience, and will dove-tail with other initiatives described elsewhere particularly with the use of the Friends and Family Test, Patient and Care Opinion and Healthwatch.

4.3.2 Complaints Management

As well as proactively seeking feedback from patients and the wider community, we will have arrangements in place to handle any complaints raised within the statutory complaints management framework. We will ensure:

- The public will have information easily available to tell them how to make a complaint
- There will be systems in place for recording and managing complaints, and taking actions as a result.
- Complaints will be dealt with efficiently and be properly investigated.
- People who make complaints will know the outcome of their complaint investigation.
- The public will be told what has been learned from complaints and what actions have been taken to improve the quality of care and patient experience.
- We will acknowledge when mistakes happen, apologising, explaining what went wrong and putting things right quickly and effectively.

4.3.3 Feedback from Healthcare Professionals – Yellow Card Scheme

We will put in place a 'Yellow Card Scheme' for GPs to use to alert our CCG of any issues of concern that they wish to raise. The Yellow Card Scheme is planned to be a single point of contact by phone or by email to the quality and patient safety team. This information may be about a patient-safety issue or feedback of patient experience but will all add to the quality of care intelligence gathered by the quality team. Where necessary an investigation will be initiated, or trends and individual issues will be fed back to care providers and learning shared with commissioning teams to help ensure that quality issues are considered when planning or reviewing services.

4.3.4 Equality and Diversity

Equality must lie at the heart of the work of our CCG to ensure the needs of all patients are met. We are committed to reducing inequality, to improving quality of care and patient experience.

Mindful of our public sector duty under the Equalities Act, we will ensure that people who might not normally get heard are asked for their views. It is known that people with the most complex needs and the worst experience of care are rarely asked for their insights by commissioners or providers. We will engage with Healthwatch in both Torbay and Devon, with interest groups locally and with hard-to-reach individuals and groups directly, and ensure their opinions are fed into the commissioning process.

4.3.5 Involving Patients and Communities in Planning and Designing Services.

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

All the clinical pathway groups will connect with patients with our support. We will also be working with Patient Participation Groups in the various communities and localities to ensure their voice is heard by the clinical pathway groups.

4.3.6 Transparency and Accountability

Transparency and accountability to the public is one of the CCG's core values, and this will be reflected in our relationships with stakeholders, patients and their carers, and the wider communities we serve. The availability and transparency of information is key to ensuring patients and the public are able to exercise informed choice in the services they receive and can help drive improvement.

During the next two years we will continue to focus on improving access to information for the public and in particular access to information regarding the quality and safety of services to inform choice.

5.1 Our three commissioning priorities

As set out in our Plan on a Page and developed in conjunction with our partners the following high-level priorities have been agreed:

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

In order to measure whether we have made improvements for patients within these overarching priorities we have chosen three specific areas to set trajectories for improvement as part of the Quality Premium, which are as follows:

- **Reduce alcohol admissions through the use of proactive case management (see section 5.2.2).**
- **Reduce emergency admissions from care homes (see section 5.2.2).**
- **Reduce the length of time patients have to wait from assessment to treatment for mental health conditions (see section 5.2.4).**

These measures will form part of our 'CCG Progress Monitoring Dashboard' for next year (along with the key indicators for activity and finance and also progress against the CCG Outcomes Framework). This dashboard will be reviewed by the CCG's Business Planning and Performance group (see sections 7.4.2 and 7.4.3 for more detail) on a monthly basis, with progress reports to the Clinical Commissioning Committee every quarter.

5.2 Work streams & key outcomes

In order to deliver our three overarching commissioning priorities, and improve quality in line with the Commissioning Outcomes Framework, the following work streams have been identified, and described over the next three years:

5.2.1 Primary Care

Evidence Base

The Deloitte report on the future of primary care (2012) highlights the importance of primary care: 90% of all patient contacts are made in primary care. Consultations have increased over the last ten years and the challenges of an ageing population with more patients living with long- term conditions look set to place further demands on the service. Spending on primary care has risen by only modest amounts in the last few years.

The 2012/13 Joint Strategic Needs Assessment makes reference to the role of primary care in a number of areas, including the role of primary care in tackling hospital admissions, managing health through prevention and optimal management of chronic conditions. The impact on primary care of managing long-term conditions is significant with 50% of all GP appointments being for long-term conditions.

CCG Outcomes Indicators

The following indicators in the 2013/14 CCG Outcomes Indicator Set will be tackled through this work stream:

- C2.3 People with Chronic Obstructive Pulmonary Disease & Medical Research Council dyspnoea scale ≤3 referred to a pulmonary rehabilitation programme.
- C2.4 People with diabetes who have received nine care processes.
- C2.5 People with diabetes diagnosed less than one year referred to structured education.
- C4.1 Patient experience of GP out of hour's services.

Key outcomes to be achieved

- To increase the capacity in primary care in order to treat more patients, only going to secondary care where absolutely necessary.
- To encourage collaboration between practices, to deliver the best services for patients, when it is needed.

Key pieces of work to be undertaken

This year we will establish a primary care re-design group to take forward the primary care strategy and outcomes for primary care. The group will include clinical and management representation from the CCG, members of the Local Medical Committee and the NHS Commissioning Board Area Team. We will devise and implement a primary care quality dashboard to better understand, and seek to reduce, variation in quality and access.

We will commission and engage practices in organisational development programmes designed to focus on improved access and patient experience including Dr First, Productive General Practice and the Primary Care Foundation's 'Urgent Access in Primary Care' scheme. We plan to see a 2% reduction in total emergency admissions from those practices participating in these schemes.

We will ensure that primary care capacity and demand considerations are part of the whole system re-design work being undertaken as part of the Joined Up Cabinet work.

As a result of patient feedback outlined in section 4.3.1, all re-design boards will continue to identify elements of care pathways where care may be delivered closer to patients, for both planned and unplanned care, and also where the preventative agenda can be progressed further. This work will need to include quantification of the workload for primary care and the resources necessary to achieve change.

In years two and three we will implement the primary care strategy devised in year one and reduce variation in quality and in access to primary care services. We will evaluate the three organisational development programmes to establish what works best from each scheme and share the learning points. We will secure and provide additional targeted investment in primary care to recognise quality improvements, capacity issues and access developments.

Locality Focus

Moor to Sea locality has identified primary care as a particular priority. It will be developing capacity in primary care to improve the management of long-term conditions and urgent care and also ensuring good access to appropriate care. It wants to enable joined-up working between primary care, district nurses, care homes, social services, mental health services and the voluntary sector.

5.2.2 Community Care

Evidence Base

The over 85 population is expected to increase from 3.9% in 2012 to 4.8% in 2021 in South Devon & Torbay, higher than the national average. On average older people cost the most per head with regards to hospital care.

A higher number of people are expected to suffer from long-term conditions: conditions that cannot be cured but can be controlled through treatment and behaviour. People with long-term conditions are the most frequent users of healthcare services. They account for 29% of the population, but use 50% of all GP appointments and 70% of all inpatient bed days.

Across South Devon and Torbay there is estimated to be unmet need for patients with Chronic Obstructive Pulmonary Disease (COPD) in the region of 3,300 (1.2%). We know that COPD patients can be supported to live with their condition, both through self-care and through multi-disciplinary team support in the community. By actively targeting this population we can reduce the number of emergency admissions caused by an exacerbation of symptoms caused by poor self-care.

The rates of unplanned hospitalisation for chronic ambulatory care sensitive conditions (chronic conditions that can often be managed in primary care) 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 in order to address this we need to develop care plans that treat the patient as a whole, not per condition.

CCG Outcomes Indicators

The following indicators in the 2013/14 CCG Outcomes Indicator Set will be tackled through this work stream:

- C1.1 Combined indicator on potential years of life lost (PYLL) from causes considered amenable to healthcare adults and children and young people.
- C1.6 Under 75 mortality from respiratory disease.
- C2.1 Health-related quality of life for people with long term conditions.
- C2.2 People feeling supported to manage their condition.
- C2.6 Unplanned hospitalisation for chronic ambulatory care sensitive conditions in adults.
- C2.8 Complications associated with diabetes including emergency admission for diabetic ketoacidosis and lower limb amputation.
- C3.1 Emergency admissions for acute conditions that should not usually require hospital admission.
- Improving the experience of care for people at the end of their lives – TBC.
- Improving people's experience of integrated care – TBC.
- Improving recovery from injuries and trauma – TBC.
- Improving recovery from fragility fractures – TBC.
- Helping older people to recover their independence after illness or injury – TBC.
- Enhancing quality of life for carers – TBC.

Key outcomes to be achieved

- To achieve fully joined-up and cost-effective seven-day services from the acquisition process.
- To increase the number of patients who are actively case managed to avoid unnecessary hospitalisation and reduce bed based care.

Key pieces of work to be undertaken

This year we will build on the virtual ward model, ensuring full multi-disciplinary input, including secondary care outreach, and virtual bed allocation according to risk score not practice size. We will use risk stratification to identify the top 5% high risk patients and develop active care plans for early intervention to increase their health and well-being, reduce their likelihood of emergency admissions and embed the principles of self-care into their care plans.

The acquisition process offers an opportunity for the system to move a step closer to our vision of excellent, joined up, seamless care for our population. The removal of organisational boundaries provides a chance to remove duplication and ensure the patient receives the right care, optimising the outcomes. Through the integrated business plan for acquisition we expect to see a reduction in the cost base of the system. Our CCG sees this as step one in achieving our vision of a truly integrated care organisation for our population.

We will continue to increase the number of end of life patients on the electronic palliative care co-ordination system and ensure each of those patients is offered a treatment escalation plan if appropriate.

We will work with our locality commissioning groups to continue to build relationships with care homes, establishing partnerships with local practices and community teams. Through our work with care homes we plan to reduce total emergency admissions by 0.5%. We will have a single point of access for health and social care services which suits the need of each locality and review community nursing provision in order to achieve more fully integrated community nursing teams with GP practices.

Our aims for community nursing tie in with the Department of Health "Care in Local Communities – district nurse vision and model" January 2013, including:

- Focus on enabling the move from acute to community settings.
- Enhance partnership between district nursing, health, social care, voluntary sector partners and patients to support care in people's homes (including care homes) and in other community settings.
- Promote and support self-care.
- Tackle social isolation and mental as well as physical health needs especially in frail older people.

In years two and three we will implement self-care training for all staff involved in the virtual wards. With our Locality Commissioning Groups, we will work towards each care home having a linked GP practice and community nurse. We will increase the provision of community services to allow for seven-days-a-week discharge from acute hospitals. We will also define the role of community hospitals and develop a commissioner strategy for carers.

Locality Focus

Newton Abbot locality has identified community care as a particular priority. It will be developing an integrated community team, which is crucial for managing complex multi-system medicine at home for an ageing population.

It will be actively managing caseloads, supported by the services at Newton Abbot Hospital. It will also continue the development of Virtual Ward best

5.2.3 Urgent Care

Evidence Base

Assuming a linear cost for urgent care (not adjusting for inflation or other factors), we might expect to see cost for the over 85s rise from around £14.5m to £18.5m in 2021, through demographic change alone.

Emergency admissions in South Devon and Torbay are assessed as generally lower than expected (Dr Foster), even though we have seen a sharp rise in line with national trends throughout 2012. Emergency admissions for injuries and poisonings (related 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.

CCG Outcomes Indicators

The following indicators in the 2013/14 CCG Outcomes Indicator Set will be tackled through this work stream:

- C1.2 Under 75 mortality from cardiovascular disease.
- C1.3 Cardiac rehabilitation completion.
- C1.3 Cardiac rehabilitation completion.
- C1.5 Mortality within 30 days of hospital admission for stroke.
- C1.7 Under 75 mortality from liver disease.
- C1.8 Emergency admissions for alcohol related liver disease.
- C2.7 Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s.
- C3.2 Emergency readmissions within 30 days of discharge from hospital.
- C3.4 Emergency admissions for children with lower respiratory tract infections. People who have had a stroke who :
- C3.5 Are admitted to an acute stroke unit within four hours of arrival to hospital.
- C3.6 Receive thrombolysis following an acute stroke.
- C3.7 Are discharged from hospital with a joint health and social care plan.
- C3.8 Receive a follow-up assessment between 4-8 months after initial admission.
- C4.6 Patient experience of A&E services.

Key outcomes to be achieved

- To improve access to GP services, in and out of hours, to avoid unnecessary visits into secondary care.
- To increase self-care and pro-active case management e.g. diabetes, alcohol etc.
- To review patient journeys through A&E in order to redesign services to avoid unnecessary admissions.
- To increase the level of pro-active care in residential homes.

Key pieces of work to be undertaken

This year we will undertake a review of all minor injury units, encompassing opening hours, staffing levels and demand to ensure a consistent minimum set of

services on offer at all units. This will reduce variation in patient experience and the use of services.

We will improve the medical support for patients placed in the care of the intermediate care team, both in care homes and in their own home, to allow the service to be used more as a step-down service as well as step-up.

We will review patient journeys through A&E so we can redesign services; ensuring patients get the right care in the right place. For all long-term condition specialties we will ensure that detailed reviews of emergency admissions and emergency re-admissions by diagnosis are performed and ensure initiatives are in place to support admission avoidance where possible.

We aim to reduce alcohol-related hospital admissions by working intensively with a small cohort of individuals with complex needs (often alongside their families, partners or others) who experience compromised psychological and/or physical health due to alcohol consumption, to keep them well and supported in the community. We currently commission targeted alcohol workers to provide this service and will continue to monitor and evaluate the outcomes to inform future commissioning. Our monthly Frequent User Review Panel also provides a multi-disciplinary approach to supporting those patients who are high users of our emergency services, including use arising as a result of alcohol consumption. Through these work streams we plan to reduce total emergency admissions by 0.5% by the end of the first year.

We will be working with our care home providers to improve the quality of life of patients in care homes, reducing the number of hospital admissions. Nurses from the medical admissions team (who are based in the hospital) will offer training and support to nurses in the nursing homes to enable them to deliver acute nursing treatments, such as intravenous treatments and blood transfusions. In residential homes the team supports patients by delivering acute nursing treatments in these settings, enabling them to remain in the home rather than go to hospital. We will continue to engage with our care homes, and work towards a solution where all patients receive active care and have comprehensive treatment plans, in particular strengthening relationships with primary care and identifying training needs for care home staff.

We are committed to ensuring that self-care is fully integrated and embedded into all healthcare services so will build on the existing training programme for health and social care professionals. We will commission a self-care service which provides a flexible approach to offering advice and support around self-care, assessing the individual's needs. To complement this, the service will also ensure it provides the local workforce with support to offer advice and the skills to patients to help them self-care when this is appropriate.

In years two and three we will increase the provision of community services to allow for seven-days-a-week discharge from acute hospitals. We will develop 'urgent care centres' in the community, according to need, which will provide a wider range of urgent care services including x-ray facilities and diagnostics, as an alternative to attending A&E.

5.2.4 Mental Health, Dementia & Autism

Evidence Base

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.

As a result of the Autism Act (2009) the Secretary of State has issued statutory guidance for local authorities and the NHS stating how we must meet the needs of people with autism; this forms the basis of our commissioning intentions for autism.

CCG Outcomes Indicators

The following indicators in the 2013/14 CCG Outcomes Indicator Set will be tackled through this work stream:

- C1.12 People with severe mental illness who have received a list of physical checks.
- C2.9 Access to community mental health services by people from BME groups.
- C2.11 & C2.12 Recovery following talking therapies (all ages and older than 65).
- C2.13 Estimated diagnosis rate for people with dementia.
- C2.14 People with dementia prescribed anti-psychotic medication.
- C4.8 Patient experience of community mental health services.

Key outcomes to be achieved

- To assertively case manage patients in primary care, through integrating mental health into community teams.
- To commission a Single Point of Access to joined-up mental health services.

- To improve access to, and patient experience of, psychological therapy and crisis services, especially for children.
- To implement the local Dementia Strategy.

Key pieces of work to be undertaken

As a result of patient feedback outlined in section 4.3.1, we will commission a 'single point of access' for mental health services, including crisis, older people's mental health services and drug and alcohol services. We will work with providers to develop good quality care plans and agreed protocols for the transition of patients into primary care, to include fast-track access back into specialist services.

We will be working with providers and localities to develop relationships between secondary care specialists and community teams and explore the advantages of having a named link worker for each locality and input into a virtual ward style of individual case-management.

We will ensure better access and choice of evidence-based psychological therapy in a timely way. We will review specialist psychological therapies and health psychology services with a view to reducing waiting times for treatment to 18 weeks. We also wish to further develop a home treatment approach to urgent psychiatric care for people experiencing acute emotional distress and anxiety.

We will be implementing memory clinics for dementia across South Devon and Torbay. We will ensure consistent access to drugs for those diagnosed with dementia and, where appropriate, to anti-psychotic drugs. We will also work with the independent sector to ensure people with dementia live well in care homes.

We will be working closely with local authority colleagues to produce a local strategy for autism. We will also be reviewing services to ensure ease of access and use for adults and children with autism.

In years two and three we will move towards a greater emphasis on early intervention services as we move from a treatment and management approach towards a preventative model. We will be working on delivery of the eating disorder day service and increased access to therapy for people with personality disorders.

5.2.5 Planned Care

Evidence Base

Benchmarking data suggests a need to review the top seven specialities which account for 50% of first outpatient spend. The focus will be on orthopaedics, obstetrics, ophthalmology, ear, nose & throat (ENT), gynaecology, paediatrics and colorectal surgery, as well as on the specialties accounting for 50% of follow-up spend - orthopaedics, paediatrics, ENT, cardiology, clinical oncology and ophthalmology.

Elective hospital admissions are significantly higher than expected in the younger age groups, while significantly lower than expected for the older age groups. There is a significantly higher than expected number of elective admissions for cancer treatments, which include on-going treatments and attendances at fracture clinics.

CCG Outcomes Indicators

The following indicators in the 2013/14 CCG Outcomes Indicator Set will be tackled through this work stream:

- C1.9 Under 75 mortality from cancer.
- C1.10 a and b Cancer survival: all cancers 1 and 5yrs.
- C1.11 a and b Cancer survival: breast, lung & colorectal 1 and 5yrs.
- C1.13 Antenatal assessment < 13 weeks.
- C1.14 Maternal smoking at delivery.
- C1.15 Breastfeeding prevalence.
- C3.3 Increased health gain as assessed by patients for elective procedures
  - Hip Replacement
  - Knee Replacement
  - Groin Hernia
  - Varicose Veins
- C4.4 Patient experience of outpatient services.
- C4.5 Responsiveness to in-patients' personal needs.
- C4.7 Women's experience of maternity services.
- Improving the safety of maternity services – TBC.

Key outcomes to be achieved

- To ensure patients are diagnosed and receive a care plan as soon as possible.
- To ensure patients receive the appropriate level of intervention, in a local setting, avoiding unnecessary journeys to hospital.

Key pieces of work to be undertaken

This year we will review commissioning intentions with the Devon Access & Referrals Team (DART) to improve pathway compliance, beginning with musculoskeletal pathways, which we plan will lead to a 2% reduction in total referrals.

We will implement and evaluate clinical referral triage, a system for clinical review of a referral letter to determine the most appropriate place for the patient to be seen, to avoid unnecessary hospitalisation.

We will review follow-up behaviour of the top six acute specialities accounting for 50% of spend and review acute consultant to consultant referral management, which we plan will lead to a 2% reduction in total follow-ups.

We will develop commissioning strategies for key planned care specialities including: dermatology, ophthalmology, paediatrics/child health, musculoskeletal and pain.

We will also scope how self-management can be utilised effectively for planned care.

In years two and three we will continue to improve pathway compliance through the use of DART. We will review the interface with intermediate care services and commission pathways that make sense to patients. We will explore how technology/innovation can improve referral management and we will commission self-management/expert patient programmes to improve patients' quality of life

Locality Focus

Torquay and Paignton & Brixham localities have identified planned care as a particular priority for them. They will be ensuring pathway compliance by working within the DART compliance process to improve the quality of referrals, ensuring that primary care/community based interventions have taken place, and to provide wider education about agreed clinical pathways.

5.2.6 Children's Services

Evidence Base

Benchmarking data suggests a need to review the top specialties accounting for 50% of first and follow-up outpatient spend; this includes paediatrics.

Analysis from the Joint Strategic Needs Assessment of preventable health conditions in maternity and early years indicate concern 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. Childhood immunisations uptake is low in the Moor to Sea locality.

Childhood obesity has been linked with poorer health outcomes for children, such as asthma, diabetes, psychological ill health and cardiovascular risk factors. Obesity and overweight among reception years has reduced over the last 3 years while levels in Year 6 children have remained relatively static with only minimal reduction.

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

The number of unplanned hospitalisations for asthma, diabetes and epilepsy in the under 19s in 2011/12 was highest in Torquay, which accounted for around a quarter of all these admissions.

Child poverty estimates in the CCG area are, at 20% of all children, higher than those seen regionally and nationally. 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. Across South Devon, the rate of hospital admissions is highest in the Torquay locality. The rate per 10,000 of children in Torbay who were the subject of a child protection plan at 31 March 2012 was the highest in England.

CCG Outcomes Indicators

The following indicators in the 2013/14 CCG Outcomes Indicator Set will be tackled through this work stream:

- Improving children and young people's experience of healthcare – TBC.
- Delivering safe care to children in acute settings – TBC.

Key outcomes to be achieved

- To ensure children and young people receive joined-up services in appropriate settings.

- To encourage young people to be responsible for their own condition in order to prepare for transition to adulthood.

Key pieces of work to be undertaken

This year we will develop commissioning intentions for community paediatric and nursing services, as well as the role and scope of primary mental health work. We will embed the IAPT programme to give access to psychological therapies.

We will review the follow-up behaviour of acute paediatrics and acute consultant to consultant referral management.

We will develop commissioning strategies for paediatrics/child health and scope how self-management can be used most effectively for young people. We will also explore the development of a short stay paediatric unit.

We will work jointly with the NHS Commissioning Board on an assessment of the impact of the increased number of health visitors on community prevention and early help services, with an initial focus on the pilot 'Community prevention hub' in Torquay.

We will explore jointly-commissioned community services for 0-19 year olds with local authority colleagues and partners from primary care and education.

In years two and three we will commission integrated children's services provision. We will explore how technology/innovation can improve referral management and commission self-management/expert patient programmes.

5.2.7 Learning Disabilities

Evidence Base

In the last 10 years there have been a number of reports identifying inequalities in health service delivery to people with learning disabilities. These inequalities have resulted in people with learning disabilities having a reduced life expectancy and living with poorer health than the general population.

As a result of the abuse of vulnerable people with learning disabilities at Winterbourne View private hospital, the 'Transforming care: A national response to Winterbourne View Hospital Department of Health Review: Final Report' now sets out actions to be undertaken and the structures for monitoring their delivery.

CCG Outcomes Indicators

The following indicators in the 2013/14 CCG Outcomes Indicator Set will be tackled through this work stream:

- Reducing premature death in people with learning disabilities - TBC

Key outcomes to be achieved

- To implement actions set out in the Winterbourne View Report.
- To ensure mainstream care for people with Learning Disabilities by commissioning inclusive services.

Key pieces of work to be undertaken

This year we will implement the Winterbourne View actions, including arrangements for pooled budgets across health and social care.
We will work to establish equality of access for people with learning disabilities to primary and secondary care, including wider primary care services and screening programmes. (As part of our Equality Delivery System we will be working with our statutory partners and people with learning disability to assess how accessible services are to them and identify areas for improvement.)
We will target specific pathways for delivery of equality of outcomes: cancer screening, obesity, diabetes, cardiovascular disease and epilepsy.
In years two and three we will continue to ensure that universal mental health services are accessible to people with Learning Disabilities and we will continue to improve equality of access to all services.

5.2.8 Medicines Optimisation

Evidence Base

The most common therapeutic intervention made in the NHS is the use of medicines. The current thinking from the government is to expand medicines management to medicines optimisation. This means a greater focus on optimising medicines use to achieve the best outcomes for patients. We are committed to transforming the ethos of medicines management in South Devon & Torbay to medicines optimisation.

Key outcomes to be achieved

- To review and reduce prescribing variation in all settings, in keeping with national best practice.
- To fully explore and make use of gain-share opportunities with all providers.

Key pieces of work to be undertaken

This year we will work with our partners to develop processes for reducing prescribing variation through aligning Joint Formulary processes and developing mechanisms for accessing new pharmacological technologies. A county-wide commissioning committee will be developed with appropriate representation in order to assess the effectiveness of new medicines. We will continue to benchmark practices' prescribing of common core drugs, in order to promote the use of specified preferred medicines. In doing this we plan to make efficiency gains of 4% in the primary care prescribing spend.

We will also work with our colleagues at the acute trust in order to fully utilise gain-share opportunities. Initially we will develop processes for routine monitoring of high cost drugs with the acute setting and explore the extent of patient access schemes. Additionally we will examine areas of mutual benefit with other providers. In doing this we plan to make efficiency gains of 4% in secondary care prescribing spend.

In years two and three we will develop mechanisms to benefit both South Devon and Torbay CCG and South Devon Healthcare NHS Foundation Trust though mutually beneficial gain-share arrangements.

6.1 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.

Our IT Vision Statement is:

Technology, systems and processes will be implemented and used to maximise the opportunity to support efficient working with the right useable information and tools available to the right people whenever and wherever needed.

6.2 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 the quality and efficiency programme, QIPP.

'Innovation Health and Wealth' defines six *'High Impact Innovation'* areas of innovation for the coming year and sets out that from April 2013 compliance with the high impact innovations would become a pre-qualification for CQUIN. In order to qualify for CQUIN payments our providers will need to satisfy at least 50% of the pre-qualification criteria that apply to them.

We are actively working with our providers, creating a culture within which 'joined-up' innovative thinking is positively encouraged and supported. We will harness the creativity of our local community by establishing the mechanisms by which innovative ideas can be easily put forward, or commented upon by anyone, be they a patient or carer, employee (at any level within their organisation), third sector organisation or private sector organisation.

6.3 Communications

This commissioning plan details an ambitious set of intentions with regard to the aggregation of experience and local feedback into a set of meaningful commissioning objectives. To realise this, we will need excellent communication at all levels. We have appointed a small but effective communications team and will retain internal control of key communications functions (including the development of excellent stakeholder engagement throughout our healthcare economy, internal, external and media communications and the use of technology to support engagement (such as 'Patient Opinion'.) We are working on a collaborative model with our sister CCG in NEW Devon to manage broader communications requirements (such as media analysis and archives and on-call arrangements). We will also be working closely with our providers in order to communicate joint messages about key commissioning decisions and potential service changes.

The appointment of a Clinical Lead for Engagement and Communications on the Governing Body is a statement of our commitment to meaningful joint work with our populations.

GP Engagement

This is facilitated through the creation of localities (described in section 2.1) and a Council of Members. A regular meeting of these bodies ensures that we retain the goodwill, ideas and input of our constituent members, and was the mechanism through which we created and adopted our Constitution. We consulted our GPs early on in the authorisation process regarding communications, and thus we have created a light-touch approach through weekly updates as well as practice visits where requested.

Population Engagement

The design of our organisation (described in section 2.1) shows the inclusion of a 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 already using the considerable knowledge and experience of its members to inform the commissioning of our CCG. Our Non-Executive Director for Patient and Public Involvement regularly attends SPIG and reports delivery to the Governing Body on key points.

Our CCG has actively supported the development of Healthwatch in Torbay and has begun to build a framework through which work with both Torbay and Devon Healthwatch will lead to the creation of a focal point for engagement right across the healthcare community.

6.4 Workforce

The workforce of the CCG has been constructed using a two-faceted approach which we believe will serve the organisation well into the long term. Firstly, the fair and full redeployment of staff under the transitional guidance for human resource (HR) management, during which we have maintained a legacy approach to ensuring that talent and organisational memory is preserved through transition from PCT to CCG. And secondly, a robust approach to selection throughout the organisation. Using open and transparent systems of recruitment (including assessment centres), we have required senior management and clinical leads to compete for key roles, thus ensuring the best possible competence and capability within the organisation.

Due to its geographical constraints, size, and the nature of its vision, the 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 quality and safety. Where economies of scale can be achieved through outsourcing, this has been negotiated and is described in section 6.4.

Distributed Leadership and Clinical Partnerships

In accordance with our vision, we have designed and set up a distributed model of leadership throughout the CCG. Wherever possible we have appointed (through selection) healthcare professionals and GPs to lead redesign, innovation, communications, engagement, workforce planning, education, quality improvement, patient safety and other key work streams in support of excellent commissioning. Some 50 GPs are now involved in this distributed model of leadership which is already yielding early success through the creation of a ‘management partnership’ model of support. Throughout the organisation,

clinical leaders work alongside a manager who supports their work, ensures delivery and thus enables the release of clinical leadership in its purest form.

Talent Management and Training

We are fortunate to have the engagement of a wide range of clinical leaders in the CCG, as well as a competent and enthusiastic management team, but we know we must work to plan for the future. A range of factors influence this view, including the age and gender profiles of our existing clinical leadership as well as the relative immaturity of our management model in a new and uncertain world. The addition of 'professional leadership' to the NHS Planning Framework for 2013/2014, as outlined in 'Everyone Counts', provides us with a helpful impetus against which to consider the leadership development of our clinical partnerships (as described above). We have already written and adopted a simple yet effective framework for appraisal and performance management which asks managers and leaders to consider behaviour, track record, ambition and stretch when managing staff.

We are considering a range of initiatives to 'grow' a new generation of clinical leaders. For example – we are in discussions with the South West Deanery about the creation of an ST4 programme which would operate on a 'leadership/commissioning/backfill' educational basis.

6.5 Commissioning Support Arrangements

Our CCG has entered into an agreement with the Best West Commissioning Support Unit for them to provide clinical procurement services and sustainability expert advice and support.

It has also been agreed that NEW 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 DART.
- Contract management for the Out of Hours service.
- PALS and Complaints.
- Medicines Optimisation support.
- Specialist Business Intelligence functions.
- Communications support.
- Freedom of Information requests.
- 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 & Care NHS Trust via Service Level Agreements. These are:

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

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

7.1 Financial Planning

The NHS Commissioning Board will take on its full powers from 1 April 2013, overseeing expenditure against England's £95.6 billion NHS budget to deliver the Government's mandate. Within this overall funding, £63.4 billion was part of the announcement of financial allocations to CCGs and represents 2.3% growth when compared to the equivalent 2012/13 baselines.

As part of our input into the national work to establish recurrent baselines for the CCG we have acknowledged locally that there are risks inherent in analysing baselines across a range of geographies as well as new commissioning responsibilities. CCGs will need to work together locally in order to ensure as stable as possible an introduction of the new system of commissioning in 2013/14.

The resources announced for local commissioners comprise three key elements:

- An allocation to CCGs to cover the local services they will commission on behalf of their populations (£63.4 billion, representing 2.3% nominal growth or 0.3% real terms growth). Current assumptions suggest that an average CCG successfully delivering its QIPP schemes should in fact require less than 1% to cover expected cost pressures;
- The running costs allocated to CCGs, as published on 8 November 2012 (£1.3 billion); and
- An allocation to local authorities to fund services that benefit both health and social care, which will increase by 38% to £0.9 billion in 2013/14, as previously announced.

A summary of the above for the CCG is as follows:

	£'000
Adjusted CCG Baseline (excluding Running Costs)	360,503
2013/14 Growth at 2.3%	8,292
Total Revenue Allocation	368,794

CCG Running Costs Allocation	6,717

Total CCG Allocation (including Running Costs)	375,511

Allocation in relation to social care (including growth)	5,366

The indicative CCG budget and draft plan for 2013-14 is presented at Appendix 5. It has been developed to reflect our assessment of the local impact of national and local planning assumptions. This includes required surplus (nationally 1%) and headroom (2%), and as well as our investment priorities and efficiency requirement.

The £15-20bn national QIPP challenge is focussed on the current Comprehensive Spending Review period which ends in March 2015. NHS growth funding in real terms over the last

sixty years has averaged 4%[1]. Current growth in real terms during the current CSR is 'flat cash' or 0%. The most optimistic forecasts for UK GDP growth beyond 2015 are currently around 2%. Given these parameters, it is most likely at this point that the requirement for the NHS to continue achieving unprecedented improvements in productivity will continue long beyond 2015 and the current QIPP challenge.

QIPP will continue to be a priority for us but it is also increasingly important to describe an intention which the local health and social care organisations, commissioners and providers, can agree in terms of the wider workforce and infrastructure (estate, information technology, etc.) which will be supportive of our system priorities beyond this CSR, including the financial landscape which that requires. It will be important to demonstrate greater emphasis on maintaining health and preventing illness, with patients being treated in the least acute setting possible, and with care delivered nearer to GP practices.

A clear statement of the financial landscape as it currently exists can be seen as follows:

	2013-14	2014-15	2015-16
Draft Medium-term Financial plan for 2013/16 - Summary	**Expenditure Plan**	**Expenditure Plan**	**Expenditure Plan**
	£000	**£000**	**£000**
Area of Expenditure			
Purchase of Healthcare			
Secondary Heathcare & Ambulance Services	185,584	185,783	185,783
Mental Health Services	28,444	28,458	28,458
Community Health Services	47,700	47,715	47,715
Other NHS Commissioned Services	7,379	7,917	8,329
Non-NHS Healthcare Services	19,532	19,860	20,168
Total Purchase of HealthCare	**288,638**	**289,732**	**290,452**
Primary Care Commissioning			
Primary Care - Out of Hours, Enhanced Services	4,893	4,893	4,893
Primary Care Prescribing	47,340	48,287	49,253
Total Primary Care	**52,233**	**53,180**	**54,146**
Complex Care Commissioning (CHC, IPP, etc)	**25,522**	**26,798**	**28,138**
Other Programme Services			
Other Purchase of Healthcare			

[1] NHS and Social Care Funding: The Outlook to 2021/22. Nuffield Trust & IFS, July 2012

Total Other Purchase of Healthcare	**0**	**0**	**0**
Total Purchase of Healthcare	**366,394**	**369,711**	**372,737**
Non Healthcare Purchase			
Running Costs	6,717	6,717	6,717
Total Non Healthcare Purchase	**6,717**	**6,717**	**6,717**
Plan Requirements & Reserves			
Headroom & Contgingency	5,532	5,726	5,890
National & Local Investment Requirements	479	1,034	2,023
Other Programme Services Risk Reserve (Non-Recurrent)	932	2,609	5,218
Total Plan Requirements & Reserves	**6,943**	**9,369**	**13,131**
Total Planned Spend	**380,054**	**385,797**	**392,584**
Revenue Resource Limit	**385,697**	**389,636**	**396,511**
Under Spend Against Revenue Resource Limit	**5,643**	**3,839**	**3,926**

Planned QIPP Requirement in Expenditure Plans	**(4,356)**	**(6,049)**	**(5,875)**

Planning Requirements: National and Local

A key expectation for our CCG is to continue to achieve a surplus at a minimum of 1% which, based on the CCG allocation, would equate to £3.688m. Locally, we will plan to achieve surplus at £5.643m although over time would expect this to return to the national position of 1%.

It is anticipated, and part of our medium term planning assumptions, that surpluses achieved in 2012/13 will be made available to future commissioning organisations (including CCGs). For future years we will continue to plan on this basis and for the achievement of surplus in line with current National Operating Framework planning assumptions. We will keep this under review as further national guidance emerges.

Our financial plans are also compliant with the requirement to plan for 2% of the revenue allocation to be available recurrently to fund the cost of change in 13/14. This equates to £7.376m and can only be committed to cover non-recurrent costs, and is likely to require the approval of the NHS Commissioning Board area team before funding can be released.

Inflationary and Volume Growth Assumptions

The table below outlines the key inflationary assumptions used in the development of the 2013/14 plans:

Expenditure Area	Planning Assumption	Rationale
NHS Secondary Care Contracts	-1.3% (2.7% inflation less 4% Efficiency)	As indicated within National Planning Guidance
Primary Care Prescribing	2% (6% less 4% Efficiency – Covering price and volume change)	As per recent trends, reflected in local planning assumptions
Continuing Healthcare	5% (covering price and volume)	As per recent trends, reflected in local planning assumptions
Volume increases in Secondary Care Contracts	1% by value	As per underlying demographic changes
CQUIN	Remains as for 2012/13 at 2.5% of contract value	As indicated within National Planning Guidance

Running Cost Requirements

In preparation for the new commissioning infrastructure from 1st April 2013, we will be expected to manage our running costs within an overall limit of £25 per head of population. The current plans are consistent with this requirement, and the draft CCG structure is reconciled regularly to the £6.717m running cost allowance. It is reported to and reviewed by the CCG Senior Management Committee, the Finance Committee and the Governing Body. Our plans assume we will continue to operate within the £25 per head, or £6.717m running cost allocation during 13/14 and into 14/15.

Financial Management

We have been actively leading the in-year risk assessment and financial management across the range of our activities in 12/13 including managing the overall budget for NHS Torbay in the final year of its operation; this will include production of the final annual accounts for the organisation. We have developed our medium term financial plan, as indicated, in line with national and local planning expectations and will be leading the contract negotiations with provider organisations through to agreeing contracts in March 2013. This understanding of, and commitment to, a transparent approach to financial management in 12/13 will allow us to continue to build on our track record of managing within delegated budgets, regular reporting, achieving financial targets, and providing a credible approach to achieving the challenge ahead in 13/14.

The Clinical Commissioning Group currently acts as the lead, or co-ordinating, commissioner for South Devon Healthcare NHS Foundation Trust (2 associate CCG commissioners), South West Ambulance Services NHS Foundation Trust (4 associate CCG commissioners), and Torbay & Southern Devon Health & Care NHS Trust (1 associate CCG commissioner).

In addition, we are currently an associate commissioner to other significant NHS contracts with Royal Devon & Exeter NHS FoundationTrust and Plymouth Hospitals NHS Trust. We are also working collaboratively with the NEW Devon CCG regarding the Devon Partnership NHS Trust contract.

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

In agreeing contracts for 13/14 we will be mindful of the need to plan for medium term sustainability within available resources. As such, it is likely that for the NHS providers contracts will be agreed which seek to limit in year financial variation between organisations in order to ensure stability.

Finance, Performance and Contract Governance

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

The performance, quality, and financial aspects of contracts are managed through performance & contract meetings held regularly with provider organisations.

We will ensure that appropriate collaborative commissioning relationships continue the effective arrangements we have built to date. With due regard for developing guidance we will agree with local partner CCGs how the new arrangements will best reconcile with a desire for a greater emphasis on local commissioning whilst acknowledging the advantages of the collaborative approach. The enhanced governance proposed in the new collaborative commissioning guidance, including appropriate delegation from Governing Body and more formal dispute resolution processes, will provide greater assurance that the outputs of collective commissioning are rigorous and reliable.

The CCG would envisage a more direct contracting relationship with our six principle NHS contracts (South Devon NHS Foundation Trust, Royal Devon & Exeter NHS Foundation Trust, South West Ambulance Services NHS Foundation Trust, Torbay & Southern Devon Health & Care NHS Trust, Devon Partnership NHS Trust, and Plymouth Hospitals NHS Trust). This is in line with the significance of the financial sums involved and the need for a local voice at the relevant contract review meetings. However, the approach is expected to develop such that greater or lesser emphasis is placed on involvement at each stage as collaborative arrangements and relationships develop.

The Finance Committee of the CCG will have input to, will oversee, and will recommend the approval of finance and commissioning plans to the CCG's Governing Body. These plans will achieve the financial performance required of the CCG. The Committee will also formally review financial performance throughout the year and assist the CFO in holding the organisation to account for the delivery of financial performance targets. In-year financial reporting will be a standing item for the CCG's Governing Body.

Finance Sub-committee of the Clinical Cabinet

The Clinical Cabinet plays a key role locally in bringing together and co-ordinating a joined-up approach to strategic service planning. Clinically led, it oversees the integration programme as well as other key service developments. The Finance Sub-committee of the Clinical Cabinet was established to assess the adequacy of the current financial arrangements in place across primary, secondary, and community care commissioning in terms of enabling the most efficient, effective, and economic use of resources in the community. This has included a review of all areas of commissioning to identify areas of opportunity for local service development.

The group is chaired by the GP Governing Body member with a lead for finance and governance and is attended by clinical staff, as well as the Directors of Finance for the acute hospital and the community provider locally as well as the CCG's Chief Finance Officer. In 12/13 the group successfully agreed an approach to contracting with the local acute hospital which allows flexibility for clinical redesign but which better allows the alignment of cost and income reduction within the hospital.

The group will continue to work to ensure that contracts and finances are aligned to allow for community wide achievement of statutory duties alongside the QIPP programme.

7.2 Key Contracting Intentions including QIPP Requirements

Further progress will be needed in the recurrent delivery of the quality and efficiency programme, QIPP. Managing planned and urgent care activity to contracted levels, particularly in acute hospitals in 13/14 is a key determinant of achieving sustainable contract agreements in 14/15.

QIPP plans in 13/14 cover four broad areas. The first three, increasing primary care capacity, reducing the number of unplanned admissions from care homes, and reducing the number of alcohol related admissions are also our three commissioning priorities as a CCG. The fourth, reducing prescribing spending will cover prescribing in primary (GP Practice) and secondary care (hospital based).

Capacity for GPs to manage increasingly complex patients in order to prevent unplanned admissions to hospital is a key aim for us. GP practices as members of the CCG are working with the University of Exeter to understand the key determinants and impacts on primary care capacity in order to ensure we are making best use of current capacity. At the same time, we will be working with our Area Team to develop plans to further improve capacity in primary care as part of the National Commissioning Board's role as the commissioner for primary care. These plans are described in more detail in section 5.2.8 but are expected to realise a 2% reduction in unplanned admissions in 13/14.

Our plans to reduce unplanned admissions from care homes and as a result of alcohol misuse are described in detail in section 5.2.3 but are expected to reduce unplanned admissions by 1% (when taken together).

Optimising the use of medicines aims to achieve improved health as well as ensure efficient prescribing. Inflation in primary care prescribing is stable but needs to be maintained at

levels at or below the total 2.3% uplift for the CCG. Inflation in secondary care (hospital based) prescribing is significantly higher (partly as a result of new drugs and technologies) but we still need to ensure prescribing is achieving the best outcomes for our population. Section 5.2.8 describes this approach in more detail.

These four broad areas are a necessary step in ensuring the CCG lives within available resources in 13/14 and beyond. However, further efficiencies will be required and are more likely to be 'structural' in nature, i.e. require a fundamental change in the way our providers deliver healthcare.

The potential vertical integration of our community care provider gives an important opportunity for the shaping of local plans to produce an economically sustainable future. Commissioners will be clear that any integration must be predicated upon enhancing primary care and community capacity and designing services increasingly around practices in order to provide services which mean patients can avoid unnecessary admissions to hospitals. It must also deliver a community hospital infrastructure which is responsive to local community needs. Seen in the context of QIPP, and planned growth levels, the integration will be required to deliver CIP in excess of 4% per annum to 14/15. These are key agreements which will require a joined-up approach to financial planning and cost improvement plan implementation. This work has already begun in the Finance Sub-committee of the Clinical Cabinet.

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

In thinking through options for contracting in 13/14 and beyond, and given the financial context in the NHS and Local Authority sectors as well as the proposed acquisition of the local community provider by the acute provider, alternative approaches to the current contract are being discussed in order to understand whether a better balance of risk could be achieved in support of this wider agenda.

It is felt that a longer term (3 year) agreement would offer incentives to providers (particularly as part of ensuring stability through an acquisition process) to achieve cost savings.

Commissioners have been clear that such an approach would necessarily be contingent on a clear (and auditable) understanding of the hospitals cost base, the maintenance of all quality and other performance measures, as well as cost improvement plans and the achievement of agreed efficiencies. This latter part would depend on the production of detailed infrastructure (estate, IT,etc.) and workforce plans which describe a redesigned health and social care system capable of responding to higher demand, but at the same or reduced cost (in real terms).

Workforce plans, activity plans, and finance plans need to be better integrated. We expect to achieve this by agreeing and monitoring acute and community hospital Cost Improvement Plans as part of contract sign off and on-going contract monitoring. This will form an important part of a financial framework across the community which better enables the delivery of QIPP in the medium term.

CQUIN should be system wide and be across organisational boundaries. Although CQUIN schemes exist in common across providers in 12-13 most are achievable independently, i.e.

one provider can deliver their CQUIN scheme independently of another provider's delivery. Moving to increasingly co-dependent schemes which more clearly require joint working to ensure delivery would be a resource backed move towards a system-wide integration.

7.3 Procurement

Our role as an authorised CCG is to secure services that meet the health needs of our population, delivering best quality to patients and value to taxpayers. 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 the Public Contracts Regulations 2006, NHS (Procurement, Patient Choice and Competition) Regulations 2013, Treaty on the Functioning of the EU, Health & Social Care Act and Choice & Competition regulations.

Procurement is a key enabler in stimulating the local healthcare market, helping to create more choice and supporting systems reform and as such is an integral part of our commissioning cycle.

We are receiving specialised procurement expertise from the Peninsula Purchasing & Supply Alliance (PPSA) in association with Best West Commissioning Support Unit. This arrangement provides us with proven knowledge and experience, and a procurement network that could not be achieved as a CCG alone.

Our procurement work programme for 2013/13 commences with the continuation of the procurement for provision of a NHS 111 service across the county. Other areas for consideration include the review of services undertaken via Any Qualified Provider, Community Services, in particular the provision of equipment services, and the delivery of certain self-care programmes. Where appropriate, these services and others will be considered in conjunction with other NHS and partnership organisations.

7.4 Performance Management

7.4.1 Performance Management of Providers

We hold regular monthly/bi-monthly performance management meetings with all of our main providers, which cover quality, performance, finance and service development. We also have frequent informal 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.

7.4.2 Internal Business Planning and Performance

To support planning within the 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 and delivering the NHS contracts to plan (and therefore the financial plans of the CCG). As a result the group are responsible for reviewing business cases for both investment and disinvestment purposes, in line with the criteria which has been agreed by the Senior Management 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, communications and engagement, quality and public health. This broad membership

ensures that the appropriate due diligence is given to all service changes. It also ensures the necessary links are made within the CCG to ensure 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 Clinical Pathway Groups (CPGs) and Contract Review meetings.

7.4.3 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. Following on from the 'QIPP Report' which has been well regarded in this current year we will be developing a new 'CCG Progress Monitoring Dashboard'. The dashboard will inform BPP, the Clinical Commissioning Committee and the rest of the organisation on progress with regard to finance, activity, outcomes, and local trajectories.