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#### **HEALTH AND WELLBEING BOARD**

Thursday 16 January 2014 2 pm Warspite Room, Council House

#### **Members:**

Councillor Sue McDonald (Chair)
Councillors Nicky Williams and Dr John Mahony

**Statutory Co-opted Members:** Director for People, NEW Devon Clinical Commissioning Group representative, Director for Public Health, Healthwatch representative, NHS England, Devon, Cornwall and Isles of Scilly representative.

**Non-Statutory Co-opted Members:** Representatives of Plymouth Community Homes, Plymouth Community Healthcare, Plymouth NHS Hospitals Trust, Devon Local Pharmaceutical Committee, University of Plymouth, Devon and Cornwall Police, Devon and Cornwall Police and Crime Commissioner (Vacancy Voluntary and Community Sector).

Members are invited to attend the above meeting to consider the items of business overleaf.

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Tracey Lee
Chief Executive

#### **HEALTH AND WELLBEING BOARD**

#### PART I (PUBLIC COMMITTEE)

#### I. APPOINTMENT OF VICE-CHAIR

The Board will confirm the appointment of vice-chair.

#### 2. APOLOGIES

To receive apologies for non-attendance by members.

#### 3. DECLARATIONS OF INTEREST

The Board will be asked to make any declarations of interest in respect of items on this agenda.

#### 4. CHAIR'S URGENT BUSINESS

To receive reports on business which, in the opinion of the Chair, should be brought forward for urgent consideration.

5. MINUTES (Pages I - 4)

To confirm the minutes of the meeting held on 5 September 2013.

#### 6. HEALTH AND WELLBEING STRATEGY (Pages 5 - 20)

The Board to receive the Health and Wellbeing Strategy.

#### 7. FAIRNESS COMMISSION

(Pages 21 - 60)

The Board to receive a report on the Fairness Commission.

## 8. NEW DEVON CCG COMMISSIONING FRAMEWORK / NEW DEVON COMMISSIONING INTENTIONS

(Pages 61 - 192)

The Board to receive NEW Devon CCG's Commissioning Framework and Intentions.

#### 9. PROGRESS REPORT ON WINTERBOURNE VIEW

(Pages 193 - 198)

The Board to receive a progress report on Winterbourne View.

## 10. PROPOSED HEALTH PROTECTION COMMITTEE FOR (Pages 199 - 206) THE HEALTH AND WELLBEING BOARDS AND HEALTH PROTECTION ASSURANCE ARRANGEMENTS

The Board to look at the proposed Health Protection Committee for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council and Health Protection Assurance Arrangements.

#### 11. EXEMPT BUSINESS

To consider passing a resolution under Section 100A(4) of the Local Government Act 1972 to exclude the press and public from the meeting for the following item(s) of business on the grounds that it (they) involve the likely disclosure of exempt information as defined in paragraph(s) of Part 1 of Schedule 12A of the Act, as amended by the Freedom of Information Act 2000.

#### PART II (PRIVATE COMMITTEE)

#### **AGENDA**

#### MEMBERS OF THE PUBLIC TO NOTE

that under the law, the Panel is entitled to consider certain items in private. Members of the public will be asked to leave the meeting when such items are discussed.

NIL.



#### **Health and Wellbeing Board**

#### Thursday 5 September 2013

#### **PRESENT:**

Councillor McDonald, in the Chair. Dr Peter Rudge, Vice Chair.

Carole Burgoyne, Amanda Fisk, Councillor Dr Mahony, Dr Stephenson and Steve Waite.

Apologies for absence: David Bearman, Tony Hogg, Ann James, Sue Kelley, Clive Turner and Councillor Williams.

Also in attendance: Ross Jago – Policy and Performance Officer, Craig McArdle – Head of Joint Strategic Commissioning, Rob Nelder – Public Health Consultant and Amelia Boulter – Democratic Support Officer.

The meeting started at 2.00 pm and finished at 3.15 pm.

Note: At a future meeting, the committee will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

#### 11. APPOINTMENT OF VICE-CHAIR

The Chair reported that Peter Rudge resigned as Chair of NEW Devon CCG and would be replaced on the board by Jerry Clough, Director Western Locality. Peter stated that it had been a privilege to serve on the board and although resigned from NEW Devon CCG would continue to have links with the Health and Wellbeing Board.

The board wished Peter Rudge well for the future.

<u>Agreed</u> that Peter Rudge would remain as vice-chair for this meeting and the Chair requested that members of the board to consider outside of this meeting nominations for vice-chair.

#### 12. **DECLARATIONS OF INTEREST**

There were no declarations of interest.

#### 13. MINUTES

Agreed that the minutes of the meeting held on 13 June 2013 be confirmed.

#### 14. CHAIR'S URGENT BUSINESS

There were no Chair's Urgent Business.

#### 15. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) STEERING GROUP

Rob Nelder, Public Health Consultant and JSNA lead provided the Board with a presentation on the JSNA Steering Group. In response to questions raised, it was reported that -

- a) the JSNA is an intelligence bank to improve the health and wellbeing of the population of Plymouth. We need to stick to the priorities long enough to make a difference and the Joint Commissioning Partnership (JCP) will ensure that what is commissioned is evidenced based;
- b) they developed the public health outcomes framework were rates are high and low, this intelligence is provided to the JCP to focus geographically and to look at where in the city they need to target.

Agreed that the Health and Wellbeing Board -

- I. delegate the preparation and refresh of the Joint Strategic Needs Assessment to the Director of Public Health (DPH).
- 2. assist the DPH in the preparation and refresh of the JSNA, the JSNA Steering Group is formalised as a sub-group to the Health and Wellbeing Board and will include members from partner agencies represented at the Board.
- 3. the JSNA will be refreshed annually with findings being presented to the Health and Wellbeing Board at its second quarterly meeting of the year in the form of the Plymouth Report.
- 4. the JSNA Steering Group assist the Health and Wellbeing Board in the preparation of the Joint Health and Wellbeing Strategy by providing clear measures of progress against agreed priorities so that the Board may be held to account over time.
- 5. the JSNA Steering Group's terms of reference and membership including, but not limited to, those listed in the Terms of Reference.

#### 16. HEALTH AND WELL-BEING STRATEGY - TASK AND FINISH GROUP

Ross Jago, Performance and Policy Officer reported that the bulk of work was completed and survey results fed into the final document. The Health and Wellbeing Strategy would be a key chapter in the Plymouth Plan.

Agreed that Health and Wellbeing Board -

- I. establishes a task and finish group consisting of members and officers supporting the Board, led by the Director of Public Health, to confirm the final draft before publication, taking into consideration evidence from the JSNA and results of the Health and Wellbeing Survey.
- 2. confirms the role of the joint Commissioning Partnership as the delivery body for the Board.

## 17. FUNDING TRANSFER FROM NHS ENGLAND TO SOCIAL CARE 2013/14

The Chair provided an update on the 2013/14 funding transfer of £4.6 million from NHS England to Plymouth City Council to support adult social care services. It was reported that this trance of money is the start of the integrated funding stream. Planning to commence in the autumn and the Health and Wellbeing Board to receive more detailed plans over the coming months.

<u>Agreed</u> that the Health and Wellbeing Board approve the use of the 256 funding outlined in the report as aligned to the agreed strategic approaches of the Board which are to –

- ensure partners move resources both fiscal and human for prevention via the health and wellbeing agenda;
- ensure systems and processes will be developed and used to make the best use of limited resources, every time;
- ensure partners will work together and with those they service to take joint ownership of the sustainability agenda.

#### 18. SYSTEMS LEADERSHIP - ALCOHOL PLAN IMPLEMENTATION

Ross Jago, Performance and Policy Officer reported that Plymouth were invited to become part of a national systems leadership programme. As part of the programme the board were asked to identify a 'wicked issue' and it was agreed that alcohol would be the focus. Work on this issue would commence on the 20 September 2013.

#### 19. **EXEMPT BUSINESS**

There were no items of exempt business.

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#### **PLYMOUTH CITY COUNCIL**

**Subject:** Joint Health and Wellbeing Strategy

**Committee:** Health and Wellbeing Board

Date: 16 January 2014

Cabinet Member: Councillor Sue McDonald

**CMT Member:** Carole Burgoyne, Director for People

Author: Ross Jago, Performance and Research Officer

Contact details: ross.jago@plymouth.gov.uk / 01752 304469

Ref: HWB/JHWBS8

**Key Decision:** No

Part:

#### Purpose of the report:

Attached to the agenda is the final draft of the Plymouth Health and Wellbeing Strategic Framework for approval by the Board. The development of the Framework has been an iterative process, led and authored by members of the Board with support officers from across our system. The framework has taken into account the results of the Health and Wellbeing Survey undertaken in 2013.

This framework sets the parameters for commissioning plans across the NHS and the Council, with a key focus on integration of services. Plans to address our priorities will be appended as schedules to this framework and the Board will ensure that they reflect the direction within the framework and test them against the recommendations of the Marmot review. The Health and Wellbeing Board will seek to support commissioner's plans by adding weight and influence to these areas of work and measure success using the suite of outcomes frameworks at our disposal.

In order to affect a change in behaviours to improve the health and wellbeing of citizens, the Board will seek to kick start a movement for change within the population. The Health and Wellbeing Board's approach to change will be based on commitment to the vision of 'Happy, Healthy, Aspiring Communities' rather than compliance to organizational boundaries or hierarchies. The unique makeup of the Board can create the conditions for a movement for change to emerge and release the capacity that exists in our city for economic, social and cultural renewal.

#### The Brilliant Co-operative Council Corporate Plan 2013/14 -2016/17:

The publication of the strategy will support the corporate plan values by -

- ensuring a democratically accountable overview of the development process;
- ensuring that the Board adheres to its Statutory Duty to publish the Joint Health and Wellbeing Strategy;
- ensuring that the strategy is developed in partnership, will invite all partners to contribute toward the publication process.

Includi	ng fin	ance.	human,	. IT	and	land:

None arising as a result of recommendations in this report.

## Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management:

Actions plans which underpin the Plymouth Health and Wellbeing Strategic Framework will make specific commitments to addressing issues of child poverty and community safety.

#### **Equality and Diversity:**

Has an Equality Impact Assessment been undertaken? No

The Board, through developing and promoting this strategy will assist with the achievement of the city's/council's objectives with regards to equality and diversity.

#### Recommendations and Reasons for recommended action:

That the Board -

1. Approves the Plymouth Health and Wellbeing Strategic Framework.

#### **Alternative options considered and rejected:**

None

The publication of the Strategy is a statutory requirement of the Health and Social Care Act 2012.

#### Published work / information:

#### Sign off:

Fin	N/A	Leg	N/A	Mon Off	N/A	HR	N/A	Assets	N/ A	IT	N/A	Strat Proc	N/A
Originating SMT Member - Giles Perritt													
Has the Cabinet Member(s) agreed the content of the report? Yes													

#### 1.0 Purpose

- 1.1 This report provides an update to the Board on the progress toward the publication of the Joint Health and Wellbeing Strategy.
- 1.2 The Board, at its June meeting confirmed its vision and three strategic approaches, alongside the Board's definition of Health and Wellbeing. The vision, approaches and definition have been developed since the publication of the Health and Social Care Act 2012 and form the basis for the Joint Health and Wellbeing Strategy.

#### 2.0 The Joint Health and Wellbeing Strategy (JHWS)

- 2.1 An initial draft of JHWS was published as part of the Board's June agenda and the JHWS requires additional work to ensure that commissioners can be held to account for their commissioning decisions, the Board can measure progress against its strategic approaches and that the strategy is aligned to guidance as set out by the Department of Health. The JHWS is on course to be signed off at the meeting of the Health and Wellbeing Board in January 2014.
- 2.2 The Health and Wellbeing needs of our population are paramount to a successful and sustainable city and as such the JHWS will form an important chapter of the Plymouth Plan. The Plymouth Plan will reflect the aspirations of communities across Plymouth and will be the single strategic plan for the city for use by partners in the private, public and voluntary sectors.
- 2.3 While the JHWS is finalised work continues on addressing the issues identified by Board members. At the June meeting of the Board members spent time considering where joint efforts could be applied and where the board could have a real effect on the health behaviours which lead to poor health and wellbeing. The unique membership of the Plymouth Health and Wellbeing Board provides for working in a different way and the most important work the Board will do is address those issues which are not a priority of any single organisation.
- 2.4 After considering key themes emerging from the join strategic needs assessment, Public Health Outcomes Framework, NHS Outcomes Framework, Adult Social Care Outcomes Framework and the developing priorities of the Children's Partnership alongside the interim results of the health and wellbeing survey the board identified three issues to be explored in informal 'Solution shops'
  - Alcohol and Substance Misuse
  - Obesity
  - Mental Health
- 2.5 The Board is engaged in a national systems leadership exercise funded through the Department of Health and Local Government Association. The exercise aims to develop improved place-based collaborative leadership around a local 'wicked' issue, which in the case of Plymouth is the implementation of the city's Alcohol plan. A full update on this exercise is will be considered under a separate item to this agenda.

#### 3.0 Commissioning Requirements

3.1 The Joint Commissioning Partnership (JCP) is responsible for ensuring a coordinated and consistent approach to commissioning services on behalf of partner agencies in Plymouth. It aims to ensure a joined up approach to strategic planning and service delivery in order to

- maximise best use of public resources and deliver seamless services by working across organisational boundaries. The JCP is presently made up of partners from Plymouth City Council, office of the Police and Crime Commissioner, Health and Probation Services.
- 3.2 As the single commissioning body in the city of Plymouth, the JCP will be the delivery arm of the Board commissioning for current health needs and improving integrated working. The Board will not set further priorities for commissioners but will hold them to account for current commissioning plans and ensure that plans align with the Boards three strategic approaches.

**Foreword** 

We are in a period of unprecedented challenges in health and social care; the economic

environment, demographic demands and increasing complexity of need are all putting

immense pressure on vital front-line services designed to help our most vulnerable citizens.

The introduction of Health and Wellbeing Boards, under the Health and Social Care Act

2012, has provided us with an opportunity to work differently. People who are locally

focused and locally accountable will take shared responsibility for the Health and Wellbeing

of Plymouth citizens. Our fresh approach, driven by values of Responsibility, Fairness,

Democracy and Partnership, will be delivered through the Plymouth Health & Wellbeing

Board, bringing together partners from across the city.

This Strategic Framework for Plymouth's Health and Wellbeing Board sets out our purpose

and strategic approach; our approach to health and wellbeing and its guiding principles; our

approach to public engagement; our use of evidence and data and initial priority areas for

action.

We look forward to working with you.

Councillor Sue McDonald, Chair of Plymouth Health and Wellbeing Board

#### I. Plymouth's Health and Wellbeing Board

Plymouth's Health and Wellbeing Board (the Board) brings together key organisations to promote the health and wellbeing of all the people of Plymouth and to deliver three main statutory tasks.

- Assess the needs of the population through the Joint Strategic Needs Assessment, to include a Pharmaceutical Needs Assessment;
- Produce and facilitate the delivery of a health and wellbeing strategy from which commissioning plans are developed;
- Promote greater integration and partnership, including joint commissioning, integrated provision and pooled budgets where appropriate.

Plymouth's Health and Wellbeing Board has developed a vision of what it aspires to achieve for all the people of Plymouth and recognises that people think of their own health and wellbeing in different ways. The Board will develop plans to improve health and wellbeing in Plymouth and will have oversight of other agencies plans. The Board will engage and consult with the public, with service users and with patient representatives in Plymouth in its efforts to promote health and wellbeing.

#### 2. What is a Joint Health and Wellbeing Strategy?

A Joint Health and Wellbeing Strategy is intended to inform commissioning decisions across local services such that they are focused on the needs of service users and communities, and tackle the factors that impact upon health and wellbeing across service boundaries. Health and Wellbeing Boards must have regard to the Secretary of State's mandate to NHS England which sets out the Government's priorities for the NHS and explain what priorities they have set in order to tackle the needs identified in their Joint Strategic Needs Assessments (JSNA).

The Joint Health and Wellbeing Strategy is a unique opportunity for the Board members to explore together local issues that they have not managed to tackle on their own. However

this is not about taking action on everything at once, but about setting a small number of key strategic priorities for action. This Strategic Framework for Health and Wellbeing is the overarching statement of what the ambition is for health and wellbeing in Plymouth and what will be done to improve the health of the local population, based on the needs identified in the JSNA.

#### 3. Our vision and purpose

The Health and Wellbeing Board's vision for Plymouth is to have 'Healthy, Happy, Aspiring Communities' and to actively promote the health and wellbeing of all people in Plymouth. This vision will only be achieved by everyone working together and by achieving greater integration of health and wellbeing services.

Our Vision for Health & Wellbeing
"Happy, Healthy, Aspiring Communities"

#### **Our Purpose**

To promote health and wellbeing for all people in the City of Plymouth

#### 4. What do we understand by health and wellbeing?

There are many definitions of "health" and "wellbeing" and Plymouth's Health and Wellbeing Board recognise that people have different views of what this means for them personally or for their community. Plymouth's Health and Wellbeing Board's 'holistic' view of health and wellbeing is based on four broad wholly interrelated and co-dependent components:

- The Mind: includes mental health and wellbeing, happiness, personal growth, personal development and learning.
- The Body: includes physical health and wellbeing, having the best start in life, growing well, ageing well, and having access to good jobs, good homes and good health services.
- The Heart: includes social health and wellbeing, having good friendships, being

- loved and valued, valuing others and engaging with the world around us.
- The Spirit: includes a sense of community, a sense of meaning in our lives, a sense of belonging, and feeling we are making a difference, being aspirational and will be remembered.

The Board will assess the needs of the communities using this holistic understanding of health and wellbeing; it will also ensure action plans of the Joint Health and Wellbeing Strategy reflect this holistic view. The public will hold the Board to account for the actions it takes when promoting health and wellbeing against this holistic definition of health and wellbeing.

#### 5. Our strategic approach

Plymouth has a history of joint-working to tackle the inequalities that exist across our city. These efforts have been successful in part but health inequalities still persist and are stubborn to shift.

"We simply cannot go on doing what we have always done if we want to see different results for the people we serve."

Plymouth's Health and Wellbeing Board will facilitate all agencies work collectively and collaboratively across the health and wellbeing system. Three strategic approaches have therefore been agreed by the Health and Wellbeing Board and its members will hold each other to account for their delivery.

#### • Ensure shared ownership of a sustainable health and wellbeing system

This involves all the partners of the Health and Wellbeing Board working together, with service providers and potential service providers, the public and service users, on ways to changes the systems which results in services which are integrated, are of high quality and are sustainable. Public sector funding continues to be hard-pressed and the Health and Wellbeing Board will need to foster innovative solutions in a time of decreasing resources.

#### • Make the best use of resources, every time.

The second strategic approach is to encourage the Health and Wellbeing Board partner organisations to make the best use of their resources every time. This will involve exploring how to improve efficiency and effectiveness and creating opportunities to release resources through integration and collaboration.

#### · Focus the work on the promotion of health and wellbeing

The system will be asked to evidence how resources are being moved into the prevention agenda over the course of the coming years i.e., for the health sector the challenge will be to spend less on treating illness and more on preventing illness. The challenge for the system will be how to support health services to achieve this aspiration.

#### 6. Our public engagement

Engagement with the public and listening to their views and perspectives is essential; the Health and Wellbeing Board is committed to finding different ways to engage with the public and will learn from best practice within its partner organisations and from elsewhere. This Strategic Framework for Plymouth's Health and Wellbeing has already been informed by engaging with the public through surveys, visiting communities, listening to the public's views face to face across the city and using bespoke surveys for people with Learning Difficulties and Disabilities. The results of the public engagement surveys will be published and will inform the Board's priorities for commissioning. The meetings of the Health and Wellbeing Board will be webcast and available online for viewing at any time.

#### 7. Using the Marmot Review to improve health and wellbeing

The Plymouth Health and Wellbeing Strategic Framework will use the evidence found in the Marmot Review 'Fair Society, Healthy Lives' to test its own plans, and those of its partners for effective evidence-based approaches for reducing health inequalities. The Marmot Review covers the entire life course and if addressed collectively it will improve health and wellbeing for all people in Plymouth.

#### The Marmot Review:



#### 8. Using Evidence and the Joint Strategic Needs Assessment

Plymouth's Joint Strategic Needs Assessment (JSNA) Steering Group reports to the Health and Wellbeing Board and it is responsible for developing the JSNA. The JSNA is a series of needs assessments which will inform the ongoing work of the Health and Wellbeing Board for areas of action. The Board will ensure that this work stream is appropriately resourced and performance managed.

The Health and Wellbeing Board will also use a range of published evidence and guidance of 'what works' to improve health and well-being when designing its operational action plans. It will also make full use of the findings from the Fairness Commission for Plymouth<sup>i</sup> which is due to publish its report in early 2014.

#### 9. The focus of activity in 2013/14

In June 2013 the Health and Wellbeing Board members reviewed the JSNA, the Public Health Outcomes and the NHS Outcomes Framework for Plymouth and prioritized and agreed the key areas of focus for 2013/14.

The prioritisation process involved looking at the indicators in the Public Health Outcomes

Framework where Plymouth was 'red' compared to England and red or amber compared to our comparator group (10 Office of National Statistics regional cities). There were 32 of these indicators; the 32 indicators were then themed into the following nine headings:

- Alcohol
- Breastfeeding
- Drug treatment
- Healthy weight (children and adults)
- Mental health promotion
- Premature mortality (CVD)
- Premature mortality (cancer)
- Smoking
- Violent crime

For the NHS Outcomes Framework (60 indicators) the approach to local prioritisation was the same as that used for the Public Health Outcomes Framework i.e. looking at those indicators where Plymouth was 'red' compared to England and red or amber compared to our comparator group. The indicators in these categories were then themed into the following II headings:

- Premature mortality (CVD)
- Premature mortality (respiratory problems)
- Premature mortality (cancer)
- Smoking
- Breastfeeding
- Long-term conditions
- Diabetes
- Mental health
- Dementia
- Stroke
- Patient safety & quality

As a result of this local prioritization work it was decided that the focus of activity for Plymouth's Health and Wellbeing Board in 2013/14 would be on the following areas:

- I. Mental health
- 2. Healthy Weight
- 3. Substance misuse (including alcohol)
- 4. Health and Social Integration

By enabling a focus on these topics, each of which has a significant impact upon health and wellbeing across the life course, the Health and Wellbeing Board will make a positive and cross-cutting contribution to addressing each of their four agreed priority areas. These priorities will inform local commissioning and will lead to locally led initiatives that address the priories and meet the identified needs. We will not achieve improved outcomes for the people of Plymouth unless we work together; the Joint Commissioning Partnership has therefore been established to act as the single commissioning body for Plymouth. The Joint Commissioning Partnership will be responsible for setting commissioning plans that focus on tackling the four priority areas identified by the Health and Wellbeing Board. The four topics will be reviewed in 2014/15 and updated as appropriate.

#### 10. How will we know when we are successful?

The Plymouth Health and Wellbeing Board, through its partners, can work in a different way by demonstrating system leadership and co-operative and collaborative approaches. It will ensure that high-level evaluation of commissioned interventions is embedded into practice and that an annual assessment of progress will be measured against the Public Health Outcomes Framework, the NHS Outcomes Framework, the Adult Social Care Outcomes Framework and the priorities of the Children's Partnership.

The Strategy will be reviewed each year and progress monitored by the Health and Wellbeing Board. It must be acknowledged that during 2013 most of the Board's activity will be focus on getting the systems in place, developing this Strategy, and recognising which commissioning and work plans are already in place. The Board itself will not develop a detailed action plan for the delivery of the Strategy, as much of the work will be done

through partner and commissioned teams and units. However, the Board will make sure that the priorities are being delivered and progress is being made.

#### 11. Implementing the Strategic Framework

#### **Ensuring Strategic Alignment**

Through a public survey and analysis of the Joint Strategic Needs Assessment the Board has identified four priorities for improving the wellbeing of people in the city of Plymouth (section 9).

To start to address priority areas we will work with existing and developing strategies, plans and work programmes and this strategic framework will form part of the Plymouth Plan<sup>ii</sup>.

This framework sets the parameters for commissioning plans across the NHS and the Council, with a key focus on integration of services. Plans to address our priorities are appended as schedules to this framework and the Board will ensure that they reflect the direction within the framework and test them against the recommendations of the Marmot review. The Health and Wellbeing Board will seek to support commissioner's plans by adding weight and influence to these areas of work and measure success using the suite of outcomes frameworks at our disposal.

The council and other agencies and partnerships are responsible for a wide range of services that impact on health and wellbeing. The Health and Wellbeing Strategic Framework will influence the direction of other Strategies and plans, such as the built environment and transport to make sure that they contribute in a positive way to the overall health of the city. We will also work in partnership with other organisations for example the police, fire services, schools, the voluntary sector and local neighbourhoods to shape the actions that will deliver against the key priorities.

#### System Leadership

Plymouth signed up to be one of eight national pilots for Systems Leadership at the Health and Wellbeing Board in February 2013. In Plymouth our focus is on learning about system leadership right across the system not just at senior level and we want to embed this in real work across our organisations and community.

The learning from the pilot will be fed into the wider leadership community as a resource for learning about the Plymouth system and what might need to be different to change and embed shared leadership of system challenges across the City. A report of the work will be published in Spring 2014.

Members of the Health and Wellbeing Board work within a system which crosses geographical, organisational, cultural and political boundaries; these are volatile and complex systems of services which often do not respond well or quickly to the needs of the citizen. To address these challenges we must act as a collective rather than individuals or individual organisations and set the parameters to allow staff and citizens to make improvements to the system. This 'System Leadership' approach will be encouraged by the Board at all levels across all organisations to ensure improved outcomes for citizens.

As a Board we will use our 'System Leadership' approaches -

- to improve our understanding of our system, particularly the way the parts relate to each other;
- appreciate the different perspectives of partners and service users;
- develop new relationships in the wider system;
- to create enabling conditions for those who are part of the system, including citizens, to change the system and the population's health behaviours at the earliest point.

In order to affect a change in behaviours to improve the health and wellbeing of citizens, the Board will seek to kick start a movement for change within the population. The Health and Wellbeing Board's approach to change will be based on commitment to the vision of 'Happy, Healthy, Aspiring Communities' rather than compliance to organizational boundaries or hierarchies. The unique make-up of the Board can create the conditions for

a movement for change to emerge and release the capacity that exists in our city for economic, social and cultural renewal.

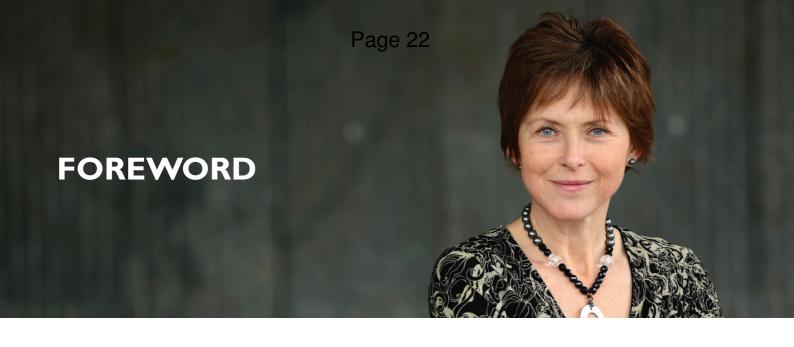
<sup>&</sup>lt;sup>i</sup> www.plymouth.gov.uk/fairnesscommission

http://www.plymouth.gov.uk/plymouthplan

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What could a group of independent people do over the course of a single year to make Plymouth a fairer city? How could we get under the skin of the city to find out what is really happening? How could we ask the people of Plymouth about what they think and feel about fairness, when many believe that consultation has simply become a tick box exercise?

These were some of the first questions I asked when the Plymouth Fairness Commission was created earlier this year.

There is good reason for these questions, along with scepticism of our task. When people are asked for a view and not really listened to, when opinions are sought but nothing changes as a result, when authorities claim to want to hear but have really already made up their minds, then consultation is brought into disrepute.

There is a deeply entrenched sense of disempowerment and passivity in Plymouth, particularly in the communities which are most disadvantaged. This is no coincidence.

It is born of decades of communities feeling done to rather than doing. Decades of public authorities, often unwittingly, exacerbating that sense of exclusion by relating in ways which serve their own purposes but ignore the real needs and desires of the people they purport to serve. By decades of those people waiting with decreasing hope for 'them' to do something to help.

So we, the Plymouth Fairness Commission, started differently. We started by truly listening, blank sheet of paper, sitting down with people and being open to whatever we heard.

What are we learning through the Plymouth Fairness Commission? We have already seen how private pain has public causes: the cost of living crisis is biting hard and the fabric of the city's private housing stock needs to radically improve - poor housing is inflating the NHS bill. The physical and social links between people (crucial for maintaining a sense of wellbeing) are getting more difficult to maintain, people often feel there is nowhere affordable to go just to be with others. When families are struggling to feed their kids is it surprising that there are city children who rarely visit the beach, let alone walk on the moors?

Making Plymouth a fairer city has already started - there is more talk now about fairness, more discussion about what needs to change. This report is the summation of what the people of Plymouth have told us about fairness and unfairness, and what we believe we must focus on to really start addressing some of the unfairness being felt and lived across the city. We now begin our consideration of what should be done about our key areas of concern so we can make recommendations that will make a difference. We want fairness to become part of our city's vocabulary, and addressing unfairness to be a joint commitment of all, whatever age, origin, place of residence, education or work, whatever religious or political persuasion. This transformation must become part of our everyday lives.

Sna Leather

Dame Suzi Leather
Chair, Plymouth Fairness Commission

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### INTRODUCING US – PLYMOUTH'S FAIRNESS COMMISSION

"The Fairness Commission, designed to provoke change, was born of a commitment from the city to address unfairness and inequality"

Dame Suzi Leather, Chair, Plymouth Fairness Commission

## The Plymouth Fairness Commission, which launched in April 2013, was set up independently to help make the city a fairer place to live and work.

The Commission aims to collect information, ideas and evidence, and provide recommendations for how the Council, other public bodies, businesses, citizens and civil society should use their roles and influences, individually and collectively, to reduce inequalities and increase the perception and experience of fairness within the local economy and local communities in ways which are both effective and sustainable. These recommendations will be published and presented to city leaders in March 2014. However, since they are for all of Plymouth: citizens, civil society, businesses as well as public organisations, implementing them will require the determination of all.

Dame Suzi Leather is the independent chair of the Plymouth Fairness Commission. The 22 Fairness Commissioners were selected for their professional expertise and skills, and their personal commitment to fairness in Plymouth. They include individuals from the police, health, private companies, charities, social enterprises and community groups, and all are giving their time voluntarily.

## WHAT IMPACT CAN A FAIRNESS COMMISSION REALLY HAVE?

Other Fairness Commissions have been set up in the past two years - Liverpool, Islington, York, Blackpool, Sheffield and Newcastle — and more continue to be set up across England and Wales. Although they vary according to local circumstances, there are some shared characteristics and areas of focus. Of those Commissions that have reported so far, common issues include income and the Living Wage, employment and the local economy, cost of living / benefit cuts, access to services and housing. All have commented on the wider social, political and economic context and the challenges presented in addressing inequality at a time of severe and unprecedented public cuts.

Whilst it is too early to assess the impact of these Fairness Commissions on a national level, what is becoming clear is that they have great potential to act as a local catalyst for change and provide an opportunity to highlight the scale and depth of poverty and inequality in an area and link it to knowledge and understanding on a range of different issues. Islington Fairness Commission, one of the first to be established, has reported good progress on implementing a number of its initial recommendations such as becoming the joint first Local Authority to gain accreditation as a London Living Wage employer in 2012.

#### WHAT ISTHIS REPORT FOR?

Over the past six months, the Plymouth Fairness Commission has undertaken a wide range of activities to find out more about the fairness and unfairness issues affecting people that live or work in Plymouth.

Our understanding of what fairness is can be found in the next section followed by details of what we have been doing, along with a summary of what we have found out.

We will not be able to address universally all fairness issues. We have therefore selected those areas which we consider specially warrant our focus because of the gravity of the issue, our ability to have an impact, or to strengthen work already done. The primary aim of this report is to present these issues of unfairness that the Commission will now focus on in order to develop its final recommendations. We have called these our key areas of concern. Whilst we don't yet know what our final recommendations will be, we want to give our city leaders advance notice as to the direction in which we are going and what they can expect when we publish our call to action around fairness.

The final section of this report explains what will happen between now, March 2014 and beyond.



# WHAT DO WE MEAN BY FAIRNESS?

At its first meeting, the Plymouth Fairness Commission acknowledged that there isn't a simple, catch all definition of fairness. There are many different opinions. This initially proved problematic - if you can't agree what fairness is, can you agree how you are going to address unfairness?

Commissioners felt very strongly that while a collective understanding of fairness and unfairness was useful to guide the work of the Commission, it was ultimately more powerful to see fairness and unfairness through the lens of those who experience it on a day to day basis. This approach enabled Commissioners to agree a draft set of fairness principles, which have guided all subsequent activities.

These draft principles of fairness are a work in progress – however a final set are expected to play a key role in the presentation of the Commission's final recommendations next March.



# OUR DRAFT PRINCIPLES OF FAIRNESS

Fairness is a perception, a relative not absolute idea. However, we can measure various indices which demonstrate that life chances in this city are not fair and that where you are born and the circumstances into which you are born are very likely to influence the rest of your life. In as much as a city can, we seek to limit the role that unequal opportunities and exclusion play in diminishing the life chances and well-being of our inhabitants.

A city should help shape the living, working and leisure environment in ways which promote well-being and the common good. This means it should positively address aspects of opportunity, inclusion and aspiration through targeted engagement and resources. It should deliberately seek to counter exclusion and the barriers to opportunity, especially to education, leisure and decent living and working conditions for these provide chances for individuals to live fulfilling and productive lives and to help themselves and others to thrive.

This is not about imposing a radical levelling out of outcomes, although it may sometimes involve an asymmetry in weighting of provision. It might sometimes be about greater provision for those who have less, but only to give everyone similar chances, wherever they live and whatever their income level or place of birth. The kind of chances we have in mind include chances to learn, access to good housing, transport and services, chances to feel happy and to be safe and to take part in decisions or policies which affect them.

Whether these opportunities are used or not, fairness demands that the more disadvantaged are given what they need so they are included. Moreover this is not just fairness; it enables everyone to contribute to the common good. Research has shown that bigger income gaps in society can lead to deterioration in trust between people, poorer overall health and poorer learning.

The city must also reflect, represent and value diversity in the community. We need to understand and value different backgrounds and identities so we can connect better with each other, attend to and learn from each other, support and celebrate with each other. This all helps to create an environment of fairness.

We believe that Plymouth as a city should commit to fairness in what it does, how it does it and in who gets what. In doing so we will work to promote these guiding principles:

- The city has a duty to allocate resources and those in greatest need should take priority.
- Distributing things which make most difference to peoples' lives matters most.
- People should be able to access opportunity regardless of circumstance.
- Those with the greatest resource should make the biggest contribution.
- The way things are done matters just as much as what is done.
- Unfairness which takes time to eradicate requires policies which endure for the long term.
- Preventing inequalities is better than trying to cure them.
- The needs of future generations and the current one should be balanced.
- Civic responsibility should be promoted and practised by all.
- Services should be provided with people not for them.

These principles apply within and between cities and regions.

# HOW DID WE FIND OUT WHAT IS FAIR AND UNFAIR?

"We wanted to do something simple but important - to listen. Listen to what people found to be fair and unfair in Plymouth. Of all the Fairness Commissions in the country none to date has, I believe, taken so much trouble to listen to the people themselves or heard so much from them."

Dame Suzi Leather, Chair, Plymouth Fairness Commission

The work of the Plymouth Fairness Commission so far has had two distinct phases, with the first informing the second.

#### PHASE I: SCOPING STAGE

Following the launch of the Commission in April 2013, a statistical review was undertaken to provide a socio-economic profile of Plymouth relating to broad themes of fairness such as health inequalities, education, housing, and employment. The purpose of this Initial Presentation of Evidence was to generate some initial thoughts about fairness and ensure that subsequent stages of Fairness Commission activity were underpinned by robust and defensible assumptions.

A Call for Evidence, informed by the statistical review, was also launched in May 2013. The aim of the Call for Evidence was to identify any initial themes of fairness and unfairness based on the views and experiences of those that live and work in Plymouth. The Call invited organisations and individuals to submit written responses against a set of broad questions ranging from what is fair and unfair about life in Plymouth to what the people of Plymouth could do to help each other live fairer lives.

In total, 50 submissions, encompassing 25 individual and 25 local organisational responses were received from the Call for Evidence. This highlighted direct experiences of inequality and unfairness issues. This evidence, along with expert knowledge provided by the Commissioners themselves and a review of the reports produced by other Fairness Commissions, was used to help inform the planning of our Phase 2 – Summer of Listening under the following themes:

- Helping individuals and families;
- Creating stronger communities;
- Growing the local economy.

#### **PHASE 2: SUMMER OF LISTENING**

A critical success factor for the Plymouth Fairness Commission is to ensure that local residents and community members have had the opportunity to share their perceptions and experiences of inequality in the city, and to recommend practical ideas for tackling them.

To do this, the Commission engaged with local residents, businesses, professional organisations, academics and community groups through a range of 'Summer of Listening' events and activities.

The aim of the Summer of Listening was to ensure that Plymouth residents and communities had a chance to share their views and ideas. We listened to over 1000 people (many of whom represented many more) over the summer through a series of events, each designed to reflect the Commission's underlying principles of engagement and openness, as follows;

- Walkabouts across the city were undertaken by Commissioners to hear directly residents' views and experiences of fairness and inequality.
- Satellite Meetings: Commissioners attended a range of meetings and events held by various groups in the city to help raise awareness of the Fairness Commission and to gather evidence and views around the three broad themes. Over 30 meetings were held with a range of groups and organisations including the Cultural Kitchen, Shekinah Mission, Age UK, MIND Plymouth, Royal Marine/ Navy Youth Forum, Plymouth Fawcett Society, Young Carers and Access Plymouth.
- Listening Events: A series of Listening Events across the city were arranged, which engaged with 70 people. During these events, members of the public could 'dropin' to meet some of the Commissioners, share the issues that affect them, and put forward suggestions to make Plymouth a fairer place.

- Street Survey: SERIO, a research unit based at Plymouth University, collected views on behalf of the Fairness Commission from 151 Plymouth residents through face-to-face street surveys. The Street Surveys gathered views on issues of fairness and unfairness in Plymouth and recommendations for improvement or change.
- E-Survey: An E-Survey was emailed by SERIO, on behalf of the Plymouth Fairness Commission, to organisations in the city inviting them to share their perceptions and experiences of fairness and unfairness in Plymouth. In total. 64 detailed responses were received.
- Select Committee Events: The Commissioners facilitated seven panel-led discussions between professionals, academics and the public. These presented an opportunity to question experts on the themes of; financial inclusion, food, mental health, skills and business, housing, dementia and isolation and local procurement.

A full list of the events and organisations involved can be found at www.plymouthfairnesscommission.co.uk.

## STRENGTHENING COMMUNITIES CASE STUDY

In addition to the broad range of activities already listed, the Plymouth Fairness Commission proposed to complement its evidence gathering by overseeing the implementation of a case study aimed at strengthening communities in order to promote fairness and reduce inequality.

Connecting Communities (C2) offers a practical and transferable case-study of how it is possible for service providers and local authorities to work differently with local communities to create the conditions that enable sustainable and transformational change within these communities as well as in the way services are provided for these communities. These conditions act to empower both local residents and service providers to improve health, well-being and local conditions in areas that are typically labelled as being "disadvantaged".

The C2 approach seeks to connect communities in three ways:

- Within themselves creating networks and cooperation amongst local residents
- With local service providers and public agencies building a parallel community of interest amongst frontline workers
- With other communities gaining and giving learning and inspiration directly from one community to another.

The key aim of this long term case study is to develop a rich evidence basis that can determine how change that impacts on unfairness within communities can take place. It is also hoped that it will show how the learning from change in one community can be adopted in other communities within the city.

The C2 case study is taking place in one neighbourhood in Plymouth, and the learning from this will help shape the Plymouth Fairness Commission's final recommendations due in March 2014 and updated in mid-2015. However, the testing of an evidence-based, community led model aimed at addressing inequality and improving outcomes is expected to demonstrate real outcomes and benefits to the community at a much earlier stage.

# WHAT HAVE WE FOUND OUT ABOUT FAIRNESS IN PLYMOUTH?

A summary of the key findings from the initial Presentation of Evidence, Call for Evidence and Summer of Listening can be seen below. For a full account of the evidence collected and more detail on the findings, please see our Summer of Listening report.

#### THEME I: HELPING INDIVIDUALS AND FAMILIES

#### Top Unfairness Issues

Financial issues were identified as the most common area of unfairness under this theme. More specifically, the low wages in Plymouth compared to the high cost of living with particular cost areas including council tax, water, energy and housing. The personal impact of unemployment and benefit cuts were frequently mentioned across all of the Summer of Listening events.

Housing was the second most commonly identified area of unfairness under this theme, and was raised across all Summer of Listening events. Issues included a lack of affordable homes to buy, high rents and a lack of suitable social housing. The severe impact of the 'bedroom tax' was highlighted as was difficulty in finding private rented housing and the social housing allocation system.

Education was the third most frequently mentioned issue of unfairness under this theme, but did not receive comments on the scale of Finance and Housing. Areas of perceived unfairness included the differences in the quality of provision across neighbourhoods, the allocation system, the 11+ system and a difference in attainment by area.

There was also concern regarding the lack of support for those with a mental health condition, echoing feedback received under Theme 2. The vulnerability of older people was also raised as an issue of unfairness, particularly with regard to digital exclusion and feelings of isolation.

#### Top Fairness Issues

Education issues were cited most often in this theme including the positive approaches to anti-bullying, equality of access and the good standard of teaching in Plymouth schools.

The opportunity to access adult learning was the second most commonly identified area of fairness. Feedback through the Summer of Listening events indicated that some people find opportunities are plentiful and improving, with good support for individuals.

Whilst housing was mentioned less frequently than Education and Adult Learning, it was the third most commonly cited area of fairness. More specifically, comments related to the social housing allocation system and the investment in new build properties to tackle the problems of poor quality housing.

I As part of the Summer of Listening activities, issues of unfairness received significantly more mentions than issues of fairness.

#### **THEME 2: CREATING STRONGER COMMUNITIES**

#### Top Unfairness Issues

Access to goods and services was identified as the most common area of unfairness under Theme 2. Respondents were particularly passionate about the high cost of public transport in the city; access to healthcare and dentistry; and affordable healthy food. The Satellite Meetings also revealed particular concern around access to mental health and rehabilitation services.

The second most commonly identified area of unfairness under this theme was abusive and antisocial behaviour. Feedback was commonly focused on the negative impact on residents of alcohol and drug-related abusive and anti-social behaviour. Discrimination was also identified as an issue for the city, ranging from verbal abuse towards asylum seekers, to discrimination against those living with HIV.

Barriers to involvement in community activities was the third most frequently mentioned area of unfairness. Although community activities were identified as being positive in supporting interaction, residents felt that there were limited opportunities for community engagement, and that they lacked clear routes for participation in local matters and decision making.

Health inequalities and obesity also emerged as an issue of unfairness, and this was reflected in responses from several organisations.

#### Top Fairness Issues

Access to goods and services was also identified as the fairest area of focus under Theme 2, indicating how divided responses were to this issue. Some respondents placed emphasis on good healthcare provision, and the availability and affordability of public transport schemes. The Walkabouts also found examples of communities working together to enhance access to goods and services such as basic food supplies.

The breadth of volunteering and citizen engagement opportunities across Plymouth was the second most commonly identified area of fairness. Feedback also indicated support for schemes that give local people the power to influence community improvement programmes, which also help to build confidence.

Whilst acknowledging the existence of abusive and anti-social behaviour, a number of respondents felt that issues are dealt with promptly by either the Police or Police Community Support Officers. The positive response to abusive and anti-social behaviour was the third most commonly mentioned fairness example.

#### THEME 3: GROWING THE LOCAL ECONOMY

Top Unfairness Issues The most commonly mentioned area of unfairness under this theme was parking. In particular this related to the high cost and availability of parking in the city centre which was seen as a deterrent to shoppers and residents with a negative impact on businesses.

Following feedback from across all Summer of Listening events, employment was the second most commonly identified area of unfairness under this theme. More specifically, this related to a lack of employment opportunities for young people aged under 25, barriers to successful engagement in apprenticeship schemes, and concern regarding the absence of major employers in Plymouth.

Concern around the existing shopping facilities was the third most frequently mentioned area of unfairness under this theme. For some, this related to the number of shops in the city centre that have closed, impacting on its lack of visual appeal; whilst others highlighted the lack of investment in the West End of the City Centre; and the large number of national chains at the expense of local shops.

In addition to the most commonly identified areas of unfairness listed above, feedback from the Select Committee on Local Procurement indicated some concern regarding local procurement, and the potential for small businesses to have a more visible role in influencing city policy.

Top Fairness Issues Whilst nominated as a theme of unfairness, shopping facilities in Plymouth were also perceived by some to be positive, and were most commonly identified as a focus under Theme 3. More specifically, this related to the current mix of shops meeting local need, both in the city centre and selected city neighbourhoods.

Parking was the second most commonly identified area of fairness. A number of respondents felt that the parking charges are set at an acceptable level with an appropriate number of spaces. The Park and Ride facilities were also nominated as a positive provision.

Opportunities for employment and skills development was the third most commonly mentioned area of fairness. Feedback from the E-Survey indicated the development of a range of schemes and initiatives to encourage Plymouth residents into employment as being positive; whilst the Skills and Business Select Committee underlined the support to ensure equal access to skills development.



## OUR KEY AREAS OF CONCERN

"This report is the summation of what the people of Plymouth have told us about fairness and unfairness, and what we believe we must focus on to really start addressing some of the unfairness being felt and lived across the city".

Dame Suzi Leather, Chair, Plymouth Fairness Commission

As previous sections have illustrated, much time and energy has been invested by Commissioners, members of the public, community groups and organisations to find out the key issues of fairness and unfairness faced by people who live and work in Plymouth.

Using the findings from the Summer of Listening report, Commissioners selected their key areas of concern using the draft fairness principles (outlined on page 7), alongside the following questions;

- Does the nominated issue have the weight of community opinion behind it?
- Could change be affected locally for the nominated issue (or is this an issue that requires national policy change/resources)?
- Are significant resources already being invested to address the nominated issue and/or potential for significant duplication of work?

Through consensus, the Commission identified eight key areas that it should develop recommendations on. These are listed below.

- Strengthening Communities
- Individual and Family Wellbeing
- Young People and Young Adults
- Housing
- Cost of Living Crisis
- Discrimination and Social Exclusion
- Strengthening the Local Economy
- Implications of an Ageing Population

It is important to note that each area of concern cannot, and should not, be seen in isolation. The following observations were made:

- The key areas of concern often overlap with each other in terms of cause and effect:
- Many people living in Plymouth experience several or even all of our areas of concern regarding unfairness;
- Our key areas of concern address the social determinants of health, the conditions in which people are born, grow, live, work and age and which can lead to health inequalities<sup>2</sup>.

<sup>2</sup> Marmot Review report - 'Fair Society, Healthy Lives - See more at: http://www.local.gov.uk/web/guest/health/-/journal\_content/56/10180/3510094/ARTICLE#sthash.673orzlE.dpuf

#### **CROSS CUTTING THEMES**

It was also acknowledged that there were important cross cutting themes relating to fairness that needed to be applied across each key area of concern, as follows:

## Cross Cutting Theme 1: A city that has pride, aspiration and can celebrate itself

We believe that recognising the strengths and achievements of Plymouth at an individual, group, community and city level can help to address some of the unfairness issues being experienced across Plymouth. We want to ensure that the wealth of assets that Plymouth has to offer is recognised and celebrated.

## Cross Cutting Theme 2: Joining people and communities - connections

We consider that much of the unfairness we have heard about is relational, to do with how we live together and regard each other. This reflects the increasing body of evidence which connects economic inequality and social breakdown.

## Cross Cutting Theme 3: Governance and inclusion

We believe that, in order to address issues of fairness and inequality, there is an urgent need to rebuild or refine the relationships that exist between public authorities and the communities they serve, and how decisions are made. This would also extend to the role of citywide partnerships.

## Cross Cutting Theme 4: Innovative approaches to funding and sustainability

We aim to add value to existing activity across Plymouth to address our key areas of concern by exploring new, innovative and co-operative models of organisation and funding, including social enterprise, to address fairness and inequality, while also ensuring the long term sustainability of our final recommendations.

## Cross Cutting Theme 5: Measures of success

We believe that what an organisation measures determines its values. We will be looking at new ways to measure success that incentivise co-production, strengthen communities and the connections between people, and reduce inequalities.

This section will present each area of concern in more detail, including a summary of the available data<sup>3</sup>, relevant evidence collected by the Fairness Commission, predominantly during the Summer of Listening period, and the specific issues that Commissioners are looking to explore over the coming months.

<sup>3</sup> All data has been taken from the Fairness Commission's Initial Presentation of Evidence - http://www.plymouth.gov.uk/plymouth\_fairness\_commission\_introductory\_analysis.pdf

## **KEY AREA OF CONCERN I STRENGTHENING COMMUNITIES**

#### Information we already had

- There is a low percentage of residents in Plymouth who feel they can influence decisions. Surveys highlight a degree of public 'political apathy' with people feeling disenfranchised and ignored.
- There is however a high percentage of residents who are satisfied with the area in which they live.
- People from more deprived neighbourhoods are more likely to experience social isolation than others.
- Lack of access to open spaces for recreational activities appears to be a common issue for a number of neighbourhoods.

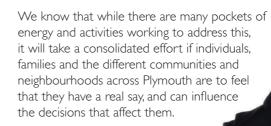
#### What we found out

- The existence of barriers to involvement in community activity and volunteering was a common theme in the Summer of Listening.
- Residents felt they were constantly removed from the decision making processes and lacked clear routes to get engaged.
- The isolation of older people was a common theme across the Summer of Listening strands, particularly the low-level of interaction with other generations and digital exclusion.
- The community and voluntary sector are under constant pressure to survive on ever smaller levels of funding and cope with the sharply increasing demands from people.
- Residents were supportive of community engagement activities and there was a willingness to participate, however practicalities or bureaucracy often got in the way.

#### What we are concerned about

We have heard from many individuals and groups across Plymouth about the perceived lack of control over their own lives, and we are concerned about such feelings of isolation and helplessness.

We are concerned about the existence of a deeply entrenched sense of disempowerment and disengagement in Plymouth, particularly in the communities which are most disadvantaged. We are concerned about a culture of being done to rather than doing, and of residents, groups and local businesses feeling isolated and excluded.





#### What we will explore

We will explore opportunities to create the conditions that promote stronger relationships and connections between people, a better sense of wellbeing and empowering people to engage in decision making. We will also explore whether greater use of community assets mapping could help to achieve this.

We will be exploring how to strengthen the role of civil society, including more volunteering opportunities to build social capital, cohesion and enterprise, and break down barriers between individuals and communities.



## **KEY AREA OF CONCERN 2 INDIVIDUAL AND FAMILY WELL-BEING**

#### Information we already had

- There is a 12.6 year gap in average life expectancy between the most and least deprived areas of the city.
- The most deprived neighbourhoods in Plymouth are far more likely to experience violence in the family and/or poor mental health.
- There is a high prevalence of domestic abuse in Plymouth (27% of all violent crime compared to a national figure of 16%). Four of the five neighbourhoods with highest rates of domestic abuse are among the ten most deprived in Plymouth. The estimated cost to Plymouth of domestic abuse is £49 million per annum (Commissioning Plan for the Plymouth Domestic Abuse Partnership 2012 2019).
- We know that alcohol negatively affects the lives of too many of our residents and visitors. It contributes to antisocial behaviour, violence, harm to children and young people and a range of health problems.
- During 2011/12 there were 2,513 recorded crimes attributable to alcohol and nearly 7,000 hospital admissions. Every year a significant number of children experience poor care and neglect due to parental alcohol misuse.

#### What we found out

- Some areas of Plymouth have a lack of access to healthcare services such as GPs and dentists.
- The lack of support for people with mental health issues was highlighted, particularly the lower than average spend on Mental Health services and long waiting lists for services despite higher than average levels of mental ill health. There is a particularly high number of women with mental health issues in the city.
- Evidence collected suggests that Plymouth has around 89,000 people per year requiring support, treatment or therapy for some form of mental health distress and there is no proper infrastructure to address needs or to provide services to all of these people.
- There is a pressing need for better access to Mental

- Health services in Plymouth for children, with long waiting times to use Child and Adult Mental Health Services (CAMHS) for those with severe mental health issues, including severe depression and threats of suicide.
- Devon and Cornwall has one of the highest number of people detained under the Mental Health Act. Vulnerable people are ending up in police cells (even children as young as 12) because there is nowhere else for them to go. This also has an impact on police time.
- Debt is a common problem for people living with mental health problems but the link is rarely discussed. When debt mounts up, so does stress and anxiety.
- Plymouth has one of the highest levels in the country of self-harm (hospital stays for self-harm have more than doubled since 2008/09).
- 25% of the entire mental health budget is spent on out of area placements.
- There is currently no comprehensive mental health policy or plan in Plymouth.

#### What we are concerned about

The profound differences in average life expectancy between the most and least deprived areas; that some residents face difficulties accessing basic general and mental health care. We are very concerned to hear that when people need help, they may be finding it difficult to see a doctor, dentist or other health practitioner, particularly with regards to mental health. We are also concerned about the high level of family violence and the broader impact, including the intergenerational effect, this is having on families, children and on local communities as a whole.

While we identify that the misuse of alcohol is a concern for many of our residents, we also acknowledge the significant amount of work being undertaken under the guise of the five year





## **KEY AREA OF CONCERN 3 YOUNG PEOPLE AND YOUNG ADULTS**

#### Information we already had

- There is a clear attainment gap at all levels, from Early Years Foundation Stage through to Key Stage 4 (secondary school) and post 16 education, between those from lower and higher income households.
- In 2011, 21.5% of the city's residents aged 16+ held a qualification above level 4 (degree or equivalent) significantly lower than the England average of 27.4%.
- The 18-24 age group in Plymouth makes up a comparatively high proportion of the total benefit claimant count and experienced the sharpest recessionary rise in unemployment.
- The proportion of out of work benefit claimants that are aged 18-24 is higher than the national average (33% as opposed to 27% in some wards as high as 40%). The numbers of 18-24 year old out of work claimants is highest in more deprived neighbourhoods, as at October 2013 the highest number was in Stonehouse (120), which compares to none in Woodford. Other neighbourhoods with high numbers of claimants include; Devonport (85), Stoke (80) and Honicknowle (70).
- At the end of October 2013 there were 521 children classed as Not in Education, Emplyment or Training this equates to 6.9% of those children in academic years 12 -14 Source: Careers South West.
- The percentage of Plymouth's pupils going into Higher Education Institutions (HEI) at 47% is lower than the England average of 52%. There are stark differences in the percentage of pupils going into HEI when schools across Plymouth are compared (2009/I0) Devonport High School for Girls and Devonport High School for Boys have the highest percentage of pupils going into HEI (both 66%). This compares to over 55% at Lipson Co-operative Academy, and 36% at All Saints Academy and Marine Academy.
- In 2009/10 5% of Plymouth pupils went on to study at a Russell Group university (excluding Oxford and Cambridge) which is below the England average for local authorities (8%). Pupils in Plymouth who attend schools that serve more deprived areas are less likely to go on to attend Russell group universities. 17% and 16% of

pupils go on to these universities from Devonport High School for girls and boys respectively. This compares to 0% of pupils from John Kitto (now All Saints Academy), Lipson Community College, St Boniface College and Tamarside (now Marine Academy Plymouth).

#### What we found out

- Education was an important issue of unfairness raised under the Summer of Listening, particularly the allocation system and the differing quality of education provision between areas.
- We heard about the attainment gap between children eligible for free school meals and their peers.
- Child poverty and the poor health of some children were cited as a growing concern for our schools. Delivering high quality education was considered to be more challenging as poverty increases. The need for additional wrap around support for children, young people and families was cited as essential to enable a more effective learning environment.
- Some young people feel that their voices are not heard and they have little say in their communities. When they express a view they are ignored. They lack appropriate spaces to come together and meet within their own neighbourhoods.
- The lack of collaboration is perceived to damage childrens opportunities to access excellent teaching. We also found out that while there is excellent and innovative practice happening across the city, particularly within the Primary sector, this is not always replicated in the secondary and further education sectors.
- There is a fragmented system of sixth form education in the city, and most schools maintain a sixth form.
- Some young people discussed how they felt disappointed with the quality of their education and that they had left school with insufficient knowledge and skills. A reduction in independent accredited career advice was noted as a significant issue.
- Many employers claim that young people are not ready for work when they leave education so a focus on civil, health and financial literacy is required.

- There is a lack of employment opportunities for young people, as well as opportunities with training and prospects for career enhancement, with an absence of major employers and existing employers offering a limited number of opportunities to those aged under 25.
- Apprenticeships are often suggested as a potential route into employment, however there appear to be significant barriers to this. There are currently apprenticeship vacancies across the city and Plymouth is one of the few areas where the number of apprenticeships filled has fallen. A number of difficulties in filling these vacancies were reported.

#### What we are concerned about

We are concerned about the reasons why not all children across the city are being given the opportunity or resources to achieve their full potential on the journey to adulthood. We are also concerned about perceived differences of opinion of what it means to ensure a young person is and feels work ready, along with the availability of suitable employment ready to take them on.

#### What we will explore

We will look at how we can make education fairer for children and young people, particularly those communities and schools that may need extra support and vulnerable groups facing additional challenges, for example young carers. We will focus on skills and standards, and a collaborative approach to building excellence within schools, while also acknowledging the importance of parental involvement in children's learning.

We will also explore how schools and businesses can work together better to enable work ready young people. This will include reviewing how career advice is currently being provided, what additional opportunities are being created to ensure that jobs are available for young people, and the mechanisms to enable businesses including micro and small and medium enterprises to invest in the future workforce.



## **KEY AREA OF CONCERN 4 COST OF LIVING CRISIS**

#### Information we already had

- Plymouth has a higher rate of child poverty than the national average with 21.9 per cent (11,560) of children living in poverty, of which 10,190 are under 16.
- Plymouth has a high level of economic inactivity, particularly due to long-term sickness or disability. Since mid-2011, the number of long-term out of work benefit claimants has risen dramatically, reaching a peak of 1,785 (28% of all claimants) in September 2012 the highest since 1998.
- The median gross weekly wage for full-time workers in Plymouth in 2012 was £454 compared to South West and UK averages of £477 and £506 respectively.
- Analysis of the impact of Welfare Reform suggests that changes will impact on 20% of the city's population, and will disproportionately affect some of Plymouth's most vulnerable families. The loss of income to the city for 2012/13 was estimated to be £20 million.
- In 2012, the Plymouth Foodbank based in Stonehouse reported a 40% increase in those receiving food to over 4,000 people.
- During 2010/11, Plymouth Citizen's Advice Bureau (CAB) dealt with over £43 million of debt. It is known that the highest levels of debt in Plymouth are in areas identified as being among the most deprived.
- It is estimated that nearly 14,000 Plymouth households are living in fuel poverty, with significant challenges in treating the number of homes that can be made energy efficient.

#### What we found out

■ Financial issues were a common area of concern across all events. People living in Plymouth are particularly concerned about low wages compared to the high cost of living, benefit cuts, suitable employment and the high cost of public transport.

- The rising cost of energy, water and housing were all raised by residents.
- The most vulnerable groups such as older people, lone parents, younger people and families of disabled children are disproportionately impacted by financial issues.
- The use of the Foodbank is on the rise and access to meals for children during school holidays is of particular concern. Access to affordable, healthy food appears to be a problem issue varying across different life stages.
- According to recent figures obtained from Money Advice Devon and Cornwall, 29.3% (62,182) of Plymouth's adult population is overindebted at least three months behind with their bills in the last three months or state that they feel their debts are a heavy burden. This number is much higher than in any other of the local authority in the south west. Nationally, Plymouth's population is the 48th most indebted out of 406 local authority areas Bristol sits at 110th and Torbay 137th and South Hams 310th.
- People on low income have limited access to financial services, which can lead to the use of high interest credit sources and spiralling debt and stress. According to the Royal College of Psychiatrists, I in 2 adults with debt may have a mental health problem.

#### What we are concerned about

We have heard the message loud and clear that, like in many other cities, Plymouth residents are struggling to cope with the rising cost of living. Businesses are also struggling to survive in the current economic climate. Plymouth is being hit hard — with nearly 1 in 4 children living in poverty, high levels of economic activity, changes to benefits and lower than average wages — this struggle is affecting working households alongside those not able to work.

#### What we will explore

We are concerned about and will be exploring how the city can respond to this crisis. This will include a living wage economy, accessible, affordable credit and financial services such as budgeting advice, a more inclusive school meals service, a sustainable food economy, community cafes, growing and eating projects and other co-operative ways for individuals, families, communities and organisations to purchase or act together to pay less for household basics and



## **KEY AREA OF CONCERN 5 HOUSING**

#### Information we already had

- Poor housing impacts on the physical health and wellbeing of people and those most vulnerable bear the biggest impact.
- Around a third of Plymouth's private sector stock across the city is old and considered non-decent this equates to around 30,000 private sector homes of which 9,500 are occupied by 'vulnerable' residents in receipt of qualifying benefits.
- Social housing, located predominantly in the West of the city, is often well maintained and more energy efficient than older private sector housing.
- The age, condition and tenure of private sector housing stock in Plymouth is of concern and impacts on the health of the most vulnerable families.
- Plymouth has high levels of families with children living in overcrowded housing.
- The waiting list for social housing currently stands at over 12,000. Over 3000 households are in priority need, on average there are only 23 lets available every week.
- The number of homeless families requiring temporary accommodation is rising.
- Over 20% of households earn less than £16,000 whilst 50% earn less than £20,000 and have insufficient income to buy a home.

#### What we found out

- Issues highlighted during the Summer of Listening include a shortage of affordable homes, substandard accommodation in the private rented sector and lack of suitable social housing.
- The new centralised allocation system has led some families to feel that they would never be able to access social housing but found that the private rented market did not want people who were in receipt of benefits.
- Young people report finding it difficult to access temporary accommodation and housing issues are often left unresolved for long periods of time.
- Some tenants feel fearful of raising concerns with private

- landlords or the authorities about the quality of the accommodation. Conversely, some landlords also suffer severe damage to property caused by tenants.
- Some of our military families reported poor housing and a lack of clarity about where responsibility lies and how to access advice.
- While Plymouth was reported as having a good hostel system which allows access to health services, there is an unmet need for follow on accommodation.
- Many former 'council' homes have recently been brought up to standard which will have a positive immediate and long term effect on health outcomes.

#### What we are concerned about

We consider good quality housing to be a basic right for people living in Plymouth. We have heard about the poor state of some of our private sector housing and how many people are scared of reporting irresponsible landlords for fear of being evicted. We have heard about the long waiting lists for social housing and the difficulty that many families then have in finding suitable and affordable homes in the private rented sector. We are concerned that the basic housing needs of many households across Plymouth are not being met, and that many are stuck in a vicious cycle of not being able to secure decent, affordable homes. We are also concerned about the financial and health impact that poor housing is having on our most vulnerable households.





## **KEY AREA OF CONCERN 6 STRENGTHENING OUR LOCAL ECONOMY**

#### Information we already had

- Plymouth's economy is characterised by low rates of productivity – Gross Value Added (GVA) per job is around 84% of the UK average and this 'gap' has persisted for many years.
- Plymouth has a relatively low business density (205 per 10,000 residents vs. 334 for UK), partly reflecting a relative abundance of large employers associated with its defence and manufacturing heritage. The low business density masks the fact that it has a comparatively large number of bigger businesses.
- Business birth rates are among the lowest in the country, although at the very micro level there are some indications of positive entrepreneurial activity. Plymouth has recently become one of the first social enterprise cities in the country.
- Plymouth has a larger than average proportion of employees working in the public sector around 35% compared with 27% nationally (2007 figures).

#### What we found out

- The suitability and visual appeal of local shops was an issue of concern as was the number of closed or empty shops. The dominance of national chains over local bespoke shops was cited as a concern as was the disproportionate level of funding to some retail areas.
- The cost of parking was a concern to many people and, along with expensive public transport, may be deterring people from visiting the city centre or preventing them from accessing jobs or leisure activities.
- While desirable by local residents, buying local services is perceived as less convenient and more costly.

#### What we are concerned about

We are concerned about the future for local business, in particular micro, small and medium enterprises.

We have heard that opportunities for suitable, well-paid employment are perceived as poor across the city, with

many of our young workforce seemingly unprepared for the world of work. We have heard that while there is a desire to support local businesses, this can often be difficult due to a lack of flexible and affordable public transport links, and a lack of parking incentives.

We know there is concern about the greater presence of major retailers, seen as being to the detriment of the independent West End retail sector. For some, it is simply a lack of choice within their neighbourhoods.

#### What we will explore

We will explore a fairer system for local procurement where local businesses and local communities benefit most. As part of this we will explore how to reduce barriers whilst enhancing the ability and will of local businesses to engage and benefit from such systems. We will also look at how we can strengthen the sustainability of the local economy, keeping more money generated within the economy circulating locally.

Finally, we will be looking at how the city can address perceptions of unfairness with the availability and cost of public transport and parking charges when accessing key services and amenities across the city, particularly getting people from more deprived residential areas to the major employment areas in the city centre.



## **KEY AREA OF CONCERN 7 DISCRIMINATION AND SOCIAL EXCLUSION**

#### Information we already had

- As is common in other cities, issues of discrimination are under reported and are often not raised in general research and consultation.
- Our Black and Minority Ethnic (BME) population is small but growing rapidly. The latest census information shows that just under 4% of Plymouth's population were not of White British or White Irish descent (2011) compared with just under 15% nationally.
- 161 racist incidents were reported within schools in 2009-10. In 120 of these incidents, it was deemed necessary for the school to take follow up action with both the victim and the perpetrator
- 11,655 (6.7%) of people in Plymouth consider themselves permanently sick or disabled (the national figure is 5.5%).
- 22% of disabled people in Plymouth had experienced harassment in public because of their impairment.
- There is no local data on the numbers of Lesbian, Gay, Bi-sexual and Transgender (LGBT) people in Plymouth, but it is nationally estimated at between 5 to 7 %. This would mean that approximately 12,500 people aged over 16 in Plymouth are LGBT. Local surveys have found that fear of abuse and bullying is common.

#### What we found out

- Evidence suggests racism and abuse in Plymouth is prevalent and massively under-reported.
- Views from resident and community groups suggest that racism and discrimination are common catalysts for abusive and antisocial behaviour. Fear of abusive behaviour impacts across the wider community and can make people feel unsafe in their neighbourhoods and even in their own homes.
- Issues raised by people with disabilities related to the difficulties of access leading to isolation, these included unsuitable parking facilities, restricted bus passes, problems with pavements and street furniture and difficulties with access in public spaces.

- There are problems with accessing leisure services for people with Physical and Learning Disabilities.
- Digital exclusion is a growing problem and makes people feel isolated as well as preventing them from accessing key information.

#### What we are concerned about

We are concerned about what we have heard from many individuals, groups and organisations across Plymouth about their experiences of attitudinal and structural discrimination across the city. We are also concerned at the feelings of exclusion that prevails across many of our most 'disadvantaged' communities. We are concerned about the personal impact this is having on those affected, as well as the impact this is no doubt having on the city — on how we treat our residents and how welcoming we are perceived to be by others. This is really important when one of the city's aspirations is to attract more international visitors and students.

#### What we will explore

The Commission aims to investigate what action can be taken to reduce different types of attitudinal and structural discrimination and to promote the incorporation of a genuinely pro-diversity approach within the city. In recognition of the need to promote greater social cohesion and social inclusion, we will extend our review beyond the nine protected characteristics (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation), to also include discrimination based on socioeconomic status. We will examine the extent to which policy makers incorporate diversity thinking into their

We will look at ways of developing a stronger culture of kindness, respect and empathy, with the development of a city culture where people are encouraged and enabled to give their time, skills and support to help meet the needs of others across the city.



## **KEY AREA OF CONCERN 8 IMPLICATIONS OF AN AGEING POPULATION**

#### Information we already had

- Between 2010-2031 the total population of Devon is expected to grow by 13% but with marked differences by age group. The number of Devon residents aged 65-84 will grow by 40% and 85+ by 78%.
- There are an estimated 43,400 people over the age of 65 in Plymouth and this is projected to rise to 49,200 by 2020.
- 7.7% of Plymouth's population are over 75 with over 75's predicted to rise faster than any other group (19,000 in 2008 to 31,000 in 2028).
- Older people requiring social care will double by 2025.
- Currently just over 10,000 older people are estimated to live alone and this is projected to rise to 11,800 by 2020.
- In 2014 it is predicted that in Plymouth, 3,166 people over the age of 65 will have a dementia and by 2020 this will be 3,667.

#### What we found out

- There are growing numbers of older people in the city which will increasingly challenge the ability of service providers to support the delivery of quality services to older people and other vulnerable people living in Plymouth.
- There is a lack of opportunity for older people to come together both with people of their own age and with other generations.
- As more information and services become available only online, some older people will be increasingly excluded and disadvantaged.
- Some older people are fearful of leaving the house or cannot afford to go out and this impacts upon their mental and physical health.
- A key finding from the Dementia Select Committee was that the city should develop a shared 'Strategy for Ageing'

#### What we are concerned about

We have heard that Plymouth's ageing population will grow very significantly in numbers and proportionally over the coming decades and this brings with it challenges to ensure our older people are included and supported, as well as challenges to ensure the care they require is available. We have heard from people experiencing dementia as well as from their carers about issues such accessing support, appropriate housing, isolation and difficulties in mobility and transport to access basic services such as local shops and GPs.

We also heard that older people were particularly vulnerable to rising costs of living, alongside cuts in pensions and benefits. Residents reported a lack of intergenerational contact and a lack of drop in groups and support for older carers. Plymouth's pioneering work to become a dementia friendly city demonstrates the impact of joint working but much more needs to be done to help support our older people.

#### What we will explore

We will explore the adequacy of plans being put in place to address our concerns, and investigate the broader implications and opportunities for Plymouth of the ageing population. In particular, we will explore ways in which older people are being excluded from the socio-economic life of the city, and how we can work together to combat isolation. This will link closely with other areas of concern we will be exploring including housing, strengthening communities, discrimination, access to transport and cost of living.



## WHAT HAPPENS NOW?

This report has briefly outlined some of the key concerns that the residents and organisations of Plymouth have fed back as part of the Summer of Listening. More detailed information is available in the Initial Presentation of Evidence and The Summer of Listening report.

Over the next three months, the Commission will be focusing on its eight key areas of concern and will investigate each area in order to provide informed, realistic recommendations for action.

Each key area of concern will be reviewed by Commissioners using the following:

- Critical friend partnering (e.g. national organisations or other Fairness Commissions)
- Select Committee Panels with expert witnesses
- Best practice reviews
- Additional research / data (including national comparisons)
- Visits to other areas / projects
- Expert presenters
- Review of other Fairness Commissions findings/recommendations
- Local discussions/networking with key stakeholders, groups and elected members
- Recommendations collected as part of the Summer of Listening
- Emergent learning from the C2 case study

It is expected that while the majority of recommendations will have a local focus, some will be more appropriately addressed at national government. Where possible, we will engage with other Fairness Commissions on common issues of local importance that require a national response, in order to maximise our influence.

The final report of the Plymouth Fairness Commission, with recommendations for action, will be published in March 2014. The Commission will reconvene in 2015 to review progress.

## **COMMISSIONERS**

#### **Steve Baker**

Principal, Lipson Co-operative Academy

Since 1995 Steve has been Principal of Lipson Co-operative Academy. He has specialised in linking the co-operative learning pedagogy to the values of the international Co-operative Alliance, and sits on the national executive of the Schools Co-operative Society. During his tenure as Principal, Steve has led national and regional conferences; trained as an 'Education Action Zone' consultant; undertaken the National College for School Leadership (NCSL) consultant leader programme; sat on the national executive group for the Schools Network (SSAT) 'Future Schools' group and on the Department for Education Innovations Unit 'Expert' Headteacher group for personalising learning. He is a 'National Leader of Education', the Branch Secretary of Association for School and College Leaders (ASCL), and chaired Plymouth Schools Forum from 2010 to 2012.

#### Mark Bignell

Chief Executive, Hamoaze House

Mark is the Chief Executive of Hamoaze House, working in this field for over 20 years and is responsible for the day to day management of the programmes that it offers. Hamoaze House was incorporated on the 30th June 1998 and attained registered charity status on the 7th July 1998. The charity's principle activity is the operation of day support rehabilitation facilities for people in the community affected by the misuse of drugs and or alcohol, and for their families and associated persons. The secondary activity based at Seymour House is to provide an education service as an alternative to pupil referral units.

#### **Andy Boulting**

Chief Superintendent, Plymouth Commander, Devon and Cornwall Police

Chief Superintendent Andy Boulting began his policing career in 1987 as a Police Constable in Devon and Cornwall Constabulary, and has spent much of it working in Exeter and Plymouth.

His first posting was to Ilfracombe before a move to Exeter as a detective and then on to Plymouth. He was stationed at Crownhill as a sergeant before making Detective Sergeant working for Charles Cross CID. A stint at the Force Crime Squad, working surveillance and major investigations was followed by a return as Detective Inspector in Plymouth and then East Cornwall.

Currently the Plymouth Commander, Chief Superintendent Andy Boulting is responsible for the overall policing for Plymouth including crime and performance. He sets local priorities in consultation with partners, the local community and police personnel, which meet local needs and support organisational goals. He works with partners to address community and agency needs and contributes to the reduction of crime and disorder.

#### **Prof Kevin Elliston**

Public Health Consultant in Health Improvement, Public Health England

Kevin recently took up a post with Public Health England following a short term as Acting Director of Public Health for Plymouth City Council. Prior to that, Kevin worked in the NHS for 31 years. He studied Human Geography at Plymouth Polytechnic and a career path change saw him train as a Registered Nurse and later specialising as a cancer nurse. For the past 23 years, Kevin has further trained in public health and research and has worked in public health related practice in Plymouth and the surrounding areas. He is also a Visiting Professor in Public Health with Plymouth University and a Fellow of the UK Faculty of Public Health.

#### **Marc Gardiner**

#### Director, Zebra Collective

Marc has worked all his life in his home town, Plymouth, in multifarious community work and social care settings: with people with learning disabilities, people using mental health services, young people in care and in youth work settings, people with alcohol or drug issues, and with innercity communities facing big challenges. From 2002 until its conclusion in 2011, he was chair of Devonport Regeneration Community Partnership, a £48.7m New Deal for Communities programme in his local community designed to spearhead regeneration initiatives in the UK through an action research approach.

In 2002 to 2003 he drove the foundation of Zebra Collective, an equal-pay worker cooperative which exists to promote equality and tackle social exclusion through its activities of: training in (a) equality and diversity, (b) communications skills for people who work with people facing extra challenges, and (c) community development, community development and facilitation, mediation and conflict resolution

#### Jo Higson

#### Life and Business Coach, Blue Parakeet Coaching CIC

Jo is currently running a small community interest company in Plymouth having previously been the Equalities Lead for the Government Office for the South West followed by three years working for a local charity. She has been working in the equality and diversity field for the last twenty years in both the public and voluntary sector and is personally and professionally passionate about the issues of equality and justice. Jo's family settled in Plymouth in the 1970's and she chose to return with her own children six years ago.

#### Mike Jarman

#### Chief Executive, Plymouth Zone

Mike is currently the Chief Executive Officer of The Zone (Youth Enquiry Service Plymouth Ltd) the city's largest non-statutory provider of youth services. The Zone works with in excess of 6,500 different young people a year, and services delivered span early intervention in mental health, homelessness prevention, sexual health and personal development programmes. Previous to this he worked locally in the NHS for 17 years, originally employed as the HIV Prevention worker across South & West Devon, but developing skills to become a service commissioner and Public Health Specialist. His background is in youth and community work and community arts. In this capacity he managed a not-for-profit Theatre Arts Company in Greece for 7 years, overseeing a European Funded Programme for working with long term unemployed youth.

#### Joanne Kaye

#### SW Regional Secretary, UNISON

Currently Regional Secretary for the South West region of UNISON, Joanne has worked for UNISON for 22 years, having started in Northern Ireland and worked in Yorkshire and East Anglia before moving to the South West in 2001. She initially graduated in Law and her first job was working for an unemployed workers centre in Barnsley, run by the Trades Council, which sought to get unemployed people back into work in the late eighties/early 90s.

#### **Ann Kinahan**

#### Chief Executive, Plymouth Citizen's Advice Bureau

A non-practising barrister, Ann started her working life with the law publishers, Sweet and Maxwell, but has had a long career within the Citizens Advice Service, in which she believes as the best possible tool for enabling the population at large to implement their rights. Over the last ten years, Ann has worked with Citizens Advice to improve efficiencies across the Service. Much of this has related to increasing public access, making use of improved technology which allows groups of Bureaux to work together. As Director of Plymouth CAB, Ann has also been privileged to oversee the development of Bureau partnerships with significant private partners, South West Water, EDF Energy and Working Links, for instance, in order to bring real financial gains and better financial management skills to local, regional and national CAB clients.

#### Paul Lacey

#### Music Leader, Plymouth Music Zone

Paul is a music leader who specialises in rap and beatboxing at the Plymouth Music Zone, a local charity that works to educate young people across a wide spectrum of musical genres.

#### **Dame Suzi Leather**

Chair of the Commission

Suzi has a wide professional background having been Chair of the Charity Commission, the Human Fertilisation and Embryology Authority, the School Food Trust, the School Meals Review Panel and the Council of Food Policy Advisers. She was the founder Deputy Chair of the UK Food Standards Agency.

In the health services field she chaired the Exeter and District Community NHS Trust; the Health Forum, an inter-agency partnership body formed to promote the public health agenda in North and East Devon; was the first chair of St Sidwell's Healthy Living Centre, then the UK's only combined healthy living centre and UK online centre and chair of a research project on low income teenage pregnancy, funded by Tommy's: the baby charity.

She has been a member of Consumer Focus, the Human Tissue Authority, an observer member of the Human Genetics Commission and sat on the steering group of the UK Stem Cell Bank.

She is Vice President of Hospiscare, sits on the Prime Minister's Rural Dementia Task and Finish Group and serves on the boards of the General Medical Council and the United Kingdom Accreditation Service; she chairs the Ethics Committee of the Royal College of Obstetricians and Gynaecologists and also the Lankellychase Foundation, a charity which works to bring about change that will transform the quality of life of people who face severe and multiple disadvantage. She is a Deputy Lieutenant of Devon and went to primary school in Plymouth.

#### **Glynis Lidster**

Centre Manager, Welcome Hall

Glynis is Centre Manager for Welcome Hall Limited which opened in 1995 as a Community Resource Centre to promote the benefit of those people residing or working in the Devonport area. She supports volunteers from within the local community and around the world, via various language schools, helping develop their social and language skills. A resident board member on the Devonport Neighbourhood Board, Glynis has a wide range of both work and life experience and believes in equality for everybody.

#### **Robert Nelder**

Consultant in Public Health

Robert worked in the NHS for 22 years before joining Plymouth City Council in April 2013. As well as being an experienced public health professional, he has particular expertise in public health intelligence and has recently been admitted to the UK Public Health Register through Defined Specialist Portfolio assessment and has become a Fellow of the Faculty of Public Health. Robert is also a Visiting Research Fellow at the University of Plymouth.

#### **Councillor Chris Penberthy**

(Labour, St Peter and the Waterfront) is Plymouth City Council's Cabinet Member for Co-operatives and Community Development.

His portfolio includes lead responsibility for community safety, homelessness, social and private rented housing, social inclusion, the voluntary and community sector, child poverty, neighbourhood working, and social enterprise development.

Chris has spent most of his working life in charities and has been awarded a fellowship of the Royal Society of Arts in recognition of his contribution to the sector and volunteering.

Chris is on the Board of Plymouth Municipal Charities, Millfields Community Economic Development Trust CIC and Plymouth Energy Community, he is also Chair of Safer Plymouth and the newly-formed Millfields Inspired.

#### **Father Sam Philpott**

Father Sam is a member of the Society of the Holy Cross and in 1978, he became the Vicar of St Peter's Church, Stonehouse, Plymouth. He was made a Prebendary of Exeter Cathedral in 1991 and was awarded an MBE in the Queen's New Year's Honours List for 2012, at the age of 71, for service to the community of Plymouth. He has been at the forefront of pioneering projects including the Ship homeless hostel, Plymouth Mediation and The Millfields Economic Development Trust, which he chairs.

#### **Ann Pointon**

#### Chair, PADAN (Plymouth Area Disability Action Network)

Ann moved to Plymouth from Milton Keynes 12 years ago and worked as a disability consultant and trainer until her retirement in 2007. She was co-chair of the Board of Trustees of Equata UK/Kaleido the disability arts agency for the South West from 2005 to 2010, and became a trustee and Chair of PADAN (Plymouth Area Disability Action Network) in 2011. Ann has a background in broadcasting, working at the BBC from 1965 and producing BBC Open University social science television and radio programmes from 1978 until she left the BBC to go freelance in 1989. From 1991 to 1995 she was Channel Four's part-time disability consultant, and was involved as a panellist and committee member in a number of British Film Institute and Arts Council England disability and diversity employment and education initiatives from 1991 to 2002.

#### **Ian Potts**

#### Managing Director, Architects Design Group

lan is an architect and graduate of the Plymouth School of Architecture and Corporate Member of the Royal Institute of British Architects. Elected to the board of the Chamber of Commerce II years ago, lan is a member of the Operations and Central Policy groups and is the Chair's spokesperson for regeneration and the built environment. These positions offer the opportunity to work with the private sector in partnership with the public and community sector leaders for the good of the City of Plymouth.

Founding Partner/Director of The Architects Design Group – now based at the new Studio 5-11 Building in the centre of Plymouth and working predominantly across the South of England. Buildings and the spaces around them are the physical expression of our towns and cities. Ian's particular focus is on the development of architectural and urban design and their role in the regeneration of Plymouth and the towns and cities of Devon and Cornwall.

#### **CIIr Dr David Salter**

A fourth-generation Plymothian, David qualified as a medical research scientist at St. Bartholomew's Hospital and the University of Oxford. Besides working in the NHS and in several countries overseas, he has been a Professor at three UK Universities, an expert witness in US Federal Court, a business developer for Ernst & Young in London and Chief Scientist of a multinational manufacturing PLC. He has also been a carer for his father with dementia and a daughter with a chronic sleep disorder. Since 2003 he has been a City Councillor and from 2007 to 2010 was Cabinet Member for Adult Health and Social Care.

#### Sue Shaw

## Director of Homes and Neighbourhoods, Plymouth Community Homes

Sue has worked in the sphere of social housing for around 25 years, joining Plymouth Community Homes – Plymouth's largest housing association – at its inception in 2009. Immediately prior to this, Sue ran her own small company working with housing providers and other charitable bodies to improve organisational governance and accountability; this included mentoring and coaching social housing tenants to develop an effective voice, expanding their capacity to influence the Boards on which they served, or aspired to join. Sue has also worked regionally as a specialist in the regulation and turnaround of failing housing associations.

#### **Lesley Shorrocks**

Chair, Plymouth Federation of Small Businesses

Lesley is managing director of Sigma, a marketing and advertising agency based in Plymouth. Prior to establishing Sigma in 1992, Lesley studied for an English degree in York and then embarked on an 11 year career in public and private sector leisure, arts and entertainment marketing. Lesley is Chair of the Plymouth Branch Federation of Small Businesses, which has over 1,000 members in the city, is on the Plymouth Area Business Council Executive and a member of the Chamber of Commerce. Lesley is also an active Rotarian and is a past President of Plymouth Mayflower Rotary Club, undertaking local and international service projects.

#### Sheila Snellgrove

Director, Barbican Theatre

Sheila is the company director of the Barbican Theatre, Plymouth. She has worked in the city for over 30 years as a teacher, theatre practitioner and community facilitator. She was trained at the Central School of Speech and Drama and quickly realised that her passion was in using the arts as a vehicle to bring people together – to celebrate, challenge and change things – hopefully for the better. The Barbican Theatre is proud of its history of inclusion work making its auditorium home to some of the most diverse audiences in the city.

#### **Prof Richard Stephenson**

Plymouth University, Dean of the Faculty of Health/PVC/ Prof of Rehabilitation, Faculty of Health, Education and Society

Following a successful clinical career as a chartered physiotherapist in which he specialised in neurological rehabilitation and mental health, Richard entered higher education in 1989. During the past 24 years, Richard has established a national reputation in the development and implementation of innovative education programmes at all levels, with a particular focus on the development of interprofessional and interdisciplinary learning and working.

Since 2003 Richard has held significant leadership roles in academia, holding Dean of Faculty roles in two universities. He is currently Pro-Vice Chancellor and Executive Dean of the Faculty of Health, Education and Society at Plymouth University and Professor of Rehabilitation. Through his national profile on the Council of Deans of Health Executive body, Richard has worked extensively with numerous governmental, regulatory and professional bodies. He is a member of the Plymouth Health and Wellbeing Board.



To find out more visit plymouthfairnesscommission.co.uk

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@plymfairness



Plymouth Fairness Commission



## Northern, Eastern and Western Devon Clinical Commissioning Group

#### **NEW Devon Clinical Commissioning Group**

#### Report for Devon Health and Wellbeing Board Meeting: January 2014

#### Recommendation

These agenda items aim to provide an update to the Health and Wellbeing Board in relation to the CCG's Commissioning Framework and intentions for 2014/16. This brief overview paper will be supplemented by copies of the Commissioning Framework Launch presentation and Modules circulated so far including CF04 - Top 6 commissioner Priorities and the Board are asked to note the update schedule and contribute views in relation to the process.

#### 1. Commissioning Framework 2014/16

NEW Devon Clinical Commissioning Group has been creating its Commissioning Framework. We are mandated to produce a five year strategy which will focus on how as a health and social care community we create a high quality and sustainable system that delivers on our ambition to place individuals at the centre of our work.

We recognise that we cover many providers and health communities in NEW Devon CCG. Our commissioning framework therefore delivers a single, clear and robust approach that will apply to each community consistently: our unit of account is to deliver success to all areas within the CCG.

We recognise the challenges within this planning round and believe that by setting out a clear framework and looking to work collaboratively with all providers and across organisational boundaries offer the best chance of collective success with the best patient and population outcomes. The framework will also allow us to adopt solutions for individual communities where these fit within the key principles we establish.

The framework also allows us to bring together, summarise and track all key documents in one place and to provide a forum to answer questions in a way that benefits all interested parties.

A launch event was held in Exeter on December 4<sup>th</sup> for key stakeholders to introduce the principles of the framework, which are:

- To place the individual at the centre of our work to support the delivery of our vision
- To produce a single, clear, consistent and robust framework for all our commissioning activity
- To work equally with all providers by providing the same information at the same time and acting consistently

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- To achieve key national targets sustainably from within our resource base
- The framework is composed of a series of modules.
- Through the planning process we will issue more detailed guidance for each module and in response to any national guidance published.
- We will issue an update each fortnight during the period December March.

NEW Devon CCGs commissioning plans have taken account of the Joint Strategic Needs Assessments and will contribute to delivery of the Joint Health and Wellbeing Strategies.

#### 2. Commissioning intentions

Our combination of intentions seeks to balance equity of outcome, timely and reasonable access and value for money in the provision of services for our entire population. Reduction of health inequalities will focus on outcomes and on access. Investment may be made on a differential basis in order to achieve this.

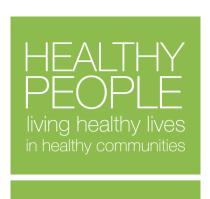
The necessary transformation of the system will focus on the provider landscape and we can anticipate consolidation of expertise and provider development in line with the location of needs, consistent with the recommendations of the Keogh Review. A key next step with Local Authorities, specialist and primary care commissioners and health providers is to embark on the design which delivers and sustains explicit health and social care outcomes and begins from an ambitious scope for the Better Care Fund (previously the Integration Transformation Fund).

Explicitly, this will require reinvestment of current resources. An ethical framework will guide the inevitably difficult investment and disinvestment decisions across competing priorities. Such decisions must be taken. We would look for and expect provider support in reaching and implementing such decisions.

We intend to establish with providers a mutual responsibility for:

- Managing the demand for services and;
- Lowering the commissioned costs and provider unit costs of provision.

The attached CF04 document outlines our 'Top 6 priorities'. Further documents will be published on 10<sup>th</sup> January 2014 to outline our additional commissioning intentions.





### Northern, Eastern and Western Devon Clinical Commissioning Group

# CF01 NEW Devon CCG Commissioning Framework 2014 - 2016



**NEW Devon CCG Commissioning Framework 2014-2016** 

# Page 64

## **NEW Devon CCG Commissioning Framework 2014/16**



Northern, Eastern and Western Devon Clinical Commissioning Group

A document that sets our five-year strategic direction,
delivered with a focus on quality,
a detailed and robust plan for 2014/16 and
a financial framework that combine to
support the delivery of our vision







## **Executive Summary of Our Intentions**

Northern, Eastern and Western Devon Clinical Commissioning Group

#### 1. Purpose

- To place the individual at the centre of our work to support the delivery of our vision
- To produce a single, clear, consistent and robust framework for all our commissioning activity
- To work equally with all providers by providing the same information at the same time and acting consistently
- To achieve key national targets sustainably from within our resource base

#### 3. A Plan for Quality

- We want high quality of care to become a right and an expectation for our population. High quality, cost effective care must be a feature of all the services we commission, reducing variation, commissioning evidence based care and focusing on quality improvement
- Patients have a right to be cared for with kindness, dignity and respect and we will ensure that the experience of people is at the centre our commissioning framework

#### 2. Strategic Planning Approach

- To place a focus on strategic planning to ensure that NEW Devon CCG has a clear 5 year plan for submission in early 2014 that guides shorter term actions
- To engage with Local Authorities, neighbouring CCGs and the Area Team of NHS England to ensure alignment of all key commissioning strategies
- To engage with the public and communities through each element of strategic change

#### 4. Detailed Planning Framework for 2014/15

- To produce a process for 2014/15 that is clear and robust
- To use the CCG's core strategies to look to work in collaborative partnership with providers, based on an understanding of positions built from national contracting guidance
- To align system levers so that we focus effort, attention and reward based on the areas we want to change
- To produce commissioning intentions that are comprehensive and cover all aspects of care

#### **5. Financial Framework**

- To ensure the CCG has a deliverable financial 5 year plan and strategy to sustain comprehensive and sustainable high quality health services to its population
- To work on system and health community sustainability rather than simply on the CCG position
- To work with the Area Team to produce the most robust position possible, given the challenging financial position for all organisations





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Northern, Eastern and Western Devon Clinical Commissioning Group

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The framework is composed of a series of modules.

Through the planning process we will issue more detailed guidance for each module and in response to any national guidance published.

We will issue an update each fortnight during the period December – March.





## **Section 1 : Purpose**

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## 1.1 Purpose of the Commissioning Framework



Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our Intention**

- To place the individual at the centre of our work to support the delivery of our vision
- To produce a single, clear, consistent and robust framework for all our commissioning activity
- To work equally with all providers by providing the same information at the same time and acting consistently
- To achieve key national targets sustainably from within our resource base

#### **Engagement and Involvement**

- Active local engagement with all providers through contract discussions & periodic CCG wide events
- Co-commissioners in Social Care are key to success and collective effort will drive our commissioning ambition
- Working closely with the Area Team on both primary care and specialist commissioning will be crucial elements

#### **Next Steps and Actions**

- The launch of this framework is supported by a CCG wide partner organisation event
- We will organise further events, subject to partner request and support
- We will meet individually with all stakeholders to explain the local implications of our approach
- We will produce further guidance each week to support the planning process

#### **Background and Context**

We are mandated to produce a five year strategy which will focus on how as a health and social care community we create a high quality and sustainable system that delivers on our ambition to place individuals at the centre of our work.

We recognise that we cover many providers and health communities in NEW Devon CCG. Our commissioning framework therefore delivers a single, clear and robust approach that will apply to each community consistently: our unit of account is to deliver success to all areas within the CCG.

We recognise the challenges within this planning round and believe that by setting out a clear framework and looking to work collaboratively with all providers and across organisational boundaries offers the best chance of collective success with the best patient and population outcomes. The framework will also allow us to adopt solutions for individual communities where these fit within the key principles we establish.

The framework also allows us to bring together, summarise and track all key documents in one place and to provide a forum to answer questions in a way that benefits all interested parties.



## NHS

## 1.2 Purpose of this Document

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our Intention**

- To enable all our partners and stakeholders to have a shared understanding of the CCGs approach to the commissioning and planning process in the short and longer term
- To provide the basis for the planning process that will build to be a comprehensive framework
- To outline the information and guidance we will share as part of this process

#### **Engagement and Involvement**

- To ensure all providers have an opportunity to participate and influence commissioning decisions and planning
- Test with partners areas where further detail at a CCG level would be helpful
- Further discussion with leaders about owning and leading on system wide change and strategic issues

#### **Next Steps and Actions**

- We will add modules to this core document to build to a full and detailed framework covering all aspects of our commissioning plan
- Work with co-commissioners in Local Authorities and with the Area Team to work on ensuring that all our commissioning process are well aligned

#### **Background and Context**

In our first year as a CCG building our commissioning intentions we have reflected on how we pulled together plans in shadow form 12 months ago. We have also listened hard to feedback we have received.

As a CCG we recognise that we need a clear and consistent framework that drives towards equity for our population and therefore applies to all providers and contracts equally. Within the parameters set, this unified approach can then be negotiated to fit to local circumstances.

Our process to create commissioning intentions has therefore been a single, CCG wide effort with a set of collective workshops pulling together our clinicians and senior managers.

Therefore being more explicit and transparent around our decision making processes, our commitment to sharing guidance and information to foster strong, open and collaborative relationships with our joint commissioning colleagues and providers is key.

This document is the first phase of that journey.





### 1.3 NEW Devon CCG Context

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our Population**

The CCG covers a population of approximately 890,000 people and spends £1.1 billion to provide large elements of their care. We serve populations with some similar but differing needs and our commissioning intentions reflect the need for us to operate within a single, clear, consistent framework that is sensitive to our diverse communities.

Our priorities emphasise areas requiring focus to achieve consistent quality of service and the NHS Constitutional standards for access. We will ensure that we support patients' decision-making in relation to their conditions to enable them to take ownership of their care.

We place particular emphasis on better management of the interfaces between services, health and social care providers and other agencies. The Devon Predictive Model and the use of risk stratification will continue to be a fundamental approach to our work in keeping people well.

Clinical outcomes are good, However the cost of total provision in a number of areas is higher than other places and, when combined with the economic outlook and shifts in demography, lead to a need for change. Our strategies look to move resources towards prevention and self care and better management of long term conditions and urgent care.

#### Context

Financial sustainability for the health economy is critical. By working on a CCG-wide basis on high cost and volume pathways and in areas where the opportunity for financial return is the greatest, we will enable investment in services which provide the greatest health gain, moving towards equal outcomes and reasonable access for our whole population.

The CCG will build stronger and clearer commissioning and contracting relationships with our providers. Explicitly in these arrangements, managing down and controlling growth in activity will be approached as a joint issue for all organisations. It will require all our combined expertise and better engagement with the public.

The CCG will support services to lower the costs of provision for providers, which we see as consistent with shifts of care settings and the development of more efficient and effective pathways. Our financial incentives will be aligned to support the sustainable implementation of such changes.





## Section 2 : Strategic Planning Approach

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## 2.1 Overview and Commissioning Principles

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our Intention**

- To place a focus on strategic planning to ensure that NEW Devon CCG has a clear 5 year plan for submission in early 2014 that guides shorter term actions
- To engage with Local Authorities, neighbouring CCGs and the Area Team of NHS England to ensure alignment of all key commissioning strategies
- To engage with the public and communities through each element of strategic change

#### **Engagement and Involvement**

- Engagement with stakeholders, providers, cocommissioners and the public in each element of the strategic plan
- Work with co-commissioners on alignment of strategies to ensure best use of resources to achieve the highest quality of services
- Work with providers to expand discussions between providers about best organisation of services

#### **Next Steps and Actions**

- Engage external support to produce a high-quality strategic plan in 2014 that effectively captures and documents the wealth of work that has been undertaken within NEW Devon CCG on a range of initiatives
- Review next steps with providers following initial meting with Chief Executives held on 27<sup>th</sup> November 2013

#### **Background and Context**

The Commissioning Framework is a combination of an operational and strategic plan. We recognise the accountability we hold over both timescales and are clear that we need to have a clear long-term, strategic intent to guide our shorter term actions in order to create sustainable health and care systems.

We are engaged in a number of different strategic discussions that also sit alongside commissioning changes such as NHS 111 and Out-of-Hours services. Both our work on Transforming Community Services and the opportunities inherent in integration of services supported by Integration Transformation Fund are significant in terms of scale and potential to transform the landscape.

It is important that we are able to pull all different elements of strategic planning in to one, coherent plan for NEW Devon CCG that also relates to neighbouring communities.

We will complete a five year plan early in 2014 and also recognise that we will need to continue to work further on this during 2014/15.



## 2.2 Health and Wellbeing Strategies – Plymouth



Northern, Eastern and Western Devon Clinical Commissioning Group

#### The Health and Wellbeing Board intends:

- · To develop plans to improve health and wellbeing
- To have oversight of other agencies plans relating to health and wellbeing improvement.
- To engage and consult with the public, service users and patient reps in order to promote health and wellbeing.
- To work in a different way by demonstrating system leadership and co-operative and collaborative approaches

NEW Devon CCG will work with its partners to commission services that contribute to the delivery of the Joint Health and Wellbeing Strategy

#### **Engagement and Involvement**

- The H&WB is committed to finding different ways to engage with the public and will learn from the best
- Plymouth's strategic framework for H&WB has been informed by surveys, visiting communities, listening to the public's views face-to-face and using bespoke surveys
- The meetings of the Board are webcast

#### **Next Steps and Actions**

 The Joint Commissioning Partnership is responsible for setting commissioning plans that focus on tackling the Health and Wellbeing Board priorities, (1) mental health, (2) healthy weight, (3) substance misuse, and (4) health and social care integration

#### **Background and Context**

Plymouth's Health and Wellbeing Board has developed a vision of what it aspires to achieve for all the people of Plymouth, recognising that people think of health and wellbeing in different ways.

The Health and Wellbeing Board's vision for Plymouth is to have healthy, happy and aspiring communities and to actively promote the health and wellbeing of all people in Plymouth. This vision will be achieved by everyone working together and by greater integration.

Three strategic approaches have therefore been agreed by the Health and Wellbeing Board and its members will hold each other to account for their delivery.

Plymouth's Strategic Framework for Health and Wellbeing will use the evidence found in the Marmot Review 'Fair Society, Healthy Lives' to test its own plans, and those of its partners for effective approaches for reducing health inequalities.

NEW Devon CCGs commissioning plans have taken account of the Joint Strategic Needs Assessments and will contribute to delivery of the Joint Health and Wellbeing Strategies.



## 2.2i Health and Wellbeing Strategies



Northern, Eastern and Western Devon Clinical Commissioning Group

#### The Health and Wellbeing Board intends:

Devon

- To invest in evidence-based preventive interventions across the life-course
- To work through effective partnerships to address the inequalities in health that exist across our localities
- To reflect the importance of mental health and emotional wellbeing alongside physical health priorities

NEW Devon CCG will work with its partners to commission services that contribute to the delivery of the Joint Health and Wellbeing Strategy

#### **Engagement and Involvement**

 Developing effective engagement and involvement processes with the protected characteristics groups is a priority. To achieve this will involve strengthening our links with voluntary and community bodies and partnerships e.g. Devon's Equality Reference Group if we are to engage with local people who are most disadvantaged

#### **Next Steps and Actions**

- Contribute to the Health Needs Assessments for protected characteristic groups and long term conditions
- Produce an end of life care commissioning specification
- · Support carers and people with dementia
- Promote healthy lifestyle through physical activity, healthy eating, stopping smoking /alcohol & substance misuse

#### **Background and Context**

Devon's Joint Health and Wellbeing Strategy has four strategic priorities:

- · A focus on families
- · Healthy lifestyle choices
- Good health and wellbeing in older age
- · Strong and supportive communities.

This life-course approach recognises the importance of a healthy start to life as well as the need to support people through healthy ageing.

Within each priority a number of themes and topics that require joint working are identified including;

- Reducing and preventing domestic and sexual violence and abuse
- Promoting healthy lifestyle
- · Providing accessible sexual health services
- Improving diagnosis and dementia services
- Supporting carers of all ages
- Reducing and preventing suicides
- Supporting people with multiple/complex needs
- The needs of people with sight loss/impairment.

NEW Devon CCGs commissioning plans have taken account of the Joint Strategic Needs Assessments and will contribute to delivery of the Joint Health and Wellbeing Strategies.



# 2.3 Integration and the Integration Transformation Fund



Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our Intention**

- To develop and adopt a shared set of commissioning principles with local authority partners
- To integrate our commissioning, services delivery and health and wellbeing
- To fully embrace the opportunity presented by the Integration Transformation Fund to change the nature of commissioning and speed & scale of integration

#### **Engagement and Involvement**

- Engagement by our GP members with the public in each of the 3 localities
- The involvement of stakeholders as part of the TCS process & the development of commissioning principles
- We have been actively involved in working with our local authority partners to develop plans for integration

#### **Next Steps and Actions**

- To work with each of our local authority partners to refine vision and plans for integrated commissioning.
- To develop business cases, engaging providers in the delivery of plans that integrate health and care services
- To develop plans that optimise use of the Integration Transformation Fund; submitted by 14th February 2014
- To provide an update on progress to Devon and Plymouth Health and Well Being Boards in January 2014 and at future meetings

#### **Background and Context**

Our population, through the engagement events that have taken place on the subject of Transforming Community Services, our clinical membership and the King's Fund all identify integration as a key priority. Integration is not an end in itself, but a means of continuing to improve outcomes for our local population whilst achieving sustainable use of shared public resources.

Locally NEW Devon is working with Devon County Council and South Devon & Torbay CCG, a national pioneer site, to develop an integration plan and share learning across a large population and geography. At the same time NEW Devon is also working on an integration plan with Plymouth City Council who are part of the Labour group of Innovation Councils.

The development of an Integration Transformation Fund, as recently announced by NHS England and the Local Government Association now offers a real opportunity to integrate the commissioning of out of hospital services and this will form a essential approach as part of NEW Devon's Commissioning Framework and 2 to 5 year plan.





## 2.4 Transforming Community Services

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our Intention**

- To design and commission a model of community services with clear and consistent outcomes for patients, carers and communities
- To take notice of the strong messages from stakeholders and communities about joined up care where organisational boundaries are invisible
- To achieve a sustainable pattern of provision with personalised and out of hospital care at the centre of this

#### **Engagement and Involvement**

- Extensive engagement of patients, carers and the public throughout North, East and West Devon
- Involvement of a large system wide stakeholder reference group at key milestones in the process
- Active involvement of local authorities in all aspects of the Transforming Community Services Programme

#### **Next Steps and Actions**

- Developing the strategy, principles and outcomes for services in the community
- Preparing a supporting implementation plan that includes proposals for sustainable delivery of services
- Continued engagement in this work including a further stakeholder event in February 2014 before the strategy and implementation plan is finalised

#### **Background and Context**

We seek to balance equity of outcome, reasonable access and value for money in the provision of services for our entire population.

Community services have a key role in supporting delivery of our vision for 'healthy people, living healthy lives in healthy communities'. Getting these right is particularly important to support people whether in an urban setting, a market or coastal town, or rural hamlet.

Although there are many examples of excellent community services in North, East and West Devon, we need to deliver care in new and innovative ways to respond to changing expectations, needs and resources.

The 2011 Transforming Community Services Programme brought about the separation of commissioning and provision of community services. It is now time to take the next steps to achieve consistent and quality outcomes for people through local services that are designed to be sustainable and stand the test of time. Our implementation route must deliver integrated and personalised pathways of care.





## 2.5 Provider Landscape and Sustainability

Northern, Eastern and Western Devon
Clinical Commissioning Group

#### **Our Intention**

- To create a clear view of the future landscape of provision (health and social care) and sustainability
- To work with providers, the Area Team and neighbouring CCGs in creating a robust picture
- To undertake independent analysis and to support local dialogue that leads to successful joint arrangements between different parties

#### **Engagement and Involvement**

- Engagement of provider CEOs and the local authorities & wider engagement of stakeholders and partners
- Further briefings for provider boards and wider staff groups through localities
- Collaboration with the Area Team(s) with regard to primary care & specialist commissioning

#### **Next Steps and Actions**

- The development of the CCG 5 year strategy will require early work on the provider landscape. The expertise lies within the provider system and therefore a series of opportunities for collaboration will be created over the coming months
- Commission external support to ensure that this thorough and considered piece of work with its clear vision of future function and form can be completed at pace

#### **Background and Context**

We are looking towards a landscape that works across pathways and is focuses on patients and not organisations as it start point.

The structural and fiscal challenges that the NHS faces over the next 5 years are of such magnitude that a sustainable NHS and social care system can only be achieved by significant and radical provider landscape change. It is imperative that commissioners have a clear view about the future function and form of the local health and social care system in collaboration with providers and in liaison with the NTDA.

There are a number of co-dependent pieces of work which include the Integration Transformation Fund delivery and TCS. In addition there are 2 enabling strategies – health and wellbeing and community capacity and workforce without which this work will fail.

We will need to work with the Area Team(s) to ensure that the impact of specialist commissioning is understood. In addition the value of co-commissioning of primary care services with the Area Team will be critical to the design of the future provider system.





## 2.6 Area Team Commissioning Strategies

Northern, Eastern and Western Devon
Clinical Commissioning Group

#### **Our Intention**

- To work with the Area Team to ensure future models of specialist commissioning and national strategies are integral to our strategic planning
- To work with the Area Team to co-commission primary care and therefore be able to describe a strategy and provider landscape that meets the needs of our populations and encompasses a full range of providers

#### **Engagement and Involvement**

- Work with providers on the impact of specialist services specifications on local services
- To sponsor conversations between provider Chief Executives on collaboration
- To work with the Area Team to ensure alignment of commissioning strategies

#### **Next Steps and Actions**

- Organise on-going meetings with Provider Chief Executives about provider landscape and specialist services
- Review specialist commissioning alignment through Specialist Commissioning Collaborative
- Agree nature of co-commissioning of primary care with the Area Team in both short and longer term

#### **Background and Context**

The new landscape for commissioning in the NHS comprises different commissioners with delineated responsibilities for parts of the health system.

In order to form an effective strategic plan it is imperative that these different elements align successfully so that we place individuals, rather than organisational accountability at the heart of our planning effort.

We know that the Area Team is keen to cocommission Primary Care with the CCG and we will work with them over the next few months to ensure there is alignment with our commissioning intentions in both the short and medium term.

The new specifications for specialist services will have a significant impact on the future shape of services and this, in turn, will have an effect on more routine hospital services. The extent to which organisations choose to work in partnership or have to consider a different service base in order to become sustainable. We recognise the current specialist centres in the peninsular.





### **Section 3 : A Plan for Quality**

Publication Date for this Module : 13 <sup>th</sup> December 2013		
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## 3.1 A Plan for Quality

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our Intention**

- We want high quality of care to become a right and an expectation for our population. High quality, cost effective care must be a feature of all the services we commission, reducing variation, commissioning evidence based care and focusing on quality improvement
- Patients have a right to be cared for with kindness, dignity and respect and we will ensure that the experience of people is at the centre our commissioning framework

#### **Engagement and Involvement**

- Commissioning for quality measures will be built on national requirements however we will also ensure that these align with provider improvement plans
- High quality care cannot be delivered in isolation we intend to bring the health and social care system together with a focus on quality improvement

#### **Next Steps and Actions**

- Produce the detailed "Plan for Quality" Module by 13<sup>th</sup> December 2013
- We will clearly set out a number of quality standards congruent with provider ambitions
- CQUIN & quality requirements aligned to commissioning
- Events will be planned for the new year with a focus on improving experience of care, quality improvement and collaboration across health and social care

#### **Background and Context**

The learning from recent national inquiries and inspections has reinforced the needs of patients to be at the centre of all the NHS does. The learning of the past and from the Keogh and Berwick reviews bring centre stage the need for all NHS staff to focus on ensuring that patients receive high quality and responsive care and that they receive a positive experience of care.

Listening, transparency and learning are all features of an effective health and social care system that rigorously focuses on quality improvement and ensuring people have a positive experience. Where failure does occur we will ensure that we will support providers and clinicians in being open and transparent with patients working to the spirit of the 'Duty of Candour'.

We will ensure that the needs of vulnerable groups are understood, that care delivery is sensitive to those needs and appropriate and that vulnerable people are safeguarded from harm.

The delivery of the Public Sector Equality Duty is not only a legal requirement but also a route to ensuring that equity of access and outcome is a feature of care delivery.





## Section 4 : Detailed Planning Framework for 2014/16

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## 4.1 Detailed Planning Approach

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our Intention**

- To produce a process for 2014/16 that is clear and robust
- To use the CCG's core strategies to look to work in collaborative partnership with providers, based on an understanding of positions built from national contracting guidance
- To align system levers so that we focus effort, attention and reward based on the areas we want to change
- To produce commissioning intentions that are comprehensive and cover all aspects of care

#### **Engagement and Involvement**

- We have listened to providers including the Chief Executives feedback on 27<sup>th</sup> November 2013
- We will discuss commissioning intentions with all providers and amend if necessary
- Discuss with all providers and communities the merits of an approach based on collaboration

#### **Next Steps and Actions**

- Produce the detailed planning approach module for 20<sup>th</sup> December 2013
- Organise monthly planning meetings for stakeholders across NEW Devon – January to April 2014
- Discuss contracting approaches within individual health communities and with each provider

#### **Background and Context**

Alongside our creation of a strategic plan, we need to produce clear, robust and coherent plans for 2014/15 and for 2015/16.

This operational plan needs to show how we plan to invest our resources and work with providers in order to secure the services we need from within our allocation. It is clear that this will be a significant, health community wide, challenge that will test our ability to work collaboratively to achieve the best outcomes for the population we serve.

Our approach is based on understanding the position of the CCG and our distinct communities based on national guidance and contracting.

We believe our three core strategies guide a positive, collaborative process that could see us working alongside providers at scale on joint programmes of quality, innovation, productivity and prevention that deliver significant cost savings whilst protecting core services.

However, we recognise that this may not work for all so we also outline a more traditional and transactional process for some circumstances.





## 4.2 Our Core Strategies

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our Intention**

- To discuss with all communities and providers the options around contracting based on collaborative partnership – aligning QIPP and provider CIPs
- To understand each contract based on full application of national guidance and the benefits of using this or other approaches
- To look for solutions that are sensitive to achieving sustainability in individual health communities, understanding risks and benefits
- To invest in relationship development to achieve collaborative approaches

#### Strategy 1

Ensure the clinical community and the public take joint ownership of the sustainability agenda

- We believe that the best chance we have of creating sustainable health communities in our area is by working collaboratively with all partners to jointly own the requirement to live within the resources we are given and provide the highest quality of services
- We will clearly set out what this challenge would mean in each community and how we could reduce risk &focus our efforts, both clinical and managerial, on the key areas where we need to transform the systems centred on the population we serve

#### Strategy 2

Ensure systems and processes are developed that make the best use of limited resources, every time

- We want to work on a single set of efficiency and productivity plans with providers and cocommissioners, recognising the wasted effort in savings initiatives that conflict or lead to poor results
- We can then collectively align the resources we have for change
- We will look at equity of resource allocation

#### **Strategy 3**

Move the focus of commissioning away from treatment and towards a prevention and maintenance approach

- We want to use headroom to facilitate change that invests in the solutions to the causes of problems, rather than the symptoms
- The more we achieve joint and collective solutions, the more we can invest in the cost of change
- · Joint commissioning will help embed this strategy

#### **Other Approaches**

 We recognise that a collaborative approach may not suit all situations. It is where we want to begin discussions (albeit, based on full PbR exposition), but will follow strict national models where required





## 4.3 Our Key CCG Intentions

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Background and Context**

Our combination of intentions seeks to balance equity of outcome, reasonable access and value for money in the provision of services for our entire population. Reduction of health inequalities will focus on outcomes and on access. Investment may be differential to achieve this.

The necessary transformation of the system will bear on the provider landscape and we can anticipate consolidation of expertise and provider development in line with the location of needs, consistent with the recommendations of the Keogh Review. A key next step with Local Authorities, specialist and primary care commissioners and health providers is to embark on the design which delivers and sustains explicit health & social care outcomes and begins from an ambitious scope for the Transformation Integration Fund.

Explicitly, this will require reinvestment of current resources. An ethical framework will guide the inevitably difficult investment and disinvestment decisions across competing priorities. Such decisions must be taken. We would look for and expect provider support in reaching and implementing such decisions.

We intend to establish with providers a mutual responsibility for:

- i. controlling the demand for services and
- ii. lowering the commissioned costs and provider unit costs of provision.

This to be supported through contracting mechanisms, strategic relationships and creative use of local flexibilities in tariff arrangements. Our emphasis is sustainability and quality. Lowering of unit costs and of demand in planned care in particular, to support shifts of resource to meet unplanned and emergency demand in the most appropriate settings of care, will be inevitable.

Patients and carers will experience seamless, coherent pathways for chronic and acute conditions with an emphasis is keeping well, early diagnosis, shared decision-making, supported self-management and independence.

The local commissioning landscape itself will undergo closer alignment to ensure coherent approaches across primary care, specialist commissioning, public health and social care leading to a single, straightforward strategy.





## 4.3 Our Key CCG Intentions

Northern, Eastern and Western Devon Clinical Commissioning Group

#### Our Intentions focus on priority issues:

- In the short-term, a 14/15 shift of unscheduled contacts to urgent planned care where possible. This, alongside planning of the future landscape of Urgent and Emergency settings of care, will realise the vision of the *Keogh Review*.
- Early exploitation of the Integration Transformation Fund with a broad and ambitious scope across Advance Care Planning and frailty, unscheduled care, admissions avoidance, 7-day working, integrated discharge planning and onward provision across health & social care and provider boundaries. This alongside local development of the care market in partnership with Local Authorities.
- Rapid access to senior medical opinion in support of optimal diagnosis, treatment and demand management. This will use our local Referral Management Centre to realise many of the gains anticipated by the NHS eReferrals Service.
- Targeted follow-up care, seeing patients according to need rather than by default when they are well. Infrastructures to achieve this are well established in exemplar sites but underexploited in Devon.
- Major pathway and service transformation on the basis of outcomes, access, evidence, value for money and benchmarked opportunities. These will include CHC, frail elderly/ complex adult pathways, orthopaedics, ophthalmology, dermatology, diabetes, respiratory medicine, psychiatric liaison, access to psychological therapies, eating disorders, personality disorders, autistic spectrum disorders and out-of-area placements.

Our Key CCG Intentions will apply to all our communities and all relevant providers.

We will develop detail for each of our commissioning intentions and publish by 20<sup>th</sup> December.

We will involve cocommissioners and providers in discussions about the exact nature of each intention.





## 4.3 Our Key CCG Intentions

Northern, Eastern and Western Devon Clinical Commissioning Group

#### Our Intentions focus on priority issues:

- Prevention and Recovery, to include expansion of 'Enhanced Recovery' practice in surgery and medicine and recovery in mental health services.
- Direct access pathology services linking evidence to clinical pathways, rationalising this provision on a value basis to achieve the large gains envisaged in *Lord Carter's Review of NHS Pathology Services*.
- Investment and disinvestment on the basis of treating equally the needs of our populations, with explicit consideration of clinical effectiveness and value for money. Transparent process to be established before the end of 13/14.
- Together with SD&T CCG and local authority partners will produce a coordinated suite of joint commissioning strategies including:
  - Dementia
  - Learning Disability
  - Mental Health
  - Carers

These strategies will share common approaches that will guide joint commissioning plans aimed at improving outcomes and empowering individuals through coordinated commissioning across the health and care system.



# 4.4 Developing Our Commissioning Intentions



Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our Intention**

- To publish full detail on each intention by 20<sup>th</sup> December 2013, including cost target for each area
- These will be specific and tangible with regard to 14/15 service change, as described opposite.
- The development of very large scale intentions such as the local consequences of the Keogh Review will require bespoke planning and provider engagement

#### **Engagement and Involvement**

- Within Localities and Partnerships' existing engagement structures with providers, work to respond to and finesse the implementation of 14/15 service changes linked to contracts
- Longer-term transformation intentions will be reflected in Provider Landscape engagement

#### **Next Steps and Actions**

- Publication of Ethical Framework for prioritisation decisions
- Mutual understanding of benchmarked opportunities.
- Development and publication of detailed Cost, Quality, Rationale, Implementability descriptions of commissioning intentions

#### **Background and Context**

We recognise that commissioning intentions and the subsequent contracting intentions are key to the process of agreement with providers in 2014/15. We have focussed on a single set of intentions that will apply across the CCG and promote consistency.

Alongside CCG intentions, additional intentions will be developed on a Locality and Partnerships basis.

Commissioning Intentions must be tangible and specific with regards to 14/15.

Where specific 14/15 service changes are concerned, alongside the detailed intention we plan to describe for each:

- Cost Savings
- Initial Quality impact
- Rationale/Evidence
- 'Implementablility'

These domains are established in NHS Evidence Case Studies of service change and lend themselves to very practical description which will support the contract and service impacts of change.





## 4.5 Aligning Levers for Change

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our Intention**

- To support delivery of our key commissioning intentions by aligning levers for change to focus on the outcomes we are seeking
- Look to apply some CQUINs across a community, thereby incentivising cooperation between providers
- Headroom directed at those providers with whom we have agreed transformation, on the achievement of measurable outcomes
- To focus levers on the delivery of sustainable, recurrent change

#### **Engagement and Involvement**

- We will discuss the overall approach with providers to ensure the alignment of levers matches the outcome we are seeking
- Through contract negotiation and service redesign forums including Clinical Partnership Groups

#### **Next Steps and Actions**

- Produce detailed guidance by 20<sup>th</sup> December 2013
- Clarify Financial Framework at contract level
- Set out decision-making framework for allocating incentives
- Exemplify examples of aligned levers eg e-prescribing and follow-up management

#### **Background and Context**

We recognise that for many years there have been criticisms that commissioners have not managed to align incentives to their key intentions. One of our key success criteria for this framework is to provide coherent alignment of incentives across all of our workplan.

This means looking at all mechanisms we have and providing one meaningful statement of alignment (albeit that many areas will not require all levers)

#### Levers include:

- Contract terms
- CQUIN
- QIPP
- Fines and penalties
- ◆ Headroom
- Quality Premium
- ◆ GP Enhanced Services

This means, for example, that for an area of change we will write clear contract terms, where the change is supported by headroom with a quality element attracting CQUIN payments and the primary care change required incentivised using an enhanced service mechanism.





## 4.6 Contracting Approach

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our Intention**

- To contract in a way that supports our collaborative ambitions
- Manage risk to both parties through development of longer term agreements, extension of benefit-sharing arrangements & implementation of a pace of change policy
- Incentivise non-face to face activity, where appropriate
- · Use contractual mechanisms to incentivise up-streaming
- · Work collaboratively with partner commissioners
- · Enforce contractual terms and challenge non-compliance
- Work with providers and follow Monitor Guidance when agreeing local prices and departures from national tariffs

#### **Engagement and Involvement**

 Through contract negotiation and service redesign forums including Clinical Partnership Groups

#### **Next Steps and Actions**

- Clarify Financial Framework at contract level by 20<sup>th</sup> December
- · Share CCG approach to local pricing
- Produce clear expositions of each contract based on full national guidance
- Follow national expectations in creating contract positions regardless of agreed contract type

#### **Background and Context**

The CCG's Contracting Principles set out how we will conduct contract negotiations in order to support the CCG in commissioning safe, patient-centred services, within the local financial context.

We have outlined how we want to work with providers and communities in collaboration and we will work to produce contracts that support this. Notwithstanding this intent, we recognise that all contracts need to be based on the highest quality of technical contracting work that clearly and explicitly give an exposition of the financial, activity and quality position.

We will work within national guidance/NHS Constitution and Monitor's guidance regarding agreement of local prices and authorisation of departures from tariff.

Contracts will have an outcome-focused approach, that provides assurance regarding quality, safety and patient experience, and will facilitate change through the alignment of incentives and disincentives.

We will agree conduct expectations for negotiations for all parties.





### **Section 5 : Financial Framework**

Publication Date for this Module : 20 <sup>th</sup> December 2013		
5.1	Financial Context	29
5.2	Framework Requirements	30
5.3	High Level CCG Financial Position	31
5.4	CCG Approach	32

### NHS

## **5.1 Financial Context**

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our Intention**

- To ensure the CCG has a deliverable financial 5 year plan and strategy to sustain comprehensive and sustainable high quality health services to its population.
- To work on system and health community sustainability rather than simply on the CCG position
- To work with the Area Team to produce the most robust position possible, given the challenging financial position for all organisations

#### **Engagement and Involvement**

We have consistently shared the CCG's emerging financial position with Provider Directors of Finance and will continue to update:

- May 2013
- 30<sup>th</sup> August 2013
- 1st November 2013
- · December 2013 date to be confirmed

#### **Next Steps and Actions**

- Produce full CCG financial framework (following release of national guidance) by 20<sup>th</sup> December 2013
- Achieve consensus on the financial position facing communities and providers within the health and social care community
- Review our allocation across our communities in comparison with national formula, when agreed

#### **Background and Context**

The CCG's plan for its £1.1bn budget in 13/14 and the adjustments for in-year performance and specialist services has meant that the CCG's allocation is over committed going in to 14/15 in a number of areas.

Benchmarking helps understand this position – the CCG performs well on emergency admissions and prescribing but invests above average in elective admissions, primary care, high cost placements and has retained a significant level of resources within community services.

In addition some large NHS providers are facing significant financial challenges in 13/14 and looking ahead at future resource levels.

The CCGs commissioning resources will be increased by 2% in the next 2 years and this will be enhanced by reductions to tariff, however this is in huge contrast to the last15 years.

Whilst allocations are reasonably certain during the next two years, changes in allocation formulae and the integration transformation fund mean the CCG is a facing a medium term reduction of 2%. The CCG is therefore expecting to operate in a flat cash environment over the next two years.





## **5.2 Financial Framework Requirements**

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our Intentions**

In order to provide the best environment to allow the whole health community to move towards sustainability the CCG will:

- Re establish a compliant financial framework with:
  - headroom of 2% 14/15 & 3% 15/16
  - surplus of 1%
  - contingency of 0.5%
- Provide for growth in services but at a low marginal cost
- Apply headroom to structural change and transformation
- Establish an agreed and all encompassing approach to use of the Integration Fund
- Develop further our transformation (QIPP/redesign) plans of 2% building on local commissioning intentions, existing local schemes, local benchmarking and efficiency analysis and NHS England value commissioning pack
- Ensure primary care and specialist commissioners plans and financial frameworks are aligned
- Ensure that the local plans and framework move the CCG towards its strategic intentions and in particular issues of financial and service equity

#### **Background and Context**

The CCG was not compliant with national planning guidance for its financial framework in 2013/14. This facilitated the maximum upfront investment in services, but left the CCG with no resources to invest in change programmes and with little ability to manage risks that have emerged in year.

It is clear that this approach has not worked as well as had been anticipated to create the conditions for change and the level of risks experienced has caused major financial concerns for the CCG and therefore the Area Team.

In developing the financial plan the CCG has made reference to assumptions included in *'Strategic and Operational Planning in the NHS'*.

The response to *Call to Action* and the opportunities identified in the '*Commissioning for Value*' insight pack are also included.

In addition, the CCG has developed an approach with its local authority commissioning partners to the *Integration Transformation Fund*.





## **5.3 CCG High Level Financial Position**

NEW Devon Clinical Commissioning Group			
Medium Term Financial Plan	2014-15	2015-16	
Medidili Terili Filialiciai Fiali	£m	£m	
Growth 2%/1.9%	21	20	
Returned Surplus	0	11	
Pace of Change to New Allocation Formula	(2)	(7)	
Tariff Deflator	13	11	
Total Sources	32	35	
Activity and Drug Growth	11	24	
Primary Care (Including Prescribing)	1	3	
Complex Care	5	8	
QIPP/Savings Requirement	(20)	(15)	
Total Applications (Net of QIPP)	(3)	20	
Position before Operating Plan Assumptions	35	15	
Headroom/Contingency	24	15	
Increase in Surplus (1%)	11	(0)	
Memorandum: Social Care Transfer/ITF	2	34	





## 5.4 CCG Approach

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our Intention**

- · To set out the financial outlook
- To produce a financial and service strategy which provides for a sustainable health and social care service
- To finalise the two year plan
- To outline likely impact on provider positions of the planning assumptions
- To set out commissioning and contracting arrangements – including outline application of transformation/headroom fund
- Provide an open and transparent approach to financial planning and the resource impact and availability on commissioners and providers
- Offer a collaborative approach to contracting and commissioning to ensure sustainable service delivery

#### **Engagement and Involvement**

- Clear statement on resources
- Compare financial projections with commissioners and providers
- Review current and future plans with commissioners and providers to determine how much of the gap can be filled
- Agree a process for collaborative working to complete the gap
- Meeting with providers 4<sup>th</sup> December 2013
- Outline financial schedules to providers on 18<sup>th</sup> December
- Engage facilitated support
- Establish joint scenario planning exercises within the health economy

#### **Next Steps and Actions**

- To share final framework on 20<sup>th</sup> December 2013
- Set out likely impact by locality and provider
- Determine type of contract to be adopted
- · Agree process for finalising contract values
- · Joint strategic approach to be supported by external strategic planning input
- To review the financial framework developed by the CCG in light of guidance and best practice
- To review the outputs from the service plans to ensure these match with resources set out





## **Section 6 : Planning Process and Timelines**

Publication Date for this Module: 4th December 2013		
6.1	Process Overview and Key Dates	34
6.2	NHS England Operational Planning Timeline	35
6.3	NEW Devon CCG Timetable	36



## **6.1 Process Overview and Key Dates**

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our Intention**

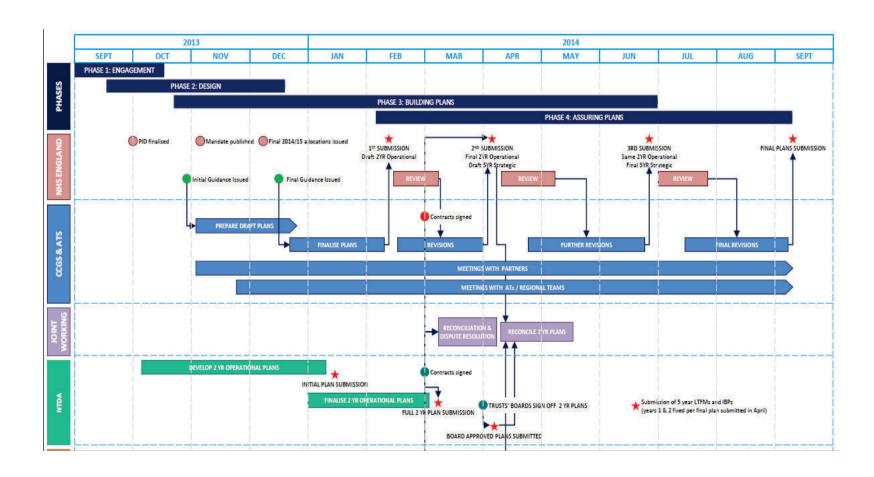
To develop a single, consistent and clear operational and delivery plan informed by the CCG membership through a rigorous process based on evidence review and clinical challenge.

Date	Key Actions
27 <sup>th</sup> November 2013	Meeting with key provider and Local Authority Chief Executives
4 <sup>th</sup> December 2013	Launch of Commissioning Framework and meeting with providers and stakeholders
13 <sup>th</sup> December 2013	Release of CF03 – Update and "A Plan for Quality" module
20 <sup>th</sup> December 2013	Release of CF04 – "Top 6 Commissioner Priorities" CF05 – "Contracting Principles" & CF06 - "Financial Framework" modules
31st December 2013	Release of CF09 Activity Planning
10 <sup>th</sup> January 2014	Release of CF11 – Commissioning update
At least fortnightly thereafter	Updates of national guidance and revised CCG framework



# 6.2 NHS England Operational Planning Timeline

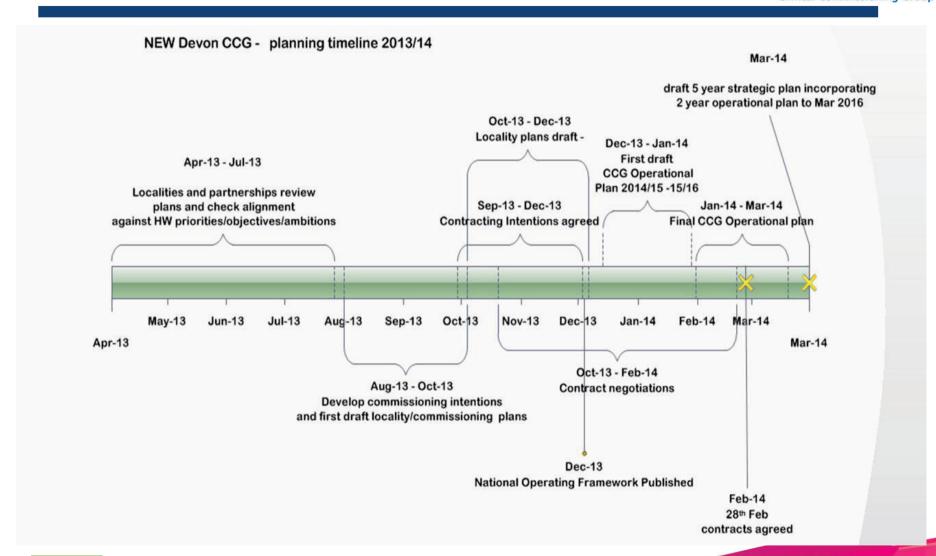








## 6.3 NEW Devon CCG planning timeline







## **Appendices**

1.	NEW Devon CCG Guidance Issued	38
II.	National Guidance & Summaries	39
III.	Total Planning Timeline	42
IV.	Responses to Questions Asked	43
V.	Links to Source Material used to support the Framework	44
VI.	Commissioning Framework on page	50





## **NEW Devon CCG Guidance Issued**

Ref	Guidance	Date published
CF01	Commissioning Framework	4 <sup>th</sup> December 2013
CF02	Devon Chief Executives Joint Session Notes 27 <sup>th</sup> November 2013	4 <sup>th</sup> December 2013
CF03	A Plan for Quality	13 <sup>th</sup> December 2013
CF04	Top 6 Commissioner Priorities	20th December 2014
CF05	Contracting Principles	20th December 2014
CF06	Financial Framework	20th December 2014
CF09	Activity Planning	31st December 2014





## II National Guidance and Summaries

	Guidance and link	Date Issued
1	A Call to Action - NHS England  Sets out the challenges facing the NHS, including more people living longer with more complex conditions, increasing costs whilst funding remains flat and rising expectation of the quality of care. A clear statement that the NHS must change to meet these demands and make the most of new medicines and technology and that it will not contemplate reducing or charging for core services. <a href="http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf">http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf</a>	11 <sup>th</sup> July 2013
2	Planning for a sustainable NHS: Responding to the 'call to action'  Sir David Nicholson, Chief Executive, writes to commissioners to focus attention and thinking regarding the development and delivery of bold and ambitious plans for the future. <a href="http://www.england.nhs.uk/wp-content/uploads/2013/10/david-letter-comm.pdf">http://www.england.nhs.uk/wp-content/uploads/2013/10/david-letter-comm.pdf</a>	10th October 2013
3	Integration Transformation Fund - LGA & NHS England letter and guidance  The 'Integration Transformation Fund' is a single pooled budget for health and social care services to work more closely together in local areas.  A fully integrated service calls for a step change in our current arrangements to share information, share staff, share money and share risk. <a href="http://www.england.nhs.uk/wp-content/uploads/2013/08/itf-aug13.pdf">http://www.england.nhs.uk/wp-content/uploads/2013/08/itf-aug13.pdf</a> <a href="http://www.local.gov.uk/documents/10180/5572443/Next+steps+on+implementing+the+Integration+Transformation+Fund/4e797e4b-0f1a-4d53-a87d-6a384a86792d">http://www.local.gov.uk/documents/10180/5572443/Next+steps+on+implementing+the+Integration+Transformation+Fund/4e797e4b-0f1a-4d53-a87d-6a384a86792d</a>	17th October 2013





## **II National Guidance and Summaries**

	Guidance and link	Date Issued
4	NHS National payment tariff system – Monitor  NHS England and Monitor have taken on responsibility for the NHS payment system from the Department of Health under the provisions of the Health and Social Care Act 2012 (the 2012 Act). The long-term aim is to improve the payment system to support delivery of good quality care for patients in a sustainable way. The payment system proposed in 2014/15, are designed to help commissioners and providers address the strategic challenges facing NHS care in their localities by:    by offering more freedom, to encourage the development of new service models;   by providing greater financial certainty to underpin effective planning; and   by maintaining incentives to provide care more efficiently.   http://www.monitor-   nhsft.gov.uk/sites/default/files/publications/2014%2015%20National%20Tariff%20Payment%20System%20A%20Consultation%20Notice.pdf	October 2013
5	Strategic and Operational Planning in the NHS – NHS England letter and guidance  This guidance outlines detail of planning process across the health and social care system and ensures commissioners, providers and local authorities know the expectations of them and can start working together <a href="http://www.england.nhs.uk/wp-content/uploads/2013/11/jnt-plann-lett.pdf">http://www.england.nhs.uk/wp-content/uploads/2013/11/jnt-plann-lett.pdf</a>	4th Nov 2013





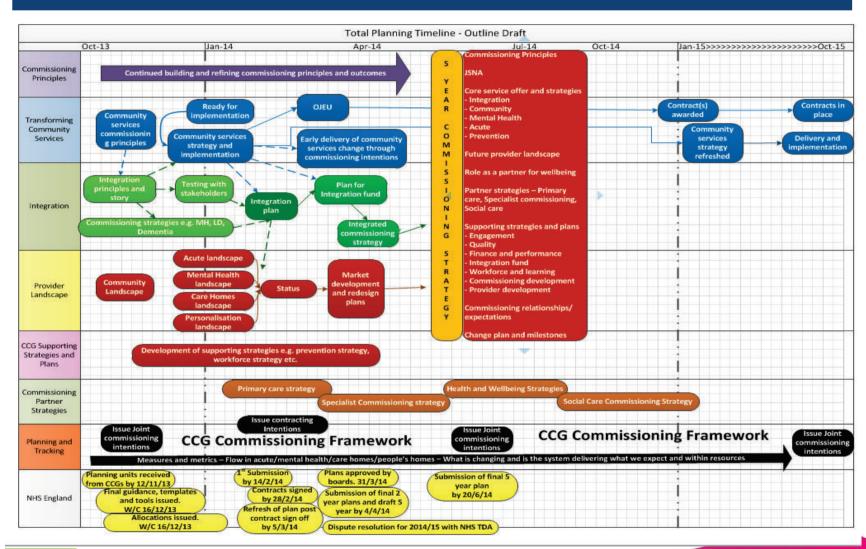
## **II National Guidance and Summaries**

	Guidance and link	Date Issued
6	NHS Standard Contract and Incentives 14/15	11 <sup>th</sup>
	Outlines the process for development of the standard contract	November 2013
	http://www.england.nhs.uk/wp-content/uploads/2013/11/lett-incent.pdf	
7	NHS Mandate	November
	Refreshed NHS Mandate – stating changes kept to a minimum to "ensure refreshed mandate remains strategic, outcomes-focused and affordable"	2013
	some specific implications for CCGs :	
	<ul> <li>CCGs work with NHS England to contribute to a new system-wide ambition of avoiding an additional 30,000 premature deaths per year by 2020 – through earlier diagnosis, reducing variation in avoidable deaths and access to the right treatment.</li> </ul>	
	<ul> <li>enabling local commissioners to stimulate the development of innovative integrated provision.</li> <li>Further focus on CCGs working with local authorities to ensure that vulnerable people, particularly those with learning disabilities receive safe and high-quality care.</li> </ul>	
	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256406/Mandate_14_15.pdf	





## **III Total Planning Timeline**







## **IV** Responses to Questions Asked

Northern, Eastern and Western Devon Clinical Commissioning Group

Question	Response





## V Source material used to support the frameworkern and Western Devon Clinical Commissioning Group

	Information Source	Date
1	Independent Review of NHS Pathology Services - Lord Carter <a href="http://collections.europarchive.org/tna/20081105144224/http://www.thecarterreview.com/downloads/CarterReviewPathologyReport.pdf">http://collections.europarchive.org/tna/20081105144224/http://www.thecarterreview.com/downloads/CarterReviewPathologyReport.pdf</a>	August 2006/May 2008
2	Plymouth Health and Wellbeing Strategy <a href="http://www.plymouth.gov.uk/healthy">http://www.plymouth.gov.uk/healthy</a> plymouth.pdf	2008
3	JSNA - Devon and Plymouth  Joint strategic needs assessment <a href="http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2012/07/Joint-Strategic-Needs-Assessment-Devon-Overview-2012.pdf">http://www.plymouth.gov.uk/jsnaplymouthinterimreport.pdf</a> <a href="http://www.plymouth.gov.uk/jsnaplymouthinterimreport.pdf">http://www.plymouth.gov.uk/jsnaplymouthinterimreport.pdf</a>	Rolling updates
4	Winterbourne View report  The Department of Health (DH) has published its final report into the events at Winterbourne View hospital and has set out a programme of action to transform services so that vulnerable people no longer live inappropriately in hospitals and are cared for in line with best practice. <a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf">https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf</a>	December 2012
5	Devon Health and Wellbeing Strategy 2013-2016 <a href="http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2012/12/Health-Wellbeing-Strategy.pdf">http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2012/12/Health-Wellbeing-Strategy.pdf</a>	Spring 2013





## V Source material used to support the framework Krn and Western Devon Clinical Commissioning Group

	Information Source	Date
6	NHS Constitution revised  The NHS Constitution has been created to protect the NHS and make sure it will always do the things it was set up to do in 1948 – to provide high-quality healthcare that's free and for everyone. No government can change the Constitution without the full involvement of staff, patients and the public. The Constitution is a promise that the NHS will always be there for you. <a href="http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf">http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf</a>	26 <sup>th</sup> March 2013
7	Guidance for commissioners on ensuring the continuity of health care services - Monitor  To support commissioners to safeguard NHS services in their local area. <a href="http://www.monitor-nhsft.gov.uk/sites/default/files/publications/ToPublishFinalCRSGuidance28March13.pdf">http://www.monitor-nhsft.gov.uk/sites/default/files/publications/ToPublishFinalCRSGuidance28March13.pdf</a>	28 <sup>th</sup> March 2013



# V Source material used to support the framework Clinical Commissioning Group

	Information source	Date	
8	The Kings Fund – 10 Priorities for commissioners	April 2013	
	Focusing a shift from acute and episodic care toward prevention, self care and integrated and well coordinated care to cope with an aging population and increase in prevalence of chronic diseases directing resources to the patients with greatest need and redress the 'inverse care law' by which those who need the most care often receive the least. <a href="http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf">http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf</a>		
9	The Keogh Review Review into the quality of care and treatment provided by hospital trusts with persistently high mortality rates. High mortality rates at Mid Staffordshire NHS Foundation Trust were associated with failures in all three dimensions of quality - clinical effectiveness, patient experience, and safety - as well as failures in professionalism, leadership and governance. Outcome of review identifies common themes and barriers to delivering high quality care across the NHS. <a href="http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf">http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf</a>	July 2013	



## V Source material used to support the framework Northern, Eastern and Western Devon

**Clinical Commissioning Group** 

NHS

	Information Source	Date
10	Berwick Review	August 2013
	This report highlights the main problems affecting patient safety in the NHS and recommendations to address them.	
	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf	
11	Northern Eastern Western Devon CCG Benchmark Review Part 1 – Acute Care (incl A&E)	August 2013
	http://www.newdevonccg.nhs.uk/ccg-intranet/corporate/commissioning-framework-documents/100886	
12	Devon Health and Wellbeing Strategy 2013-16 update <a href="http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/downloads/2013/09/Joint-Health-and-Wellbeing-Strategy-2013-update-Final-19-09-13.pdf">http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/downloads/2013/09/Joint-Health-and-Wellbeing-Strategy-2013-update-Final-19-09-13.pdf</a>	September 2013
13	NHS England Commissioning for Value insight pack - NEW Devon	October 2013
	The insights in these packs will support local discussion about prioritisation and utilisation of resources. The aim of this pack is to help local leaders to improve healthcare quality, outcomes and efficiency by providing the first phase in the NHS Right Care approach - "Where to Look". That is, where to look to help CCGs to deliver value to their populations.	
	http://www.england.nhs.uk/wp-content/uploads/2013/10/CfV-nrth-est-wst-dev.pdf	

# V Source material used to support the framework Clinical Commissioning Group

	Information source	Date
14	Closing the NHS Funding Gap: How to get better value health care for patients  Report outlines the opportunities which are available to deliver better care and close the financial gap.  Page 4 - link to PDF document: "Improvement opportunities in the NHS-Quantification and Evidence Collection <a href="http://www.monitor.gov.uk/sites/default/files/publications/ClosingTheGap091013.pdf">http://www.monitor.gov.uk/sites/default/files/publications/ClosingTheGap091013.pdf</a>	October 2013
15	The New GP Contract  On 15 November, NHS Employers and the General Practitioners Committee of the BMA announced changes to the GMS contract in England for 2014/15. The focus of the changes are on reducing unplanned admissions/accident and emergency attendances and reducing the number of indicators in the quality and outcomes framework (QOF) to allow GPs more time to spend with their patients. <a href="http://www.nhsemployers.org/SiteCollectionDocuments/Summary%20of%202014-15%20GMS%20deal%20FINAL.pdf">http://www.nhsemployers.org/SiteCollectionDocuments/Summary%20of%202014-15%20GMS%20deal%20FINAL.pdf</a>	November 2013





## V Source material used to support the framework Krn and Western Devon Clinical Commissioning Group

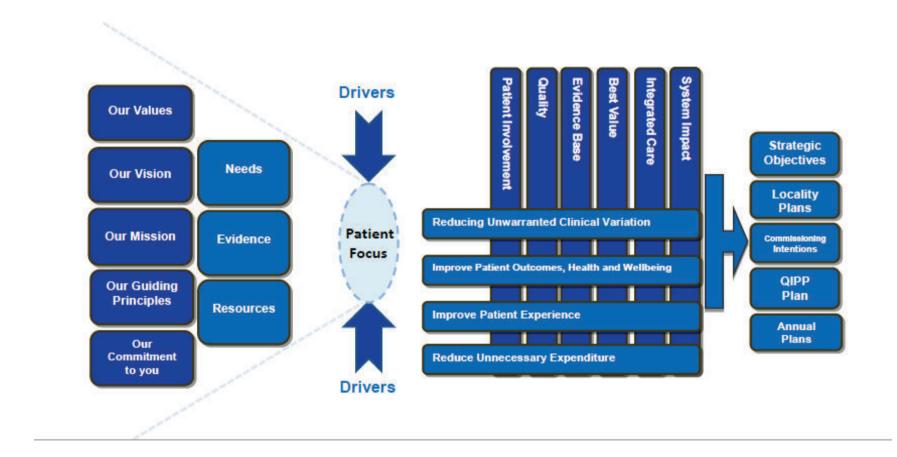
	Information source	Date
16	NHS England - Right Care Examples	November 2013
	Identifying "Value Opportunities" in West Cheshire – Service Reviews and Business Process Engineering	
	http://www.newdevonccg.nhs.uk/ccg-intranet/corporate/commissioning-framework-documents/100886	
17	Northern Eastern Western Devon CCG Baseline performance analysis and options for financial savings	November 2013
	http://www.newdevonccg.nhs.uk/ccg-intranet/corporate/commissioning-framework-documents/100886	





## VI Commissioning Framework On a Page

Northern, Eastern and Western Devon Clinical Commissioning Group









#### Northern, Eastern and Western Devon Clinical Commissioning Group

## CF03 - A Plan for Quality





#### **CF03**: A Plan for Quality

Publication Date for this Module : 13 <sup>th</sup> December 2013				
3.1	Purpose and background	3		
3.2	Our intentions	4		
3.3	Actions	5		
3.4	Engagement and Involvement	6		
3.5	Monitoring	7		



### 3.1 Purpose and Background

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Purpose**

As a CCG we place people at the centre and a positive experience of care must be a right for everyone. Quality must therefore be everyone's business and not just an NHS concept. Quality should be at the heart of all that we do collectively to improve care.

The CCG defines quality by the 3 domains set out in 'High Quality Care for All' – clinical effectiveness, patient safety and patient experience. It is only by the connection of these three elements that quality can be governed and improved.

We will achieve this through:

- A safe system of quality governance to manage risk and react proportionately
- Transparency and openness with the public to improve engagement, reputation and demonstrate accountability to our public
- Commission care based on a number of defined 'Quality Standards'

#### **Background and Context**

The learning from recent national inquiries and inspections has reinforced the need for patients to be at the centre of all the NHS does. The Keogh and Berwick reviews have brought centre stage the need for all health and social staff to focus on ensuring that patients receive high quality and responsive care and that they receive a positive experience of that care.

Listening, transparency and learning are all features of an effective health and social care system that rigorously focuses on quality improvement, ensuring that people have a good experience of care. Where failure does occur we will ensure that we support providers and clinicians in being open and transparent with patients working to the spirit of the 'Duty of Candour'.

We will ensure that the needs of vulnerable groups are understood; that care delivery is sensitive to those needs and appropriate and that vulnerable people are safeguarded from harm.

The delivery of the Public Sector Equality Duty is not only a legal requirement but also a route to ensuring that equity of access and outcome is a feature of care delivery.





#### 3.2 Our Intentions

Northern, Eastern and Western Devon Clinical Commissioning Group

Quality is the guiding principle of our framework and as such reducing variation in patient safety, ensuring that clinical evidence and best practice are applied and that the experience of people is embedded within the commissioning framework will be core. Therefore we will:

- commission for continuous quality improvement ensuring that this is reflected within commissioning plans and contractual principles
- require all commissioned services to demonstrate effective systems for safeguarding vulnerable children and young people and vulnerable adults within their care
- ensure that the rights of patients within the NHS Constitution are delivered and that all providers are compliant with these duties
- ensure that the needs of vulnerable groups are understood and that commissioning plans and care delivery is sensitive and appropriate in meeting those needs. Whilst we will jointly commission specific carer support in conjunction with our local authority partners, providers should identify and support the needs of carers of all ages. We will work in partnership across health, social care and the voluntary sector to secure high quality people focused outcomes

The Public Sector Equality Duty is core to all that we do and we will ensure that commissioners and providers reflect the principles and requirements of the Duty, ensuring that the needs of people with protected characteristics are integral to all pathways.

Integration of commissioning and delivery of care services will be at the centre of the commissioning framework and the development of the 5 year strategic planning process.





#### 3.3 Actions

Northern, Eastern and Western Devon Clinical Commissioning Group

We will work with providers to ensure quality and safety are fully embedded within commissioning and contracting processes. In particular we will ask providers to:

- 1. Engage in and deliver CQUIN requirements as a mechanism to drive real and sustainable improvements in care, supporting the principle of system wide CQUIN where appropriate.
- 2. Engage with the commissioners in the review, development and making more systematic, the integrated provider assurance meetings. This will ensure that these become a mechanism through which quality assurance and performance monitoring takes place and is also provides space and opportunity to drive improvement and innovation.
- 3. Demonstrate progress towards implementation of the relevant findings of the Robert Francis enquiry, the Berwick review, the Keogh Review and Compassion in Practice. Specifically, the Duty of Candour, transparency in reporting of patient experience and implementation of the recommendations of the national NHS complaints review, will be our priorities.
- 4. Improve safeguarding systems and processes and the mechanisms to demonstrate the implementation of safeguarding requirements. Whilst across the system many improvements have been made, there is further progress required to ensure that all vulnerable people are safeguarded from harm. We will expect providers to demonstrate compliance with national requirements and plans for improvement which embed the learning from local and national enquiries.
- 5. Finally we would expect that all providers, regardless of their setting, have robust plans in place to review, implement and monitor safe staffing levels, utilising nationally recognised tools, research and best practice in line with the recent recommendations of the recent National Quality Board publication and the government response to the Robert Francis enquiry. The impact of Cost Improvement Programmes and QIPP on the workforce and safe staffing levels will need to be considered and this will be shared with the commissioner for agreement.





## 3.4 Engagement and Involvement

Northern, Eastern and Western Devon Clinical Commissioning Group

More than any other area, safety and quality is an area where we expect to work with all providers to agree the best way forward, based on our intentions and actions. The final quality plan will be one we create together, based on comments, feedback and agreement with this draft.

We know that quality improvement can be a whole system lever for change. Following the learning from the events at Mid Staffordshire NHS Trust and the findings of the Keogh and Berwick reviews, we will focus on ensuring that we bring together all elements of the local health and social care system to explore, design and implement opportunities for quality improvement.

We know that all staff need to focus on ensuring that patients receive high quality and responsive care that is delivered with kindness and respect. However, we also know that in times of pressure and in the transition between services that sub-optimal care is a feature. We will lead a series of events which will focus on working collaboratively to address these issues.

A number of system wide quality improvement events will be held over the next year to focus on how we create a common purpose for quality improvement and how we keep the needs of people at the centre and thereby improve people's experience of care

Utilising the experience and commitment of staff within Devon the opportunities for improvement are vast. Collectively primary, community and acute services need to support the health and social care system in quality improvement. To that end, we will support the concept of a Quality Collaborative which will seek to share skills, knowledge and expertise across the system, supporting care homes and domiciliary care in this endeavor.

At the same time as supporting the system to improve, we will work with providers, not only in monitoring quality but also working to embed an improvement environment where support, encouragement, inquiry and, if required investment are a feature.





### 3.5 Monitoring

Northern, Eastern and Western Devon Clinical Commissioning Group

Quality monitoring will focus on consistent, measureable outcomes, aimed at reducing harm and variation in safety, embedding patient experience within performance and applying local and national best practice. Integrated Provider Assurance Meetings are our key mechanism for monitoring with each provider, supported by overarching actions.

As an aspiration, measures will focus on system wide improvement where possible encouraging collaborative approaches to quality across health and social care – including smart measurement, sharing information and proactive, supportive improvement.

Integrated commissioning, performance, quality and finance information will remain a feature of our approach.

CQUIN will be utilised by local commissioners to lever system transformation and quality improvement.

We will ensure that there is a 'just' culture where failure does occur. We will support providers and clinicians in being open and transparent with patients and their carers. We will therefore expect providers to demonstrate compliance with the 'Duty of Candour'.

In line with 'Compassion in Practice' we will expect all providers to be able to demonstrate that patients are treated with kindness, dignity and respect and that staff experience is given due regard. We expect providers to ensure that they use a range of communication routes to gather feedback from all groups and act on the findings.

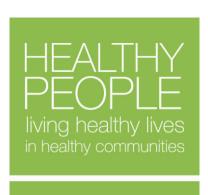
Safeguarding vulnerable people from harm is a legal and moral duty. We will expect providers to demonstrate compliance with these duties and provide evidence of a culture that supports vulnerable people and their needs and ensures that staff are appropriately trained and supported when dealing with safeguarding issues.

The Equality Act Duties will be monitored and supported through contractual arrangements. This will ensure that there is equity of outcome and equality of access for people with protected characteristics.

There will be an expectation that workforce changes and Cost Improvement Programme requirements will be shared with the CCG and that there will be clinical agreement of these between the provider and the CCG.



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#### Northern, Eastern and Western Devon Clinical Commissioning Group

# CF04 – The Top 6 Commissioner Priorities 2014 - 2016





## **CF04 : The Top 6 Commissioner Priorities**

Publica	Publication Date for this Module : 20 <sup>th</sup> December 2013							
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#### Introduction

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Background and context**

Our combination of intentions seeks to balance equity of outcome, timely and reasonable access and value for money in the provision of services for our entire population. Reduction of health inequalities will focus on outcomes and on access. Investment may be made on a differential basis in order to achieve this.

The necessary transformation of the system will focus on the provider landscape and we can anticipate consolidation of expertise and provider development in line with the location of needs, consistent with the recommendations of the Keogh Review. A key next step with Local Authorities, specialist and primary care commissioners and health providers is to embark on the design which delivers and sustains explicit health and social care outcomes and begins from an ambitious scope for the Better Care Fund (previously the Integration Transformation Fund).

Explicitly, this will require reinvestment of current resources. An ethical framework will guide the inevitably difficult investment and disinvestment decisions across competing priorities. Such decisions must be taken. We would look for and expect provider support in reaching and implementing such decisions.

We intend to establish with providers a mutual responsibility for:

- managing the demand for services and;
- lowering the commissioned costs and provider unit costs of provision.

This to be supported through contracting mechanisms, strategic relationships and creative use of local flexibilities in tariff arrangements. Our emphasis is sustainability and quality. Lowering of unit costs and of demand in planned care in particular, to support shifts of resource to meet unplanned and emergency demand in the most appropriate settings of care, will be inevitable.

Patients and carers will experience seamless, coherent pathways for chronic and acute conditions with an emphasis on keeping well, early diagnosis, shared decision-making, supported self-management and independence.

The local commissioning landscape itself will undergo closer alignment to ensure coherent approaches across primary care, specialist commissioning, public health and social care leading to a single, straight-forward strategy.





#### Introduction

Northern, Eastern and Western Devon Clinical Commissioning Group

#### Finance, contracting and commissioning plans:

- On 4 December 2013, we launched CF01, our Commissioning Intentions document. This set out our high level intentions for 2014-2016
- Since then we have also issued, our Quality Schedule covering the same time frame
- CF04, our detailed plan, is released today, 20
  December 2013 and is accompanied by CF05, our
  contracting principles and CF06 the second, more
  detailed version of our medium term financial plan. It
  is recommended that these three documents are read
  together

#### **Next steps and actions:**

- A further suite of detailed commissioning intentions will be published on 10 January 2014
- We will publish an ethical framework to underpin prioritisation decisions
- We will continue to develop a mutual understanding of benchmarked opportunities
- We will further develop and publish detailed cost, quality, rationale and implementation descriptions of our commissioning intentions

#### Our intentions focus on the top 6 issues

This plan sets out, in detail, our initial 6 priority areas for commissioning change during 2014/15. These are:

- 1. Right care targeting resources to best effect
- **2. Targeted follow-up care** targeting resources to best effect
- **3. Elective orthopaedic care** focussing on conservative management and evidence based practice
- **4. Non-elective care** transforming our urgent care system with a real emphasis on services for frail older people
- **5. Individual patient placements** ensuring that individuals are cared for in the best setting to improve their outcomes and longer term goals
- **6. Diagnostics** standardising our approach to diagnosis and management planning





#### The Next Suite Of Plans

Northern, Eastern and Western Devon Clinical Commissioning Group

The next suite of detailed plans will be published on 10 January 2014 and will include the following commissioning/contracting intentions:

- · Ambulance conveyances
- Children and young peoples' services
- · Consultant to consultant referrals
- · Continuing healthcare
- Dermatology
- Diabetes
- · Elective care definition of admission
- · End of life care
- Enhanced recovery (medicine)
- Enhanced recovery (surgery)
- · Learning disabilities
- Mental health
- Non-elective care definition of admission
- Ophthalmology
- Paediatric definition of admission
- Pass through drugs
- Person care market development
- · Personal health budgets
- · Rapid access
- Respiratory
- Use of technology





## **Health and Well-Being Boards**

Northern, Eastern and Western Devon Clinical Commissioning Group

Our Chair and a number of our Executive Directors are members of the Health and Well-Being Boards in Devon and Plymouth. We will continue to work alongside our partners to deliver the strategies of these Boards alongside the strategies of our own organisation.

#### Plymouth's Health and Well-Being Priorities

Five key priorities for action to explicitly address health and well-being related areas:

- Inequalities in all plans through target setting, re-focusing investment and rigorous use of equality impact assessment
- To shift the focus of investment to address prevention and health promotion, particularly in specified areas
- Mental health promotion
- To directly address identified issues of access and take-up of specified services
- To further develop services to promote independence

#### **Devon's Health and Well-being Priorities**

The priorities are based around four strategic themes:

- Early family intervention and support encompassing issues such as the prevention of sexual and domestic violence, employment and the family as a safe environment
- Lifestyle interventions and the prevention of ill health - incorporating healthy, eating and exercise - and increased personal responsibility for health and wellbeing
- Older people including promoting independence
- Social capital and the building of communities





## **Ensuring Strategic Alignment**

Northern, Eastern and Western Devon Clinical Commissioning Group

	NEW Devon CCG strategic ambitions							
Commissioning Intentions (Top 6 issues)	Preventing people from dying prematurely	Enhancing quality of life for people with long-term conditions	Helping people to recover from episodes of ill health or following injury	Ensuring people have a positive experience of care	Treating and caring for people in a safe environment and protect them from avoidable harm			
Right care		X		X	X			
Targeted follow-up care		X		X	X			
Elective orthopaedic care		X	X	X	X			
Non-elective care	Х	X	Х	X	X			
Individual patient placements		X	X	X	Х			
Diagnostics		X	Х	X				



# How Each Intention Impacts On Our Health And Well-Being Priorities



Northern, Eastern and Western Devon Clinical Commissioning Group

	Ply	mouth Healt	rities	Devon Health and Well-Being Priorities					
Commissioning Intentions (Top 6 issues)	To explicitly address health and well-being related inequalities	investment to address prevention	Mental health promotion	To directly address identified issues of access and take-up of specified services	To further develop services to promote independence	Early family intervention and support	and the	Older people	Social capital and the building of communities
Right care		X		X			X		
Targeted follow-up care		Х		Х	Х		×	Х	
Elective orthopaedic care		Х		X	Х		×	Х	
Non-elective care	Х	Х		X	X		Х	Х	
Individual patient placements	Х	Х	Х	Х	Х	Х	Х	X	Х
Diagnostics		X		X					





## **Commissioning Intentions Our Top 6 Issues**

1	Right Care	11
2	Targeted Follow-up Care	22
3	Elective Orthopaedic Care	27
4	Non-Elective Care	32
5	Individual Patient Placements (complex care)	39
6	Direct Access to Diagnostics	43





## **Commissioning Intentions Our Top 6 Issues**

1. Right Care





Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our intentions**

- To maximise the value that a patient derives from their own care and treatment
- To maximise the value the whole population derives from the investments in their healthcare

There are three work-streams to achieve these intentions:

- Reinforcing Commissioning Policy with regard to procedures of Limited Clinical Effectiveness.
   Implemented via contract
- Support to shared decision making.
   Implemented as a system change via CQUIN and/or headroom
- Targeted investment and disinvestments, implemented via contract

#### **Potential system levers**

Commissioning general practice or other providers (as appropriate)to support any (unlikely) return of work to primary care

#### **Engagement and involvement**

We will reinforce current LVP and LPP policies and their application and seek a confirmation of distribution to clinical and management leads. With regard to binding commissioner decisions which extend those commissioning policies, we will agree with providers, their responsibilities for implementing updates in clinical practice and in contracts.

Shared decision-making requires a particular focus via targeted specialty Clinical Pathway Groups/Clinician to Clinician groups.

Targeted investment/disinvestment will be under-pinned by an Ethical Framework

#### Volumes and values

Re-embedding the existing 7 limited value procedures: £861,000 (Plymouth Hospitals NHS Trust)

£354,000 (Northern Devon Healthcare NHS Trust)

£594,000 (Royal Devon and Exeter NHS Foundation Trust)

Expanding the existing 7 to 13 (slide 20) as outlined by public health: above (recurrent impact)





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#### **Background and context**

The challenge for the NHS is to get more for less in an era of "no more money". To do this, the NHS needs to shift its focus from lower value interventions to higher value interventions.

1948-1972 Free
1980s Effectiveness
1990s Cost-effectiveness
2000s Quality & Safety

2010+ Value

Figure 1. Evolution of emphasis in healthcare investments

Value being defined as patient health outcomes relative to total costs:

"Value must be measured by outputs, not inputs. Hence it is patient health results that matter, not the volume of services delivered. But results are achieved at some cost. Therefore, the proper objective is...patient health outcomes relative to the total cost. Efficiency, then, is subsumed in the concept of value." Source: Porter ME, (2008). What is Value in Health Care? Harvard Business School.





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A summary of our right care intentions is simply to target investment and disinvestment. The rationale for the focused work-streams is as follows:

#### **Procedures of Limited Clinical Effectiveness:**

In common with all Clinical Commissioning Groups, NEW Devon CCG has long-standing policies which identify procedures of Limited Clinical Effectiveness. That is not to say that these procedures are of no benefit to anyone but that on balance their benefit is insufficient to be commissioned by default. Funding arrangements for exceptionality exist.

These policies received some renewed emphasis with providers in 2011/12 but they have not been strictly enforced. Save for isolated instances regarding particular procedures, the step change in volumes of procedures undertaken has not taken place to date.

	Volumes			Values				
	2010/11	2011/12	2012/13	2013/14 YTD	2010/11	2011/12	2012/13	2013/14 YTD
Limited Value Procedures	951	9857	9510	4996	£ 9,895,888	£ 8,442,028	£ 8,337,774	£ 4,304,752
Low Priority Procedures	5266	50737	50919	25916	£ 26,806,942	£ 23,220,428	£ 22,905,761	£ 11,714,658
Totals	6217	60594	60429	30912	£ 36,702,830	£ 31,662,456	£ 31,243,534	£ 16,019,410

Table 1. Volumes and values of LVPs and LPPs. 2010/11 - Year To Date

These figures are illustrated at a provider and procedure level at Annex 1.

We will commission with greater emphasis on the Prior Approvals process and decision-making with regard to exceptional funding.





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#### **Support to Shared Decision Making:**

International research suggests a 20% reduction in 'discretionary surgery' when Patient Decision Aids are used (Cochrane Collaborative Review).

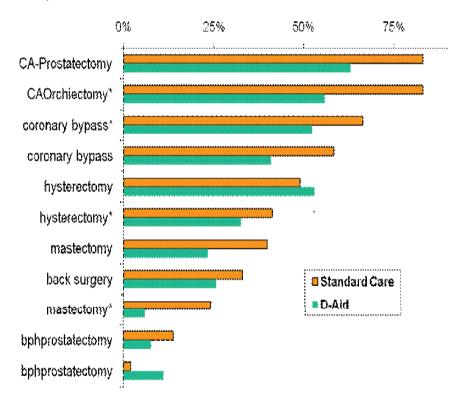


Figure 2. Decision aids reduce rates of discretionary surgery. (COCHRANE Database Syst Rev, 2011; (10): CD001431).





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The COCHRANE Systematic review supporting this work was completed in 2003 and has been refreshed in 2009 and 2011 as the body of knowledge regarding the effects of decision aids has grown and continues to conclude that such tools "reduce the choice of discretionary surgery and have no apparent adverse effects on health outcomes or satisfaction. The latest evidence suggests that not just tools but coaching in the process of deliberation has the greatest impact.

We will commission the use and promotion of evidence based tools and approaches to shared decision making.

At a specialty level, per capita costs have significant potential for reduction

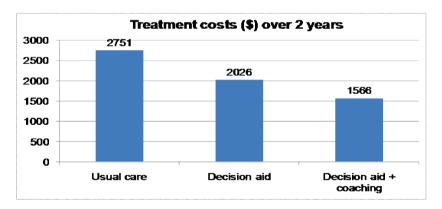


Figure 3. Decision aids and coaching in gynaecology



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Although decision support of this kind is advocated in the Enhanced Recovery approach to surgery which has gained ground in recent years, decision aids are under-exploited. Additionally, some research describes a mismatch between clinician and patient expectations in this regard which would not naturally lead to the consistent implementation of decision support. Barriers and facilitators for shared decision-making are well described in the literature

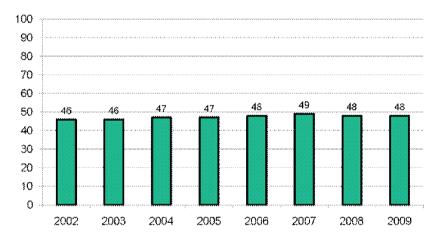


Figure 4. Wanted more involvement in treatment decisions. (NHS Inpatient surveys)



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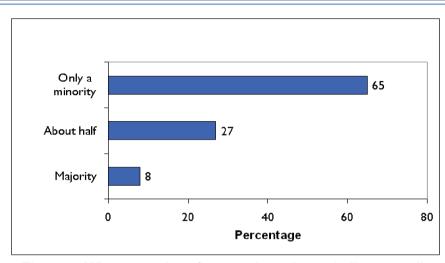


Figure 5. What proportion of your patients do you believe actually want more information than they currently receive on their treatment and its management? (SOURCE: Doctors.net.uk)

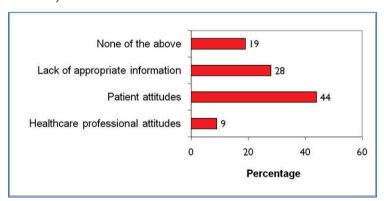


Figure 6. Which of the following do you think is the biggest barrier to increased patient engagement? (SOURCE: Doctors.net.uk)



#### NHS

### 1. Right Care

Northern, Eastern and Western Devon Clinical Commissioning Group

Additionally, compared with patients who have decision support, patients who do not are:

- 59 times more likely to change their mind
- 23 times more likely to delay their decision
- 5 times more likely to regret their decision
- 19% more likely to blame their practitioner for bad outcomes (Ottawa Hospital Research Institute)

It is now possible to significantly implement the intention for more shared and informed decision making. Thirty-Six decision aids now exist as part of the NHS Right Care Programme with a publication timetable of further decision support in 2014.

#### **Targeted investment**

Through our emphasis on the value our investments, for patients and for our population, we will focus on the evidence and rationale for current treatments. The outcome of this work will be an incrementally extended list of Procedures of Limited Clinical Effectiveness.

The work-stream spans particular interventions themselves, the specific indications for interventions and waits and access times for interventions. There will also be a focus on variation as a key line of enquiry to where thresholds or criteria may need to be established. For example, the South West has amongst the highest rates of knee replacement surgery (see Figure 7, which might be ameliorated by clearer emphasis on and support for weight loss (as is the case for some other procedures and treatments).

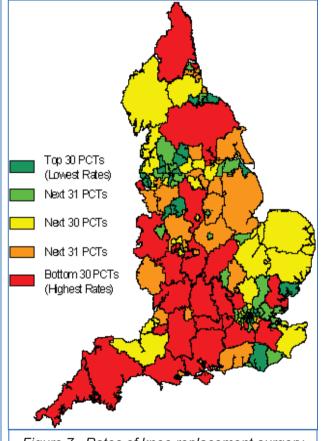


Figure 7. Rates of knee replacement surgery. (SOURCE: DH and NHS England).



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Targeted investments and particularly disinvestments will require a very robust and transparent process for decision-making and assessment of risk. An Ethical Framework will underpin this work and the work will be undertaken as a rolling programme of evaluation and decision making.

To be clear, the emphasis is not purely about the efficacy of any given investment; it is about the choice to invest in any given area limiting the ability to invest in another area of higher clinical priority.

The key lines of enquiry within this work-stream are as follows:

- Interventions and services suggested by clinicians
- Interventions and services suggested by audit and patient feedback
- Previous recommendations from effective practice and clinical policy committee
- · Review of recommendations and decisions from other CCGs and NHS commissioning bodies
- Guidance from NICE
- Systematic reviews and meta-analyses Cochrane and other

As an illustration, the following have been raised as potential candidates for additional criteria being used to target access:

- Carpal tunnel
- · Ultrasound guided (vs. Landmark guided) injections.
- · Knee arthroscopy in undifferentiated osteoarthritis in people aged over 65 years
- Shockwave therapy for tendonopathies
- Knee replacement (requiring a greater emphasis on weight loss)
- · Hip replacement (requiring a greater emphasis on weight loss





### 1. Right Care

Northern, Eastern and Western Devon
Clinical Commissioning Group

### **Next steps and actions**

- Reinforcing Commissioning Policy regarding Procedures of Limited Clinical Effectiveness:
  - · Prior approval scheme
  - · Process by which new commissioner decisions become binding on a provider
- Shared Decision Making:
  - More detailed review of opportunities. Application of evidence base to local variation and to high cost and volume
  - Implementation plan
- · Targeted investment:
  - Publication of Ethical Framework
  - Publication of candidates for disinvestment
  - Publication of NICE Guidance implementation rules relevant to the CCG's processes
  - · Ratification of decision making process by CCG Governing Body





## **Commissioning Intentions Our Top 6 Issues**

2. Targeted Follow-up Care



Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our intentions**

- To support providers in the development and implementation of innovative, co-ordinated and technology-driven approaches to the management of patients who need a clinical follow-up or continued management of long-term conditions.
- To reduce and remove unnecessary follow-up appointments for patients and their carers; improving patient experience and reducing demand on resources.
- To ensure patients receive the best possible coordinated approach to follow-up care, in the right setting, by the right person, in the right timescale and without duplication.

#### Volumes and values

Planned savings over the next 3 years (2014/15 onwards) are £7.8m based on the upper quartile opportunity and a limited range of specialties.

We are working on the assumption that we will save (full year effect):

- £3.0m in 2014/15
- £3.0m in 2015/16
- £1.8m in 2016/17

### **Potential system levers**

**Local tariffs** – to enable headroom for re-investment towards innovative approaches to follow-up care as an alternative to traditional face-to-face outpatient appointments.

**CQUIN** – to enable clinical teams to invest time in the redesign of specific local care pathways and shared best practice.

**Headroom** - an example of which could be investment in the establishment of nurse specialists, as described in the example set out in "background and context".





Northern, Eastern and Western Devon Clinical Commissioning Group

### **Background and context**

Each year in the NHS in Devon and Plymouth, there are over 860,000 (acute provider) follow-up appointments to check progress on a patient's condition, to undergo tests or receive results of tests. Whereas many of these appointments are entirely appropriate, a significant proportion of these visits are clinically unnecessary, create inconvenience and anxiety for the patient and waste valuable resources.

In the NHS, 70% of all outpatient appointments where the patient failed to attend (DNAs) are for follow-up appointments. For the three main acute providers in the NEW Devon CCG catchment, this represents 70,000 DNAs per year for follow-up appointments. This is a huge waste of NHS resource and a reflection for many patients that they do not feel their follow-up appointment is necessary. We will use our Devon Referral Support Service to enable the necessary transformation in this area.

There are significant benefits that can be obtained by avoiding unnecessary follow-up visits and providing necessary follow-up care in the right setting. Key outcomes include:

- · reduced number of follow-ups in the patient journey
- reduced DNA rates
- · increased level of nurse-led follow-ups where appropriate
- redirection of consultants' time to more appropriate clinical priorities
- · reduced follow-up appointments creating capacity to see new patients sooner
- · follow-up in the community near to home
- choice for the patient
- patient is seen by the right person, with the right skills, in the right place and at the right time specified by protocol
- enhanced continuity of care in nurse-led clinics for frequent visitors (particularly important for people with cancer)
- enhanced nurses/therapists role (in outpatient setting and primary care)
- · reduced duplication and non-value added time
- enhances timely decision making (single visit results available)





Northern, Eastern and Western Devon Clinical Commissioning Group

### **Background and context**

There are well established infrastructures for reduced patient follow-up and better patient experience which are under-exploited in Devon. For example - follow-up of patients with diagnosed prostate cancer, whereby men's PSA levels are monitored by a clinical nurse specialist 'remotely' via a blood test undertaken in the patient's GP practice. Patients are only called in for a follow-up appointment if the results of the blood test suggest change in their management plan or a more detailed consultation. If the PSA remains within an expected range, the patient receives a letter of confirmation, and is saved a visit to hospital. We will commission more of this innovative approach to follow-up care.

The scope of targeted follow-up care will extend beyond acute secondary care, to areas of mental health and children's services. The use of outpatient care models in mental health services should be considered as an outdated approach to mental health treatment and care giving. There is a particular problem about high DNA rates across the country in mental health outpatient clinics with a range of initiatives to address this not really delivering sustained improvement.

There is a priority to ensure that the functions of Community Mental Health Teams are delivered close to, or within, primary care settings, with an emphasis on close working between psychiatrists and GPs. Patients with a mental health condition should be seen by mental health specialist services for the minimum period time so that capacity is maintained, institutionalisation and dependence is reduced and links to community, home and employment are maintained. We will support the redirection of resources from outpatient work in mental health and replace with incentivised and contracted (in both primary and secondary care) activity for mental health in primary care and/or community settings. Our aim is to commission "primary care psychiatric liaison" as a model of care.

For children's services there are not many services where follow-ups are monitored specifically, such as speech and language and occupational therapies. Our focus in this area will not be to reduce the number of follow-ups per se but a focus on a course of treatment or intervention, working with others providers to deliver programmes of planned intervention.





Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Engagement and involvement**

The issue of reducing follow-up appointments across all the key providers contracted by the CCG has been a long-standing and sometimes contentious issue throughout numerous clinical pathway meetings. So far, limited success has been achieved in this area despite widespread evidence and clinical support that alternative approaches to follow-up care can be achieved without the need for the patient to have a face-to-face appointment.

Working with our clinicians in both primary and secondary care, we will develop the most appropriate and safe mechanisms for returning patients to the care of their registered GP.

#### **Next steps and actions**

Commissioning teams will work collaboratively with both their respective local providers and colleagues across NEW Devon CCG to develop a truly integrated and innovative strategy for the sharing of good practice and innovation in follow-up care. Plans will be tailored to ensure local variations in the provision and availability of follow-up care are considered. However, NEW Devon CCG will commission and contract for follow-up care, where appropriate, without the need for a face-to-face appointment, and in alternative settings to outpatient clinics.

We will also lead on the redesign of specific and agreed high-impact care pathways of follow-up care, drawing on best practice and established models of care from across the healthcare community.

We will free providers to adopt safe but radical changes to the way follow-up care is managed, putting patients' needs first and ensuring resources are directed towards a sustainable model of provision.





## **Commissioning Intentions Our Top 6 Issues**

3. Elective Orthopaedic Care



### 3. Elective Orthopaedic Care

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our intentions**

We will implement an evidence based, integrated model of elective care, intervening at the optimum point for maximum benefit. This will improve value for patients, reduce costs and ensure future sustainability in the face of increasing demand.

There will be an increasing focus on prevention and effective conservative management will be the cornerstone of care. Individuals will be empowered to make decisions and initiate care. GPs will be better informed to support patient choices.

Clinicians and patients will view surgery as the 'least preferred' option not the 'end goal' but with an efficient route for referral to surgery where it is the most appropriate solution.

We will encourage direct access to services wherever appropriate and encourage the use of alternatives to the traditional face to face contacts and commission face to face contacts with patients only where there is demonstrable clinical value to patients.

Examples of similar in other areas of the UK i.e. West Pennine Partnership: http://www.pmskp.org and Bedford CCG: https://www.bedfordshireccg.nhs.uk/news

#### Volumes and values

Over the next 3 years we will make a total reduction in acute spend of £4.2m in elective orthopaedic non-trauma activity, hip and knee procedures (equivalent to an 11.5% reduction in the number of acute spells).

This is broken down as follows over the next 3 years as £1.7m (2014/15), £1.6m (2015/16) and £0.9m (2016/17) .

Currently the indicative impact in 2014/15 by provider is forecast to be:-

- Plymouth Hospitals NHS Trust £435k
- Roval Devon & Exeter NHS F Trust £532k
- Northern Devon Healthcare NHS Trust £84k
- Other providers (including Nuffield and Care UK) £678k

#### **System levers**

A range of measures including CQUIN, headroom and supporting the shift of work from secondary care to primary care are likely to be put in place





### 3. Elective Orthopaedic Care

Northern, Eastern and Western Devon Clinical Commissioning Group

### **Background and context**

The CCG spends £2.7m above average for the Southwest CCGs on elective orthopaedic non-trauma activity and £5.4m above top quartile. The biggest productivity opportunity is in the Western and Eastern localities with a smaller productivity opportunity in the Northern locality.

Orthopaedic spend has been increasing year on year and 80% of spend is on secondary care with 50% of spend on inpatient care with evidence of lower levels of investment into conservative management or avoidance. Our peer group areas indicate better outcomes for patients by shifting investment towards prevention and maintenance.

We appear to be different from comparator group i.e. we have standardised admission rates (SAR) that are 12% higher than the national average and 8% above that of the Southwest CCGs; a local settings of care audit in Plymouth showed that 4,521 bed-days could be saved, with 1,912 of those associated with elective orthopaedics if patients were discharged when they were deemed 'non-qualified' i.e. their level of need was below the level of acuity for the bed they were staying in. Prescribing of opioid and non-opioid analgesics and NSAIDs are significantly higher than the national average with associated gastro-intestinal, cardio vascular and renal risk.

There is room for improvement in the overall health gain for individuals as a result of hip and knee replacements, e.g. in 2012/13 NEW Devon CCG had average health gains as measured by PROMs for both hip and knee replacements. However, the pre-operative health state of patients indicated that we undertook primary hip and knee replacements on patients that were significantly healthier than most CCGs nationally (putting us in the bottom quartile). This suggests we may be operating earlier in a patients journey compared to the average nationally. This could be linked to the relatively high activity levels, SARs and acute inpatient spend we report.





### 3. Elective Orthopaedic Care

Northern, Eastern and Western Devon Clinical Commissioning Group

### **Background and context**

The current service provision in Devon suggests that there are inconsistent pathways and service offers across the community and variation between acute providers. Orthopaedic referrals have increased year on year across all sub-specialties and a significant number of patients suitable for primary care are seen in secondary care due to lack of commissioned alternative (conservative) capacity.

There has been an increase in replacement surgical activity due to an increase in activity since 2005 which appears to have coincided with the increased investment in orthopaedics in order to deliver an 18-week referral to treatment pledge. Historical increases in surgical capacity have resulted in potential overcapacity (very short waiting times can drive intervention e.g. arthroscopy).

It is reported by individuals referred for treatment that they do not feel well informed before their referral and this is supported by the fact that approximately 30% of people do not go on to surgery at out-patient review.

The national direction of travel, recognition of the growth in orthopaedic demand and the variable quality and outcomes for patients is set out, and supported by Lord Darzi, in 'Getting It Right First Time - Improving the Quality of Orthopaedic Care within the National Health Service in England' (Briggs, 2012).

"The concept of "getting it right first time" is to identify and administer the correct treatment at the appropriate time, to a high standard with minimal complications. Not only will this reduce mortality and morbidity rates, but also reduce the need for often expensive revision surgery."



### NHS

### 3. Elective Orthopaedic Care

Northern, Eastern and Western Devon Clinical Commissioning Group

### **Engagement and involvement**

Fach of the Localities has some form of clinical engagement group for orthopaedic care. Whilst limited work has been undertaken in terms of engaging with people with orthopaedic conditions or disease specifically, there has been good engagement with people in Devon regarding their ambition for their future health, care and well-being through the Transforming Community Services work programme. This programme has told us that whilst some want to be completely in control of their health and wellbeing, others (the minority) want health staff to be completely in control and the vast majority of respondents are ambivalent. Partnering CCGs are also involved in the relevant Clinical Pathway Group and the Orthopaedic Project Group and Local Authority partners in Plymouth, including those commissioning children's services and public health, have been involved in the development of a proposed new model of care.

Patient reported outcome measures (PROMs) are used to identify improvement areas.

Data from referral management system on patient choices being made at the point of referral and reasons. There will be patient involvement in selection of provider if reprocurement is required to achieve outcomes.

#### **Next steps and actions**

The following next steps will be undertaken as soon as possible:

- Agreement on the generic orthopaedic care pathway
- Development of a detailed service specification
- Understanding of the current community service provision across the CCG compared to the new model of care and clarity on any additional investments that may be required to achieve the improvements in the care pathway. This may include additional investment in:-
  - Health promotion and primary prevention
  - Community services focusing on self management including physiotherapy
  - Community diagnostic service





# **Commissioning Intentions Our Top 6 Issues**

4. Non Elective Care



Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our intention**

We will commission optimal pathways of care for people presenting to secondary care in an unplanned way, specifically:

- We will work with providers of secondary care to establish child friendly pathways for children who, following assessment, need urgent access to specialist opinion and;
- In recognition of the increasing needs of older people with complex needs we will work with providers to commissioning pathways of care, that include both multidisciplinary and comprehensive geriatric assessment, in all acute hospitals that make rapid admit and discharge decisions and establish pathways of ambulatory care for all secondary care specialities.

We will re-commission pathways of urgent care in each locality, re-specifying our requirements for both out of hours primary care services and minor injury units, treatment centres and walk-in centres, to ensure that people across Devon can access the urgent care services when they need them.

The introduction of new "front door" services with capability to make rapid assessment/discharge decisions and access to ambulatory care across all pathways and specialities will mean that a significant proportion of this £9m activity could be provided in an ambulant setting on the same day and be more appropriately remunerated using out-patient tariffs.

We will continue to transform community services across Devon and commission differently for adults with complex needs. In response to the significant demographic challenge in Devon we plan to move from a bed based model of reactive care to a model of care that is closer to home and places prevention and well-being at its heart. We will start this journey in some localities in 2014/15 by changing the use of some our community hospitals. It is our intention to use funding released from bed based care to increase the capacity of our community teams, the total volume of care that is available for people living in Devon and ensure that all people living with a dementia and/or cognitive impairment are identified.



### <u>NHS</u>

### 4. Non Elective Care

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Volumes and Values**

A review of contract activity information across all acute providers identifies a volume of emergency activity, at HRG level, where an 'admission' has happened without any procedure taking place. The cost of this activity at full tariff is £9m in 2014/15.

#### **Potential system levers**

It is our intention to use contracting levers and quality payments to support the remuneration of true and extensive ambulatory care and a significant reduction in unqualified admissions across all providers.

### **Engagement and involvement**

Public health summits have been held in market towns across Devon and Plymouth to introduce the CCG's transforming community services process to allow the attending public to give their views on how they would like the services in the community to be provided in the future.

Other forms of engagement have included meetings with local healthcare professionals, stakeholders including the voluntary and community sector, councillors and members of the community. Our processes of involvement and engagement of local people and their communities are on-going in each locality.

Each locality has systems to ensure engagement for managers and clinicians from all providers. A series of pan-Devon conferences with leaders drawn from across the health and social care system have occurred in the year to develop the process and emerging consensus for unplanned care and community services.

Conversations with the public through our TCS processes have demonstrated that many people want more control over the lives and their health, want to be cared for in their own homes and to have a more preventative, holistic approach to their health, well-being and care.





Northern, Eastern and Western Devon Clinical Commissioning Group

### **Background and context**

The population of the area served by our CCG is approximately 898,800 and expected to rise by 11.9% by 2026. The population of the CCG aged 65 or over is 22%, which is 3.54% above the national average for people aged 65 and over. Eastern Devon's population of people over 65 today won't experience the same proportion of people over 65 years currently in Eastern Devon until 2027. It is estimated that the proportion of persons 85 years and over in the sub-locality Wakley today, (5.28%) compares to England in the year 2042.

In 2012, people 65 years and over residing in the CCG area accounted for 49.2% of all emergency admissions. The highest rate is observed in those 85 years and over.

If current rates of secondary care in the CCG remain constant, the number of emergency admissions as a result of increases in the ageing population is set to increase by 9.5% in less than ten years. Elective admissions will increase by 8.6%. An annual reduction of 2.02% in age-specific emergency admission rates would be required to maintain admission levels in over 65s at the 2012 baseline.

In 2012 there were 15,393 people over the age of 65 living with dementia, predicted to rise to 7,728 by 2020 (an increase of 21%). In Devon overall, it is predicted that 221 people aged between 30 and 64 have early onset dementia, most prevalent in the 50-59 age band. Devon's average prevalence of dementia is 6.56% in the over 65 age group, but Sidmouth, Seaton, Exmouth and Exeter all have higher rates.

1 in 10 people provide unpaid care for family or friends. This means that more than 72,400 people (of all ages) in Devon are carers, which will rise proportionately as the population increases. 14,400 (20%) provide more than 50 hours of care and support per week. Of the 8,700 carers in Devon who are aged 65+, 2,884 consider themselves to be in poor health, presenting risks for both the carer and the cared for. In the CCG, the number of people aged 65 and over who had had a fall in the last 12 months was 22,940, this is predicted to increase to 27,047 in 2020 (an increase of 18%).





Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Northern Locality will:**

- Work with South Western Ambulance Service (SWASFT) to further develop work-streams to reduce conveyance
  to hospital rates, and avoidable admissions based on the principle of 999 ambulances being "mobile urgent
  treatment services". We will reduce both attendances and emergency admissions to an acute hospital where the
  patient's condition can be safely and quickly managed elsewhere
- · Improve the discharge process for individuals
- Continue and expand the benefits associated with Transforming Community Services (TCS) as currently trialled in Torrington. This will be based on both needs assessment and an Asset-Based Approach to develop locality based systems founded on the principles of:
  - Improved usage of community hospitals and re-targeting health investment released by re-evaluating community in-patient beds
  - Increased investment in the skills of primary care and community nurses, including clearer specification of the district nursing role
  - Locality-based trials and public consultation to ensure that each community, share in the vision for change
    including communities who, through historical accident, have no community hospital to ensure that quality
    of, and access to, care is equal for all of our residents
- Use the opportunities presented by the redesign of out-of-hours GP services to better align services across the Northern Locality with the aim to reduce Emergency department (ED) attendances and avoidable admissions
- Work with all services, to develop more robust healthcare responses for frail older people, particularly those in care homes
- Develop a clear vision for what is required for a Single Point of Access, integrating it with all of the developments above.
- We will work with partners in the Eastern Locality and the Northern Devon Healthcare Trust to develop a locality-based model of delivery for minor injury and minor illness, delivery taking into account the geographical and population-level issues in the Locality





Northern, Eastern and Western Devon Clinical Commissioning Group

### **Eastern Locality will:**

- Continue to commission front door services for both paediatrics and adults with complex needs. The locality
  will work with the RD&E to extend further, to include all specialities, ambulatory pathways of care for people
  who do not need to be admitted to an acute hospital. This intention will seek to reduce the total number of
  admissions made to the RD&E and lower the total unit cost of the urgent care pathway for adults and children
  presenting to the RD&E in an unplanned way.
- Following the completion of current consultation and options appraisal, introduce a new model of service and configuration of minor injury/urgent care service. The consultation is expected to conclude in January and confirm the total number of minor injury units, walk-in and urgent care centres that are required across the locality. The consultation will also confirm the extent to which enhanced provision needs to be available in the community through Any Qualified Provider or from primary care. This aims to reduce the cost of providing urgent care across the locality and release funding for investment in community pathways to increase the total capacity of community nursing and therapy services and the increased provision of care at home.
- Re-specify the pathway of care for people who have suffered a stroke. The on-going consultation will conclude
  in March and confirm if a fully integrated pathway of care that includes the acute stroke unit, community
  inpatient rehabilitation beds and supported discharge service will be created across the locality. The locality will
  understand in early February if there is a need to re-procure this entire pathway. This intention will ensure equity
  of outcomes for people who have suffered stroke across the locality.
- Consult on a new model of care with the communities in Eastern Devon. The locality will evolve hubs in Budleigh Salterton and Moretonhampstead and explore further changes of use in Exeter, Crediton and Ottery St Mary. Monies released from the change in use of these hospitals will be used to increase the capacity and secure robust clinical leadership of cluster teams and services.
- Improve the discharge process for individuals.





Northern, Eastern and Western Devon Clinical Commissioning Group

### **Western Locality will:**

- Continue to commission NHS 111
- Participate in the re-commissioning process for GP out-of-hours provision
- · Review our Minor Injury Units and minor injuries provision, determining the optimal option for the future
- · Review the Acute GP Service, determining the optimal service for the future
- Extend the paediatric out-reach service (PACOT)
- · Work with NHS England's Area Team to develop the role of GPs and pharmacists in managing urgent care
- Commission and support the implementation of a revised frailty pathway
- Work with GPs and the Area Team to explore the concept, and impact, of having the GP at the cornerstone of all patient care with services wrapped around GP and the patient
- · Re-design services to ensure that individuals receive as much care a possible in their own beds
- Commission 24/7 services where evidence supports need
- Reduce delayed transfers of care by rolling out a "pull" philosophy community providers will pull people out of hospital at the best moment in their recovery
- · Commission the development of a fully integrated workforce, staffing single points of access and egress
- Commission the development and roll out of enhanced recovery (medicine) based on national best practice
- With our Partnerships Directorate and Local Authority partners, develop pooled, personal health and care budgets for a range of preventative measures and optimise long term conditions management
- Roll out the "virtual ward" to the rest of the Western Locality (currently being piloted in a sub-locality)
- Ensure that assistive technology becomes a core part of the service offer for individuals in the Locality
- Treat service users as part of the integrated team
- Truly put the individual at the centre by rolling out personal health and care budgets during 2014/15 to a small group of individuals
- Commission integrated pathways for individuals with long term conditions, ensuring that the majority of care can be offered by primary care, in the community, with a very small proportion (maybe less than 10% of individuals) needing to access specialist, secondary care provision





## **Commissioning Intentions Our Top 6 Issues**

5. Individual Patient Placements

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# 5. Individual Patient Placements Complex Care



Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our intention**

- Our ambition is to reduce the use of out of area placements for adults and children, and commission care for more people with complex problems closer to home. This ambition is set within a context of increasing numbers of people being placed out of area, and recognition of the system-wide commissioning arrangements which could create perverse incentives in the system. Our focus is upon the individual patient, to ensure best care arrangements which encourage and promote recovery.
- We will achieve change by commissioning services that are integrated, personalised, flexible and responsive to changes in individuals' circumstances, delivered within the least restrictive environment to meet needs, and as close to home as possible. We will challenge the current system model. For children we will commission an Assertive Outreach service with NHS England.

#### Volumes and values

Successful repatriation of service users from secure beds may lessen the number of secure hospital and CAMHS Tier 4 bed days required annually. However, this saving will currently be realised by NHS England rather than the local CCGs without the release of resources to the CCG. New ways of working with individuals who may previously have been cared for out of area, can also generate pressure on existing community service providers and will incur a cost to the CCG without a shift in investment. This will require further discussion with NHS England to enable us to work collaboratively to commission care provided in the most appropriate setting.

In 2014/15 we aim to reduce current spend on all IPP's by 10% and review the potential to reduce the budget by a further 10% in the subsequent 2 years. Resources will be redirected to develop local services providing appropriate care and support through a range of strategies including preventative strategies, improving system flow, more effective utilisation of locally provided services and new ways of working. This will release and redirect approximately £1.5m.



# 5. Individual Patient Placements Complex Care



Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Background and context**

As part of their experience of learning disability, mental health and social care support and treatment services, considerable numbers of people, both adults and children, are placed in facilities in the public, independent and third sectors for support. In many but not all cases, services are local to families, friends and services. For some, services may be at a considerable distance from their usual support networks. All out of area service use can impact on people's contact with family and friends and limit opportunities for social inclusion, employment, education and independence. From a commissioning and financial perspective, use of out of area services also means that funding and specialist skills are being lost to the local system that could be used to improve local capacity, capability and skills.

The Winterbourne View action plan contained clear expectations regarding the reduction in out of area placement for people with a learning disability. This plan focused on overcoming the negative consequences of out of area placement and the learning from individuals' experiences of Winterbourne View can be applied to all patient groups.

Once an individual is placed out of area there are a number of challenges for both the individual, their families and service providers. It is preferable to keep people locally focused, where their needs can be met, and this is our ambition. It is considered preferable to prevent further out of area placements or to reduce them significantly and concentrate on repatriation once the primary recovery objective has been achieved. This will have the impact of limiting the expansion of IPP spend and reductions will follow once the number of placements/days are reduced.

This plan has been developed in conjunction with Southern Devon and Torbay CCG, local providers and with NHS England. Effective planning and rehabilitation can lead to many people returning to their area of origin and to lower levels of support – 63% in one study (Killaspy et al 2009). This plan will be focused on ensuring that support and treatment prevents crises and community breakdown, therefore mitigating the need for IPPs.



# 5. Individual Patient Placements Complex Care



Northern, Eastern and Western Devon Clinical Commissioning Group

### **Engagement and involvement**

- All service users with complex needs in the community will be involved in the design of their own individualised support plans.
- All stakeholders will be involved in the development of an integrated strategic commissioning plan for Individual Patient Placements.

#### **Next steps and action**

We will work with providers to continue to improve clinically led referral and individual care review processes. We will focus on treatment outcomes, discharge planning and contingency planning, both where service users are currently out of area and within local mental health services. For example, we will continue to use the 'blue light' protocol where escalation occurs for anybody with a learning disability being considered for placement out of area. This protocol results in a multi-disciplinary discussion about alternative services and prior agreement of any short term additional service requirements to ensure a safe, local alternative.

We will focus on the prevention of out of area placements through the provision of alternatives to hospital admission and the redesign of pathways for

### Next steps and action cont/d

individuals requiring step down from higher levels of secure care.

We will consider utilising a risk stratification tool to identify those individuals most at risk of repeated admissions or an out of area placement and target resources to support these individuals appropriately.

We will improve services for people with complex needs and personality disorder and improve the integration of services for people with a dual diagnosis. We will identify service gaps and develop commissioning plans where these are identified.

We will continue to focus on re-commissioning PICU services with the primary intention of reducing the need for acute beds, followed by a greater focus on managing complex patients in local facilities.

There is a need to develop high quality multi-disciplinary CAMHS Teams as an alternative to in-patient care for children and adolescents with complex mental health needs. We will continue to work with partners to prevent complex mental health needs through early years intervention strategies for specific families.





# **Commissioning Intentions Our Top 6 Issues**

**6. Direct Access to Diagnostics** 



Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our intentions**

To reduce the variance currently observed across NEW Devon CCG. This reduction in variance will look for peer reviewed, evidence based national guidance to harmonise the requesting and use of diagnostics. These commissioning intentions will focus on the following elements of the service:

- Standardised QOF Diagnostics
- Standardised Order Sets
- Standardised Care Pathways
- · Standardised Tariff
- Standardised Commissioning/Decommissioning of Diagnostic tests

The harmonisation of the use of diagnostics will reduce unnecessary costs on the assumption that:

Variance = Waste = Sub optimal care = Increased cost

#### **Volumes and Values**

Standardised Tariff and Standardised QOF/Order Sets/Care Pathways:

Savings during 2014/15 could be as much as:

£2.5m - Northern Devon Healthcare NHS Trust

£ 0m – Plymouth Hospitals NHS Trust

£1.0m – Royal Devon and Exeter NHS Foundation Trust

Further work is required to develop the assumptions behind these numbers and agree implementation plans for changes to testing protocols.

### **Potential system levers**

Local prices will be reviewed in accordance with national guidance. Clear test protocols will be described within the contract.





Northern, Eastern and Western Devon Clinical Commissioning Group

### **Engagement and involvement**

There has been significant clinical engagement in commissioning of diagnostics. Those engagement processes have involved:

- Support from the relevant Diagnostic Consultant to Consultant or Clinical Pathway Groups
- Promotion of key operational and clinical change at GP education days
- Promotion of key operational and clinical change to Practice Manager and Practice Nurse meetings
- Ensuring that secondary care clinicians have fully supported those changes in primary care and have been actively involved in the delivery of guidance on the key topics

### **Background and context**

The diagnostic commissioning team have identified that patients do not receive the same diagnostic response for the same disease diagnosis and management across the footprint of NEW Devon CCG. This results in a variance of service according to geography. Using evidence based, peer reviewed national guidance as the basis for the standardisation of the use of diagnostics across NEW Devon CCG we aim to minimise that variance and provide patients and clinicians the assurance that the diagnostic service provided in primary care meet those national standards of care.





Northern, Eastern and Western Devon Clinical Commissioning Group

### **Next steps and actions**

The key element of this standardisation of care is that the recommendations contained in this document are delivered as a whole CCG response to reduce variance and not as a locality by locality initiative. These recommendations are:

### **Standardised QOF Diagnostics**

The current QOF activity accounts for approximately 25% of all primary care use of the diagnostic service. The type and number of tests requested for each QOF subset is not standardised across NEW Devon CCG and currently shows considerable variance from surgery to surgery, locality to locality. Using evidence based, peer reviewed national guidance commissioners will look for delivery of the same diagnostic response for the same QOF subset regardless of location. Work on the development of common QOF diagnostics has already been initiated.

#### **Standardised Order Sets**

The delivery of electronic requesting in primary care (Order Comms) enables the specification of the same order sets (protocol guided investigations) for any specific disease diagnosis and management regardless of location. Again, the constituents of the order sets will be determined by evidence based, peer reviewed national guidance. Commissioning intentions will use the work on the development of common order sets that has already been initiated using the expertise of GP's, secondary care consultants and specialist scientists.

#### **Standardised Care Pathways**

A major element of the diagnostic commissioning team's recent work has been in the development of standardised care pathways and the sharing of this work across the localities of NEW Devon CCG. The Clinical Cabinet, comprising of acute providers, lead GPs from each locality and the secondary care pathology leads from each provider Trust, and the future commissioning intentions will support and develop the continued delivery of the same care pathways across NEW Devon CCG which again will reduce the variance and waste currently identified across its footprint.





Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Next steps and actions**

#### **Standardised Tariff**

The considerable inequity of diagnostic tariff across NEW Devon CCG is apparent and previously identified. The involvement of commissioners in the development of new procurement models will look to reduce these inequities while maintaining the quality of the service and the engagement of clinicians from both primary and secondary care.

Local prices will be reviewed, in accordance with national guidance, with the aim of agreeing a CCG wide currency system and tariff to support the care pathways.

### Standardised Commissioning/Decommissioning of the diagnostic repertoire

Diagnostics is a service based on technology and science. As advancements are made in that technology and science, new diagnostic tests become available. Currently, there is no standardised approach to the commissioning of these new diagnostic processes and conversely, little common approach to the decommissioning of redundant tests or those with limited clinical value. The delivery of some new diagnostics has, in the past, resulted in increased costs for commissioners without patients seeing any clear improvements in the service delivered. Using the Clinical Cabinet as a decision making body that can utilise the specialist knowledge of secondary care and research groups, we will continue to support this process of commissioning/decommissioning and to formalise the proposed model into the current assurance structures of NEW Devon CCG such as the Clinical Policy Committee.





### **Appendix I: Elective Orthopaedic Care**

Northern, Eastern and Western Devon Clinical Commissioning Group

Extract from 'Getting It Right First Time - Improving the Quality of Orthopaedic Care within the National Health Service in England' (Briggs, 2012). Sign-up by all key stakeholders: Royal Colleges, Patients Assoc, British Orthopaedic Assoc.

"The concept of "getting it right first time" is to identify and administer the correct treatment at the appropriate time, to a high standard with minimal complications. Not only will this reduce mortality and morbidity rates, but also reduce the need for often expensive revision surgery.

Appropriate primary care pathways with a referral system designed to allow the right patient to be seen by the right specialist at the right place at the right time in secondary care by "getting it right first time", thereby improving patient outcomes and satisfaction and reducing complications which will deliver significant annual savings.

Appropriate patient follow-up: The introduction and use of new implants within the NHS needs further regulation with appropriate Specialist Units, with a proven track record of translational research, taking on a leading role in their evaluation.

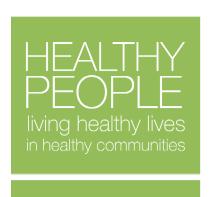
Instead of orthopaedic departments and clinicians acting alone, they should form part of a network of hospitals and treatment centres forming specialist orthopaedic units, with ring-fenced elective beds, working to quality assurance standards. This will generate standardised protocols for prostheses and treatment pathways across the NHS benefiting patients, thereby improving outcomes and reducing complications.

Specialist services, such as revision hip arthroplasty, should only be undertaken in either a specialist unit, or as part of a specialist network following agreed quality assurance standards, all aspects of which should be subject to regular performance review including audit. This will inform the CCGs and NCB so in future years networks with the best outcomes secure funding."

Advantages of this solution

- Patient focused
- Clinical solutions driven by frontline clinicians
- Improving quality
- Significant cost savings
- Significant reduction in risk of rationing







### Northern, Eastern and Western Devon Clinical Commissioning Group

### CF05 - Contracting Principles 2014 - 2016





### **CF05: Contracting Principles**

Publication Date for this Module : 20th December 2013					
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### NHS

### **5.1 Overview**

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our intention**

- Our intention is to contract and negotiate in a way that supports our ambition to work in collaboration with all providers to create locally sustainable health systems.
- In this document we describe our intention to start from national guidance in order to fully understand the challenge. It also describes how we will act if a traditional commissioning-provision relationship is used in any particular area.
- However, our ambition is to agree ways to vary these approaches to achieve maximum benefit for patients, providers and the CCG and use ideas from one area across the whole CCG.
- Manage risk to both parties through development of longer term agreements, extension of benefit-sharing arrangements and implementation of pace of change policy
- Incentivise targeted and non-face to face activity, where appropriate
- Contract to incentivise prevention and early intervention
- Work collaboratively with partner commissioners
- Enforce contractual terms and challenge noncompliance
- Work with providers and follow Monitor Guidance when agreeing local prices and departures from national tariffs

### **Background and context**

The CCG's Contracting Principles set out how we will conduct contract negotiations in order to support the CCG in commissioning safe, patient-centred services, within the local financial context.

We have outlined how we want to work with providers and communities in collaboration and we will work to produce contracts that support this. Notwithstanding this intent, we recognise that all contracts need to be based on the highest quality of technical contracting work that clearly and explicitly give an exposition of the financial, activity and quality position.

We will work within national guidance/NHS Constitution and Monitor's guidance regarding agreement of local prices and authorisation of departures from tariff.

Contracts will have an outcome-focused approach, that provides assurance regarding quality, safety and patient experience, and will facilitate change through the alignment of incentives and disincentives.

We will agree conduct expectations for negotiations for all parties.





### **5.2 Collaborative Contracting Approach**

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our intention**

- To contract in a way that supports our collaborative ambitions and ensure a greater degree of certainty and stability for both providers and commissioner, through mutually-beneficial risk management arrangements
- To develop longer term agreements
- To extend and embed risk/benefit-sharing arrangements for pass through costs
- To secure for both parties the opportunity to benefit from improvements in care and outcomes
- To work with providers to ensure that CQUIN payments can be earned in full, but reduce payments in accordance with Guidance when agreed outcomes are not achieved
- To continue to improve our definition of the portfolio of services provided across all contracts and link the funding to service specifications, currencies and key performance indicators with a particular focus on community services and mental health contracts
- To operate a standard Pace of Change Policy, applying equally to all providers
- · Incentivise targeted and non-face to face activity, where appropriate
- · Use contractual mechanisms to incentivise prevention and early intervention
- Work collaboratively with partner commissioners
- Enforce contractual terms and challenge non-compliance
- Work with providers and follow Monitor Guidance when agreeing local prices and departures from national tariffs

### **Background and context**

We want a contracting approach that is robust and based on the highest standards of technical contracting, but where we are able to use the information and analysis that we gain to work with providers in the most collaborative way to give us the outcomes we are seeking.

Providers have sought consistency from the CCG and we will move to standard policies wherever we can and to apply the same approaches, recognising the different areas we work in and two local authority partners and that opportunities and pace will need to be determined by local circumstances.

We will co-ordinate commissioning for our main providers and ensure that we work collaboratively with partner commissioners, as far as is practical to give a single, unified view in areas with an overlap of responsibility.





### **5.3 Negotiation Approach**

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our intention**

- To build on our model of commissioning and contracting for 2013/14 and strengthen for 2014/15 and beyond
- To further embed our CCG model with local application of a single, consistent, clear and robust framework
- To add senior expertise to negotiation teams for the two providers where we recognise the greatest challenge:
  - Tim Burke, CCG Chair to join the Plymouth Hospitals NHS Trust negotiation team
  - · Hugh Groves, CCG Chief Finance Officer to join the North Devon Healthcare Trust negotiation team
- To hold events that facilitate direct relationships at Chief Executive, Director of Finance and Chief Nursing Officer level throughout the negotiation process to ensure effective connection and oversight

### **Background and context**

The CCG commissions on behalf of different populations and it is important that local views drive our approach. We have created a single, clear, consistent and robust framework for commissioning in 2014 - 2016 and Locality and Partnerships Boards will endorse the local application of this overarching plan.

Locality negotiating teams will lead contracting discussions, supported by the high levels of expertise that our operating model affords in terms of Finance, Contracting, Business Intelligence, Patient Safety and Quality and other areas. This approach was largely successful for 2013/14 and we will strengthen it for 2014 - 2016.

We recognise that whilst most of our commissioning and contracting processes were successful in 2013/14 there are some areas where the scale of the challenge or the nature of the relationships have given outcomes that are in contrast to the overall picture. We are reaffirming our intention to create arrangements that allow for positive, collaborative outcomes in all areas and therefore identify two contracts where we will provide additional senior expertise that recognises the issues to be addressed.

We will be open and transparent and will hold workshop sessions in January, February and March 2014 where we will invite all major providers, co-commissioners and stakeholders to discuss progress collectively. This will ensure the CCG Chair, Chief Officer and Governing Body members are connected to the views of all providers throughout the planning process. A similar arrangement is in place for Directors of Finance and Directors of Nursing to receive regular briefings from respective CCG Chief Officers.





### **5.4 Local Negotiation Process**

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our intention**

- To have single, consistent, clearly mandated local negotiation teams for each provider
- To use Joint Technical Working Groups (JTWGs), Contract Development Groups (CDGs) to work through technical details and agree contract schedules
- · To escalate issues to the Contract Negotiation Meeting
- Consistent with NHS England, the CCG will remove excluded drug and device budgets from the contract value to which CQUIN applies
- We will not fund Interventional Procedures Guidance (IPGs) nor implement other NICE guidelines apart from TAGs, other than through Individual Request, unless endorsed by the relevant CCG governance and approvals mechanism
- Community providers will assess and review all individually funded clients wherever they are living in line with national framework timescales. These will be person centred and with outcome based care planning. Providers will ensure accurate and robust patient record keeping

#### **Engagement and involvement**

 To meet with providers regularly, through JTWGs, CDGs and Contract Negotiation Meetings

### **Next steps and actions**

- To confirm negotiating teams with each provider, including Associate and Collaborative commissioner representation
- To produce a detailed contracting timeline for each provider

### **Background and context**

For each major provider we contract with, it is imperative that we have clear processes and that will give us the very best opportunity to agree mutually beneficial contracts that focus on the best outcome for the population.

We know that this is best achieved by undertaking detailed technical work robustly and diligently and by separating this from the strategic issues within a complex contract. We also need to agree timelines early to ensure we have the right representation.

Within our single, provider specific, negotiation teams we will ensure consistent representation that harnesses our clinical leadership and the senior locality management. We will ensure that we have aligned our contracting, business intelligence and patient safety and quality resources to support the negotiation team.

We have identified contracts where we will add additional expertise from the outset to address the significant provider challenges faced to ensure that local negotiation teams have the range of experience and skill.





### **5.5 Internal CCG Contracting Governance**

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our intention**

- To take a consistent approach, sharing information with all providers simultaneously
- To understand the impact across the CCG before responding to provider proposals
- To ensure local negotiating teams are fully empowered and able to discuss and agree contracts with all providers
- To work through the Contract Negotiation Oversight Group to review progress against agreed timeframes and support negotiation teams
- To be able to report progress promptly and precisely to NHS England Area Team, as required
- To ensure the CCG Governing Body is fully aware of the contracting progress and issues
- To operate a clear and appropriate escalation process;
- To ensure collaboration with other commissioning organisations

### **Engagement and involvement**

 The Contract Negotiation Oversight Group will allow effective internal communication and engagement with NHS England

### **Next steps and actions**

- · Confirm meeting schedule
- Agree reporting requirements and proforma with NHS England

### **Background and context**

We recognise that, whilst we can demonstrate the level of expertise and experience that our operating model allows us to draw on, there are legitimate requests that we are consistent, act in a unified way and are able to respond appropriately to the complexity of issues across our providers.

Our Commissioning Framework and the modular approach is a key part of our drive to create a step change in our contracting for 2014 - 2016 whilst acknowledging the many successful negotiations we concluded in 2013/14.

Our Contract Negotiation Oversight Group will ensure that all key staff in the CCG – the Governing Body, Clinical Leads, the Leadership Team, Locality Boards and Local Negotiation Teams – are consistent and aware of issues that may impact on the approach to take locally.

In order to get consistency, we will ensure we fully understand impact before agreeing local variation in a way that is both timely and ensures that local negotiation teams are empowered.

The oversight will also ensure we are able to report accurately on our progress.





### **5.6 Aligning Levers for Change**

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our intention**

- To use levers for change to work collaboratively
- To support delivery of our key commissioning intentions by aligning levers for change
- Look to apply some CQUINs across a community, thereby incentivising cooperation between providers
- Headroom paid on achievement of measurable outcomes to providers with agreed transformation schemes
- To review independent and voluntary sector contracts to align them with the CCG strategy
- To focus levers on the delivery of sustainable, recurrent change

### **Engagement and involvement**

- We will discuss the overall approach with providers to ensure the alignment of levers matches the outcome we are seeking
- Through contract negotiation and service redesign forums including Clinical Partnership Groups

### **Next steps and actions**

- · Clarify Financial Framework at contract level
- Set out decision-making framework for allocating incentives

### **Background and Context**

We recognise that for many years there have been criticisms that commissioners have not managed to align incentives to their key intentions. One of our key success criteria for this framework is to provide coherent alignment of incentives across all of our workplan.

This means looking at all mechanisms we have and providing one meaningful statement of alignment (albeit that many areas will not require all levers)

#### Levers include:

- Contract terms
- CQUIN
- QIPP
- Fines and penalties
- Headroom
- Quality Premium
- · GP Enhanced Services

This means, for example, that for an area of change we will write clear contract terms, where the change is supported by headroom with a quality element attracting CQUIN payments and the primary care change required incentivised using an enhanced service mechanism.





# 5.6.1 Aligning Levers for Change - CQUIN

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our intention**

## Use CQUIN to support a collaborative approach

- Use some CQUINs across a community at interfaces between providers to incentivise cooperation
- Adopt provider-sponsored schemes that resonate with our key themes
- Define clear standards of achievement, setting stretching targets for providers to achieve as soon as it is practicable
- Link CQUIN to the delivery of transformation
- · Deliver fully all national CQUINS

## We will agree CQUINs which:

- Maximise Quality Premium income and mitigate the financial impact of under-performance
- · Incentivise optimal follow-up care
- Set out quality and timeliness standards for communications with GPs having regard to starting positions of each provider
- Define optimal case/patient management and incentivise delivery for each provider with specific milestones for CAMHS, Adult MH, LD, elective in hospital care and care of the frail elderly
- Incentivise a reduction in time from arrival to consultant assessment, in line with recent national directives

## **Background and context**

NEW Devon CCG will use CQUIN to:

- improve the quality and safety of care that patients experience;
- maximise the gain in the quality of care for individuals for the investment we make;
- improve the consistency of care that patients experience.

We consider that CQUIN resources are a real addition to a provider's baseline spend. Whilst intending that CQUIN should be earned in full, we will, where appropriate, link CQUIN to performance against QP targets and QIPP delivery, such that community risk is mitigated and we are therefore able to commit the maximum amount of resource at the beginning of the year. CQUIN will therefore be fully variable.

In considering how best to incentivise partners we will have regard to financial sustainability over the next two years and beyond. Where we agree that some CQUINs with some providers can be delivered without additional spend or that CQUIN financial risk will be mitigated, we will do this openly, documenting risks to sustainability. We will share our risk assessment and the outcomes of our negotiations with Monitor, NHS England and the NHSTDA.





# 5.6.2 Aligning Levers for Change - Headroom Northern, Eastern and Western Devon

**Clinical Commissioning Group** 

#### **Our intention**

#### Headroom support collaborative Use to approaches

- To provide sufficient headroom to allow the incentivisation of the level of recurrent change required, in line with national planning assumptions
- To use headroom for the delivery of our transformation schemes
- · As we move investment towards prevention and use the Better Care Fund as a key element of commissioning in 2014 - 2016, we will invest headroom to support our strategic direction to better target elective spend to ensure we have resources for urgent care growth
- · Headroom will be directed at those providers with whom we have agreed transformation, evidenced by measurable outcomes
- It will be paid on the achievement of the required outcomes, rather than for a new service - and therefore will offset the risk of any failure of delivery
- It will be applied proportionate to the need for change and not apportioned across communities pro rata to contract values or populations
- · We will publish details of our use of headroom for 2014 - 2016 periodically so that all stakeholders can review our investment

#### Context

For several years the CCG and previous PCTs in Plymouth and Devon have looked to blocked contract arrangements to give the certainty of income for providers that would allow in year changes to be made without financial penalty.

Whilst well intentioned, we recognise that this approach has not fully delivered the level of change we want and need to see within health systems locally.

In particular, a decision to invest headroom up front in order to maximise investment in health services, has helped to deal with current year issues, but this may be at the expense of investing in longer term change.

For 2014 - 2016 we therefore will fully provide for the nationally expected level of headroom and use this to invest in the CCG's transformation programme through our commissioning intentions.

We need to ensure that headroom delivers the level of recurrent change required and we will therefore need to spend more of this resource in areas that will be making the largest changes in order to create sustainable systems. We expect to use headroom collaboratively where we have joint plans agreed, in line with our preferred contracting approach.





# **5.6.3 Aligning Levers for Change**

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **QIPP**

#### **Our intention**

- Our QIPP challenge is fully embedded explicitly within all of our commissioning intentions
- We therefore have a range of QIPP schemes that apply consistently across the whole CCG
- We have "top 6" schemes that will give the biggest retains on quality and sustainability
- We will agree the implementation of QIPP schemes with local providers
- We will develop additional local QIPP schemes with providers and work to support their cost improvement schemes, or have a single set of plans, where a collaborative approach is adopted

# **Quality Premium Our intention**

- We will work collaboratively with providers to maximise the potential Quality Premium income to the local healthcare system
- We will work with NHS England to ensure that we agree the rationale for full investment of the quality premium within NEW Devon in 2014 - 2016
- We will ensure we choose targets that guide improvement in areas that link with our commissioning intentions

# Primary Care Enhanced Services Our intention

- All 2013/14 primary care enhanced schemes have been reviewed and are being re-commissioned for 2014/15 to support the CCG's strategic direction
- We will continue to pursue ways to incentivise primary care to change, where investment is believed to lead to system efficiencies
- We will look to create bids for additional resources to invest in primary care and to use additional monies to support our key commissioning intentions
- We will clearly articulate the link between primary care investment and targets and secondary care investment and targets

# **Emergency Marginal Saving and Readmissions Our intention**

- We will operate emergency threshold arrangements and emergency readmission adjustments in accordance with Guidance
- As part of our implementation of the Better Care Fund, we will repeat our exposition of the investment of the marginal rate savings in each area and show how these support the delivery of our commissioning intentions and agreed priorities with Health and Wellbeing Boards





# **5.6.4 Aligning Levers for Change**

Northern, Eastern and Western Devon Clinical Commissioning Group

# Contract terms Our intention

# To clearly document contract terms that support our collaborative approach

- We will determine clear contract terms that support the delivery of our commissioning intentions and align with our other system levers
- Whilst Audit Commission audits confirm that clinical coding is good across the patch, we will continue to review perceived inaccuracies in recording of activity and inconsistencies between local providers and between Reference Cost submissions and charging
- The PbR Code of Conduct states that providers are expected to treat patients in the most appropriate and efficient setting, taking into account clinical need. We will seek improved understanding of care pathways and their recording, particularly definitions of: admission, outpatient attendances and diagnostics
- Improvement in provider performance against key ratios, reflecting a move towards use of technology to reduce face-to-face consultations and appropriate definition of activity
- Following review of the pharmaceutical services standards in all contracts, we will issue a revised, consistent framework document

# Fines and Penalties Our intention

- We will work with providers to ensure that we have a realistic joint expectation of the delivery of all patient targets in order that we secure the best possible care for our population
- Where necessary, we will enforce contractual terms, including contract deductions, when quality and performance standards are not delivered

# Pricing Our intention

- We will follow Monitor Guidance regarding local pricing (2014/15 National Tariff Payment System)
- In collaboration with providers we will review local prices, explore variation and work towards greater consistency
- We will recurrently contract for direct access Pathology using best value prices and currencies;
- We will agree standard prices across the CCG for WA14Z (planned procedure not carried out)
- We will agree Local Variations and Local Modifications to national tariffs by 31 January 2014





# **5.6.5 Aligning Levers for Change – Example**

Northern, Eastern and Western Devon
Clinical Commissioning Group

## Optimising follow-up care - example

- We seek to align system levers to deliver transformational change. This may include consideration of:
- challenge clinicians to come up with the best possible models of follow up care, that they could proudly represent to their colleagues in the UK and across the world
- use Headroom to resource provider-driven follow-up protocols across key specialties, focussing on the major cohorts of patients
- CQUIN could incentivise creation of a risk assessed, specialty level, plan, adherence to protocol, reduction in the actual numbers of follow-up attendances, backlog reduction according to a trajectory, a 'green card' system for patients to manage their own care
- quality markers would be defined to capture patient experience and, in the course of time, we could target improvement in these scores
- A LES could be agreed with Primary Care to manage patients in the community in accordance with agreed protocols
- Any loss of CQUIN money (e.g. if the backlog does not reduce or the number of follow-ups increase) would mitigate or even eliminate any increased spend on follow ups

#### Context

A CCG theme is to create integrated, patientfriendly, self-managed pathways of care which minimise demand and avoid transactions that do not add value.

Out-patient follow-ups are remunerated mainly on a cost per case basis under PbR. The number of follow-ups rises each year, often disproportionately to changes in new attendances, and there are extensive backlogs containing significant clinical risk which may, or may not, be well understood and mitigated.

We have tried to address this issue in many different ways over the years but these have not delivered. We have been unable to agree contracts based on benchmarking new-to-follow up ratios and have simply paid for all follow up events.





# **5.7 Activity Planning**

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our intention**

- To work on a jointly-produced baseline (do nothing) activity plan
- · To share our activity planning assumptions by 31 December
- To adjust plans to exclude non-recurrent activity delivered in achieving sustainable RTT performance during 2013/14
- To establish contract values on the basis that income from Best Practice Tariffs will be maximised through the delivery of very high quality services
- To agree the baseline activity plan by 31 January, including:
  - · Applying road test tariffs
  - · Emergency threshold and readmissions adjustments

## **Next steps**

- Share activity planning assumptions 31 December 2013
- Agree baseline (do nothing) activity plan 31 January 2014
- Agree emergency threshold and readmissions adjustment -31 January 2014
- Agree Local Variations and Local Modifications
   14 February 2014
- Where the CCG is an Associate or there is a collaborative commissioning arrangement we will work with co-commissioners to align timescales and planning assumptions

## **Background and context**

Activity forecasts will be agreed between providers and the CCG and will take account of demography, past trends, as well as past and planned service redesign. It is important to recognise that demand can go up or down and that it is a shared issue, to which joint solutions need to be found.

The CCG will commission to ensure that the NHS Constitution is met with regard to Referral To Treatment (RTT) times. We will require monthly waiting list information from providers, to enable comparison of waiting times across the CCG footprint, and analysis of RTT breaches and incomplete pathways, to ensure a focus on over 18 week waiters.



# NHS

# 5.8 Escalation and Arbitration

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our intention**

- We will work towards agreeing contracts with all providers within the timescales set out nationally
- We will ensure that the best standards of technical contracting, based on national guidance, is used in all cases
- We will carefully document all agreements to ensure clarity for all parties throughout
- We will involve NHS England at an early stage if we believe a contract will not progress adequately
- We will use a three step process of internal escalation (Executive, Locality Board and Governing Body)
- We will seek to avoid arbitration and use external mediation as a first step
- Use of arbitration will need to be formally agreed by the CCG Governing Body

## **Engagement and involvement**

- Work co-operatively with providers and partner commissioners to conclude all negotiations successfully
- Early involvement of NHS England if progress is not being made

## **Next steps and actions**

 Ensure careful documentation of all agreements and technical issues to ensure clarity

## **Background and context**

NEW Devon CCG holds a vast array of contracts and the overwhelming majority of these were successfully negotiated in 2013/14, with only one contract requiring arbitration.

We recognise the concerns that any failure of local agreement raises. We will look to make sure that all contracts are concluded by 28 February 2014.

We have created a strong locality commissioning structure, supported in specific instances by additional expertise.

We will adopt a three step phase of internal escalation if exceptionally, problems arise.

**Executive** – involving the Chief Officer and Chief Nursing Officer

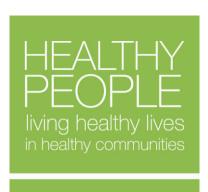
**Locality Board** – issue presented to the clinically-led Board for direction and advice

**Governing Body-** for key strategic issues and for formal agreement if arbitration is used as a last resort

Additionally in all cases, we will involve the Area Team of NHS England at an early stage if agreement looks problematic and we will seek external mediation in all cases prior to arbitration.



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Northern, Eastern and Western Devon Clinical Commissioning Group

# CF06 NEW Devon CCG Financial Commissioning Framework 2014 - 2016



**NEW Devon CCG Commissioning Framework 2014-2016** 



# CF06 NEW Devon CCG Financial Commissioning Framework 2014 - 2016

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# NHS

# **6.1 Financial Context**

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our Intention**

- To ensure the CCG has a deliverable financial 5 year plan and strategy to sustain comprehensive and sustainable high quality health services to its population.
- To work on system and health community sustainability rather than simply on the CCG position
- To work with the Area Team to produce the most robust position possible, given the challenging financial position for all organisations

## **Next Steps and Actions**

- Produce full CCG financial framework by 20<sup>th</sup> December 2013
- Review assumptions against the draft planning guidance issued during publication of this document.
- Achieve consensus on the financial position facing communities and providers within the health and social care community
- Review our allocation across our communities in comparison with national formula, when agreed

## **Background and Context**

The CCG's plan for its £1.1bn budget in 13/14 and the adjustments for in-year performance and specialist services has meant that the CCG's allocation is over committed going in to 14/15 in a number of areas.

Benchmarking helps understand this position – the CCG performs well on emergency admissions and prescribing but invests above average in elective admissions, primary care, high cost placements and has retained a significant level of resources within community services.

In addition some large NHS providers are facing significant financial challenges in 13/14 and looking ahead at future resource levels.

The CCGs commissioning resources will be increased by 2% in the next 2 years and this will be enhanced by reductions to tariff, however this is in huge contrast to the last 15 years.

Whilst allocations are reasonably certain during the next two years, changes in allocation formulae and the Better Care Fund mean the CCG is a facing a medium term reduction of 2%. The CCG is therefore expecting to operate in a flat cash environment over the next two years.





# **6.2 Financial Framework Requirements**

Northern, Eastern and Western Devon
Clinical Commissioning Group

#### **Our Intentions**

In order to provide the best environment to allow the whole health community to move towards sustainability the CCG will:

- Re establish a compliant financial framework with:
  - headroom of 2% 14/15 & 3% 15/16
  - surplus of 1%
  - contingency of 0.5%
- Provide for growth in services but at a low marginal cost
- Apply headroom to structural change and transformation
- Establish an agreed and all encompassing approach to use of the Better Care Fund
- Develop further our transformation (QIPP/redesign) plans of 2% building on local commissioning intentions, existing local schemes, local benchmarking and efficiency analysis and NHS England value commissioning pack
- Ensure primary care and specialist commissioners plans and financial frameworks are aligned
- Ensure that the local plans and framework move the CCG towards its strategic intentions and in particular issues of financial and service equity

## **Background and Context**

The CCG was not compliant with national planning guidance for its financial framework in 2013/14. This facilitated the maximum upfront investment in services, but left the CCG with no resources to invest in change programmes and with little ability to manage risks that have emerged in year.

It is clear that this approach has not worked as well as had been anticipated to create the conditions for change and the level of risks experienced has caused major financial concerns for the CCG and therefore the Area Team.

In developing the financial plan the CCG has made reference to assumptions included in *'Strategic and Operational Planning in the NHS'*.

The response to *Call to Action* and the opportunities identified in the '*Commissioning for Value*' insight pack are also included.

In addition, the CCG has developed an approach with its local authority commissioning partners to the *Better Care Fund*.





# 6.3 CCG High Level Financial Position

Northern, Eastern and Western Devon Clinical Commissioning Group

NEW Devon Clinical Commissioning Group					
Medium Term Financial Plan	2014-15	2015-16			
Medidili Terili Filialiciai Fiali	£m	£m			
Growth 2%/1.9%	22	22			
Returned Surplus	0	11			
Pace of Change to New Allocation Formula	0	(7)			
Tariff Deflator	13	12			
Total Sources	34	38			
Activity and Drug Growth	11	25			
Primary Care (Including Prescribing)	1	3			
Complex Care	5	7			
QIPP/Savings Requirement	(20)	(15)			
Total Applications (Net of QIPP)	(3)	20			
Position before Operating Plan Assumptions	37	18			
Headroom/Contingency	26	18			
Increase in Surplus (1%)	11	(0)			
Memorandum: Social Care Transfer/ITF	2	34			





# 6.4 CCG Approach

Northern, Eastern and Western Devon Clinical Commissioning Group

#### **Our Intention**

- · To set out the financial outlook
- To produce a financial and service strategy which provides for a sustainable health and social care service
- To finalise the two year plan
- To outline likely impact on provider positions of the planning assumptions
- To set out commissioning and contracting arrangements – including outline application of transformation/headroom fund
- Provide an open and transparent approach to financial planning and the resource impact and availability on commissioners and providers
- Offer a collaborative approach to contracting and commissioning to ensure sustainable service delivery

## **Engagement and Involvement**

- Clear statement on resources
- Compare financial projections with commissioners and providers
- Review current and future plans with commissioners and providers to determine how much of the gap can be filled
- Agree a process for collaborative working to complete the gap
- Meeting with providers 4<sup>th</sup> December 2013
- Outline financial schedules to providers on 20<sup>th</sup> December
- Engage facilitated support
- Establish joint scenario planning exercises within the health economy

## **Next Steps and Actions**

- To share final framework on 20<sup>th</sup> December 2013
- Set out likely impact by locality and provider
- · Determine type of contract to be adopted
- · Agree process for finalising contract values
- · Joint strategic approach to be supported by external strategic planning input
- To review the financial framework developed by the CCG in light of guidance and best practice
- To review the outputs from the service plans to ensure these match with resources set out





# 6.5 Indicative Financial Exposition

Northern, Eastern and Western Devon Clinical Commissioning Group

# Indicative Financial Envelopes and assessment of impact by locality and provider

The table setting out the provider financial exposition is set out in table x and is based on the following:

#### 1. 13/14 Contract Value

- (a) Less non-recurring variation orders
- (b) Add recurring impact of agreed variation orders

#### 2. Tariff

Tariff reduction set out in planning guidelines and PbR rules will apply to all contracts—the headline rate is 1.6% with adjustments currently being announced through NHS England & Monitor.

#### 3. Outturn

An assessment of the outturn position and it's recurring impact on the contract value will be reviewed through the contracting process – opportunities may exist to contribute to the 2% QIPP target and use or otherwise of the allowance for growth set out in the CCG plan.

## 4. CQUIN

The adjustments for CQUIN will be made explicit in the provider envelope and contract sum. The national rules and local application are set out in the contract intention setting. The financial assumption is that CQUIN will be reduced from the recurring contract sum with financial planning assumption that targets will be met and CQUIN payments made in full to providers.

#### 5. Growth

This has been planned at an overall level of 1% and can be applied to contracts on the basis of an agreed plan.

### 6. Headroom

The financial plan has allowed for the reestablishment of headroom at 2%. This is planned to be spent with providers to support delivery of the commissioning intentions. It recognises that services may need to be put in place before or as other service changes are implemented. There may also be structural changes to service provision which may also need one-off support before the longer term sustainable solution is implemented.

## 7. Commissioning Intentions/QIPP

These have an overall target assessed at 2%. This level of financial benefit has been influenced by assessment of achievement in the first year of the 5 year plan. The approach is set out in the pack CF04 Detailed Planning Framework 2014/15.

An assessment has been made on how these service changes impact on providers.





# **6.6 Any Provider**

Northern, Eastern and Western Devon Clinical Commissioning Group

	Any Provider		
		£'000	
1	13/14 Contract	×	
2	Less: Non-recurring variation orders	(x)	
3	Add: FYE variation orders	χ	
4	13/14 Recurrent contract	<b>X</b>	
5	Less: 13/14 CQUIN	(x)	
6	14/15 opening contract	Х	
	Impact of tariff deflator (-1.6%)	(x)	
7	14/15 opening financial envelope	<u> </u>	
	Outturn	To be discussed	
	Headroom	To be discussed	
9	Commissioning intentions - average 2%	(x)	
10	CQUIN	<u>×</u>	





Northern, Eastern and Western Devon Clinical Commissioning Group

## Winterbourne view position report.

## Plymouth Health and Wellbeing Board.

#### 1. Introduction

1.1 This paper outlines our current progress relating to Winterbourne View. It focuses on the number of people we are seeking to return to appropriate community placements and the current actions steps and issues we are engaged in.

## 2. Pathway

- 2.1 We have designed a pathway that supports effective "Returning home" of individuals. It follows seven simple steps that care managers and commissioners have to complete to help the person move out of institutional care.
- 2.2 The seven step model is being used to monitor the people who are moving through the pathway and the performance of the services responsible. In short, it helps us understand our position at any moment in time.
- 2.3 The pathway is attached as Appendix 1.

## 3. Monitoring our position.

3.1 Each month we are monitoring the people on our register to see how we have progressed against the pathway. The position for people placed by Plymouth at the end of December 2013 is as follows.

Step 1- 2 People

Step 2 – 3 People.

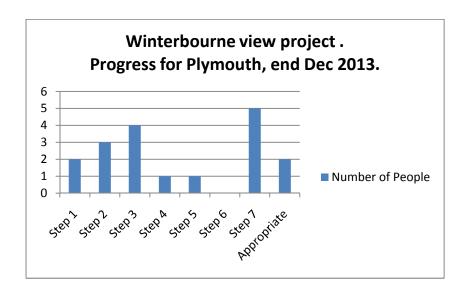
Step 3-4 People

Step 4- 1 person

Step 5 – 1 person

Step 6- 0

Step 7-5 People



The goal of moving people into appropriate community placements by 1<sup>st</sup> June 2014 was set out in the Concordat Action plan following the numerous reports regarding Winterbourne view.

There is however a small number of people that we deem to be currently appropriately placed, who are not in a position to return home as yet given their needs at the moment. For example two people are under a Ministry of Justice Sections in secure care. These clients will be reviewed in accordance with Ministry of Justice requirements.

Very good progress is being made with the Plymouth placed individuals with those moving through the steps.

## 4. Key Themes.

Below is a list of issues we have encountered in enabling people to return home.

- Getting people discharged off sections from their current provider is often very difficult; this is the single biggest delaying factor we have.
- Finding appropriate housing that meets the needs of this particular group has been challenging; due to their personal histories the majority of people returning from secure provision may have anti-social behaviour and/or acute communication difficulties. For many people supported slotting into ordinary social housing is hard as properties need to consider the needs and risks of the individuals. There have been difficulties with some communities around misunderstanding the journey that people returning from secure provision have

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been on and learning around the right level of awareness raising and information sharing at a neighbourhood level.

- We have to work with the secure services commissioners and the Ministry of Justice to move on some people.
- The seven step model works very well and enables us to track progress.
- Since the start of this work no-one has been placed out of area in an independent hospital for people who have a learning disability by Plymouth.
- The resource taken out of the community learning disability team has been significant regarding this cohort of people in order to plan safely and effectively to meet their needs. Sustaining the person in the community is as important as them returning home.
- Working closely with families and advocates has significantly improved the quality of planning and the implementation of the plans when the person moves into their own home.

#### 5. Recommendation.

The Board is requested to note the position statement.

Helen Toker-Lester.

Joint Commissioner for Learning Disability.

1

- Identification of the person as part of the review list regarding people placed out of area in independent hospitals
- Care manager/care coordinator is allocated and briefed..
- An initial review takes place.

2

- An individual service design is completed.
- Clinical care plans and risk assessment and management plans are incorporated.

3

- The Legal Framework is applied and considers the need for Mental Capacity assessments, Best interest meetings, including Court of protection if required. Ministry of Justice may be involved for some people.
- The Mental Health act status is confirmed, and plans are agreed and developed with clinicians.
- Housing application is made.

4

- Support provider is identified.
- Housing is identified.
- Contracts and tenancy agreements are signed.

5

- The staff team is recruited around the person.
- Staff are trained and are involved in the working policy documentation and any additional risk assessment and management planning.

6

• The move takes place

7

- Ongoing monitoring and support takes place.
- The person is transferred off the WBV list.

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# **Proposed Health Protection Committee for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council** and Health Protection Assurance Arrangements

#### 1. Introduction

- 1.1 The Local Authorities of Devon County Council, Plymouth City Council and Torbay Council, through their Director of Public Health, require assurance that appropriate arrangements are in place to protect their public's health.
- 1.2 The scope of health protection includes: prevention and control of infectious diseases; immunisation and screening; health-care associated infections; emergency planning and response (including severe weather and environmental hazards).
- 1.3 Alongside the Local Authorities (unitary, upper tier and lower tier), several external organisations are involved in either commissioning or the delivery of health protection functions that fall within this scope. These include North East & West Devon Clinical Commissioning Group, South Devon and Torbay Clinical Commissioning Group, Public Health England and NHS England. To deliver or commission theses functions effectively, robust partnership arrangements are required.
- 1.4 Local Authorities through their Director's of public health require assurance that their public's health is adequately protected. Therefore, formal assurance arrangements are required for the health protection system, that identify risks across the scope of health protection activity and provide adequate control with regard to riskmanagement.

#### 2. **Health Protection Committee**

- 2.1 A Health Protection Committee accountable to the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council is proposed. First and foremost, this Committee will provide an important control function with regards to the required assurance arrangements for the health protection system.
- 2.2 Terms of Reference for the Committee (Appendix 1) have been considered and agreed in principle by Local Authority Directors of Public Health, their Health Protection Lead Officers as well as representatives from Public Health England (including Consultant in Communicable Disease Control), NHS England Area Team and the Clinical Commissioning Groups.
- 2.3 A Health Protection Committee serving three Health and Wellbeing Boards allows health protection expertise from public health teams within each Local Authority to be pooled in order to share skill and maximise capacity. Furthermore, for partners whose health protection functions serve a larger geographic foot-print, this model

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reduces the burden on them to attend multiple health protection meetings with similar terms of reference and to consider system-wide risk more efficiently and effectively.

- 2.4 In addition, a number of health protection groups are either in existence or in development which can support the Health Protection Committee to discharge its risk management functions and which cover the scope of health protection. These groups and their relationship to the Health Protection Committee and Health and Wellbeing Boards are illustrated in Appendix 2 and include:
  - 2.4.1 Health Care Associated Infection Board;
  - 2.4.2 Health Protection Advisory Group;
  - 2.4.3 Devon, Cornwall and Isles of Scilly Screening and Immunisation Overview Group;
  - 2.4.4 Local Health Resilience Partnership.

Through the Local Authority Health Protection Lead Officers, terms of reference for each of these groups will be reviewed to ensure they reflect the assurance arrangements outlined in this document.

## 3. Performance Monitoring

- 2.1 A set of performance indicators that cover the scope of health protection activity will be used to monitor performance at Local Authority level and benchmarked by regional and national performance.
- 2.2 Following the dispersal of public health activity across several organisations from April 1<sup>st</sup> 2013, access to information required for performance monitoring across the scope of health protection is not available to all partners. Therefore, lead organisations will be required to report on the activities for which they are responsible and for which they have access to the information required.
- 2.3 Local Authority Health Protection Lead Officers will review their partner organisation's performance reports prior to the Health Protection Committee convening. Where under-performance is identified, data will be analysed at the appropriate spatial level with partners in order to identify reasons for variation and the mitigating action / activity required. This will inform the performance report presented to the Health Protection Committee for members to be assured that reasons for underperformance have been identified and the required actions/activities are in place to improve performance.
- 2.4 Where areas of underperformance are identified which may pose a risk to the public's health, the lead organisation will ensure that the risk is entered onto its own organisational risk register. These risks will be reported to the Health Protection Committee which will seek assurance that mitigating actions and activities are sufficient to manage the identified risk.

## 3. Risk Management

#### **Risk Management**

3.1 In relation to health protection and assurance arrangements, risk management is the logical and systematic method of establishing the context, identifying, analysing, evaluating, treating, monitoring, and communicating risks associated with health protection activity, function or process. Risk management seeks to provide assurance that all actions and activities required to mitigate against risks and their control arrangements are in place.

#### **Risk Definition**

3.2 In the context of health protection and assurance arrangements, risk is defined as the likelihood that a hazard (anything with the potential to cause harm) will occur multiplied by the severity or impact it may have on either the public's health or to the organisations involved in protecting the public's health

#### **Risk Identification**

3.2 Each organisation commissioning or delivering activities within a health protection system is responsible for identifying risks that if not adequately mitigated against or controlled could have an adverse impact on the public's health, the organisation itself and/or partner organisations. Organisations will report significant risks (normally described as high/very high) to the Health Protection Sub Committee which will seek assurance that adequate mitigating action / activities are in place to manage the risk(s) identified.

#### **Risk Mitigation**

3.3 As part of its report, the organisation will outline all actions / activities either currently in place or that are required to reduce (mitigate against) the risk identified (e.g. reducing the potential harm of the hazard / likelihood that it will occur).

#### Risk Control

3.4 The Health Protection Committee will seek assurance of the effectiveness of the mitigating actions / activities described Health protection risks that cannot be adequately controlled through the Health Protection Committee will be escalated to the Health and Wellbeing Board (s).

#### 4. Internal Audit

4.1 The role of Internal Audit is to understand the key risks of an organisation and to examine and evaluate the adequacy and effectiveness of the system of risk management and the entire control environment in operation. As an independent appraisal function, the primary objective of Internal Audit is to review, appraise and report upon the adequacy of the risk management framework and internal controls.

4.2 The Devon Audit Partnership provides Internal Audit for Devon County Council, Plymouth City Council and Torbay Council. Therefore, there is scope for the Partnership to test assurance arrangements for managing system-wide risks in relation to health protection and the role of the Health Protection Committee, subject to agreement from the three Local Authorities.



## **Appendix 1**

# Proposed Terms of Reference for a Health Protection Committee of the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council

## 1. Aim, Scope & Objectives

#### Aim

1.5 To provide assurance to the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council that adequate arrangements are in place for the prevention, surveillance, planning and response required to protect the public's health.

#### Scope

1.6 The scope of health protection to be considered by the committee will include prevention and control of infectious diseases, immunisation and screening, health-care associated infections and emergency planning and response (including severe weather and environmental hazards).

#### **Objectives**

- 1.7 To provide strategic oversight of the health protection system operating across Devon, Plymouth and Torbay.
- 1.8 To oversee the development, monitoring and review of a memorandum of understanding that outlines the roles and responsibilities of the Public Health England Centre, NHS England Area Team, Clinical Commissioning Groups (North East and West Devon & South Devon & Torbay) and upper tier/lower tier / unitary authorities in relation to health protection.
- 1.9 To provide oversight of health protection intelligence reported to the committee and be appraised of risks, incidents or areas of underperformance.
- 1.10 To review and challenge the quality of health protection plans and arrangements to mitigate against any risks, incidents or areas of under-performance.
- 1.11 To share and escalate risks, incidents and under-performance to appropriate bodies (e.g. Health and Wellbeing Boards / Local Health Resilience Partnership, NHS England) when health protection plans and arrangements are insufficient to protect the public. The escalation route will depend on the risk or area of under-performance.

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- 1.12 To agree an annual programme of work to further improve local health protection arrangements as informed by the respective Health and Wellbeing Strategies for Devon, Plymouth and Torbay and their Director of Public Health's Annual Report.
- 1.13 To review and challenge arrangements for the delivery of existing and new national screening and immunisation programmes or extensions to existing programmes.
- 1.14 To promote reduction in inequalities in health protection across Devon, Plymouth and Torbay.
- 1.15 To oversee and ratify an annual Health Protection Sub-Committee annual report.

### 2. Membership

Chair: Director of Public Health

Members: \*Chair – Health Protection Advisory Group (PHE CCDC/Health Protection

Consultant)

\*Chair - Devon, Cornwall and Isles of Scilly Screening & Immunisation Oversight Group - Consultant in Public Health (group under development)

\*Chair – Local Health Resilience Partnership

\*Chair – Health Care Associated Infections Programme Board (group under development)

Consultants in Public Health / Health Protection Lead Officers— (Devon County Council, Plymouth City Council and Torbay Council)

Head of Public Health Commissioning (Area Team – NHS England)

Head of Emergency Planning Resilience & Response – (Area Team – NHS England)

Chief Nursing Officer – (North Easter and West Devon Clinical Commissioning Group)

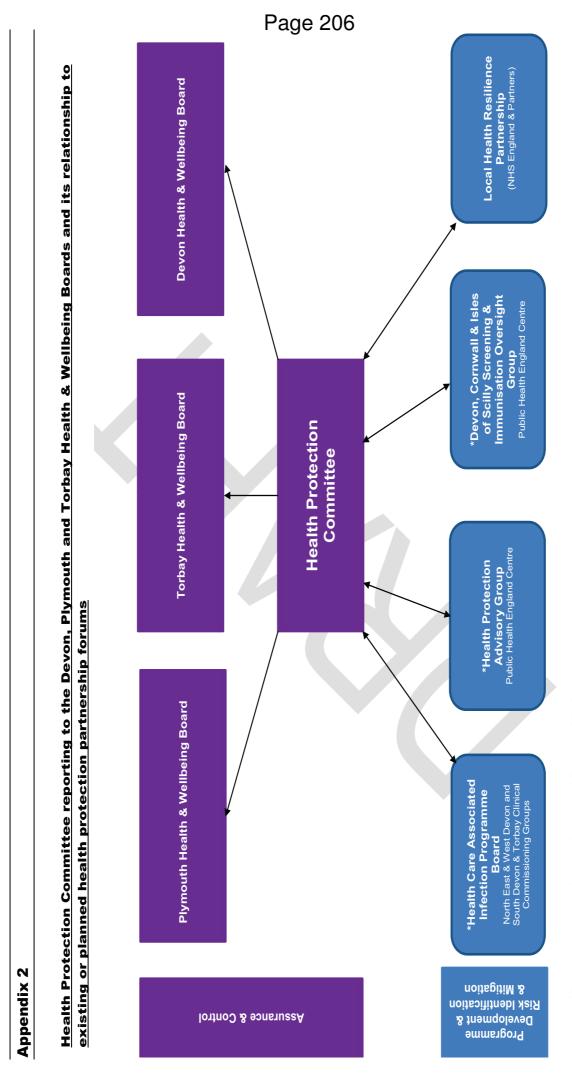
Director of Quality Governance – (South Devon and Torbay Clinical Commissioning Group)

#### 3. Meetings & Conduct of Business

- 3.1 The Chairperson of the Health Protection Committee will be a Director of Public Health from either Devon County Council, Plymouth City Council or Torbay Council. Directors of Public Health serving these councils will review this position annually.
- 3.2 The quorum of the meeting will comprise the Chairperson of the Health Protection Committee or their deputy, the Chairperson of each of the four groups listed in 2 above (\*) or their representative with delegated authority to make decisions on their behalf, at least one Local Authority Consultant in Public Health (Health Protection Lead Officer) and at least one of either the Chief Nursing Officer (North East and West Devon Clinical Commissioning Group or the Quality and Safety Lead (South Devon and Torbay Clinical Commissioning Group).
- 3.3 All meeting papers will be circulated at least seven days in advance of the meeting date.
- 3.4 The agenda (standing items listed in 3.6 below) and minutes will be formally recorded. Minutes listing all agreed actions will be circulated to members and those in attendance within 14 working days of the meeting.
- 3.5 Meetings will be held bi-monthly.
- 3.6 Standing agenda items will include the following:
- 3.6.1 Performance report;
- 3.6.2 Risk register and action plan review;
- 3.6.3 Serious incidents requiring investigation;
- 3.6.4 Work-programme update;
- 3.6.5 Policy / evidence/guideline updates (All);
- 3.6.6 Any other business.
- 3.7 A report of the meeting will be forwarded to members of the Health and Wellbeing Boards for Devon County Council, Plymouth City Council and Torbay Council and Local Health Resilience Partnership.
- 3.8 Terms of reference will be reviewed annually.

### 4. Author

Mike Wade MFPH
CONSULTANT IN PUBLIC HEALTH
Devon County Council



\*Groups currently in development / Terms of Reference to be agreed.

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