HEALTHY PEOPLE
living healthy lives
in healthy communities

NHS

Northern, Eastern and Western Devon
Clinical Commissioning Group

Integrated, personal and sustainable

Community Services for the 21st Century - A Strategic Framework

Foreword

We have a tremendous opportunity to help people improve their health and wellbeing, maintain their independence, and experience more appropriate care outside of large and busy hospitals and closer to - or in - their homes and communities. *Integrated, personal and sustainable: community services for the 21st century* sets out our proposed direction for community services and invites your views on this.

This strategic framework exists within the pillars of the Clinical Commissioning Group's overarching strategy. It is also in the context of our co-commissioning of primary care; the role of General Practice as the organising unit of care and our work with local authorities to advance integration of health and social care.

During the last year we have heard from hundreds of people about what they think is most important about community services - what is good now and what could be better. We have heard from patients, carers and communities – we have heard from bodies and organisations that represent them – and we have heard directly from senior and clinical leaders in health and social care. This has greatly influenced our thinking.

What is clear is that community health, and integrated health and care services, are highly valued. They are also ideally placed to make an impact on the whole pattern of care, shifting the emphasis of services - from acute to community settings, from hospital to home, and from care delivery to prevention of ill health. This is what people want to see, a change to the way services are delivered.

Advances in care mean there are more possibilities than before to improve, maintain and recover health. At the same time the age of the population is rising as is the complexity and scale of health need. Austerity is a reality - money is limited and costs are ever increasing - so we need to make every pound count. And, in doing so, we must keep improving quality and experiences of services.

Now we are translating many of the local views and insights we have heard so far accompanied by our understanding of health needs and information from national and local policy, into a proposed way forward - so that we can and do achieve integrated, personal and sustainable community services which are right up to date.

Getting this right requires a partnership approach. Community services benefit from the commitment of staff, carers, leagues of friends, a range of volunteers and many others. We see these existing vital partnerships - and new ones to be established with communities - as pivotal to the development and design of future services.

We would welcome your views and comments. We know future plans and services will be even better and stronger as a result. Thank you.

Dr Tim Burke
Chair, NHS NEW Devon Clinical Commissioning Group

Rebecca Harriott
Chief Officer, NHS NEW Devon Clinical Commissioning Group

21st century community services for individuals, families and communities

Facts about us

- We are the largest CCG in the country
- We have an overall budget of £1.1 billion
- We serve a total population of 898,523
- We cover a total area of 2,330 square miles
- Our CCG chair is **Dr Tim Burke** and there are three locality chairs:

  North Devon – Dr John Womersley

  East Devon – Dr David Jenner

  West Devon – Dr Paul Hardy
- Our Chief Officer is **Rebecca Harriott**

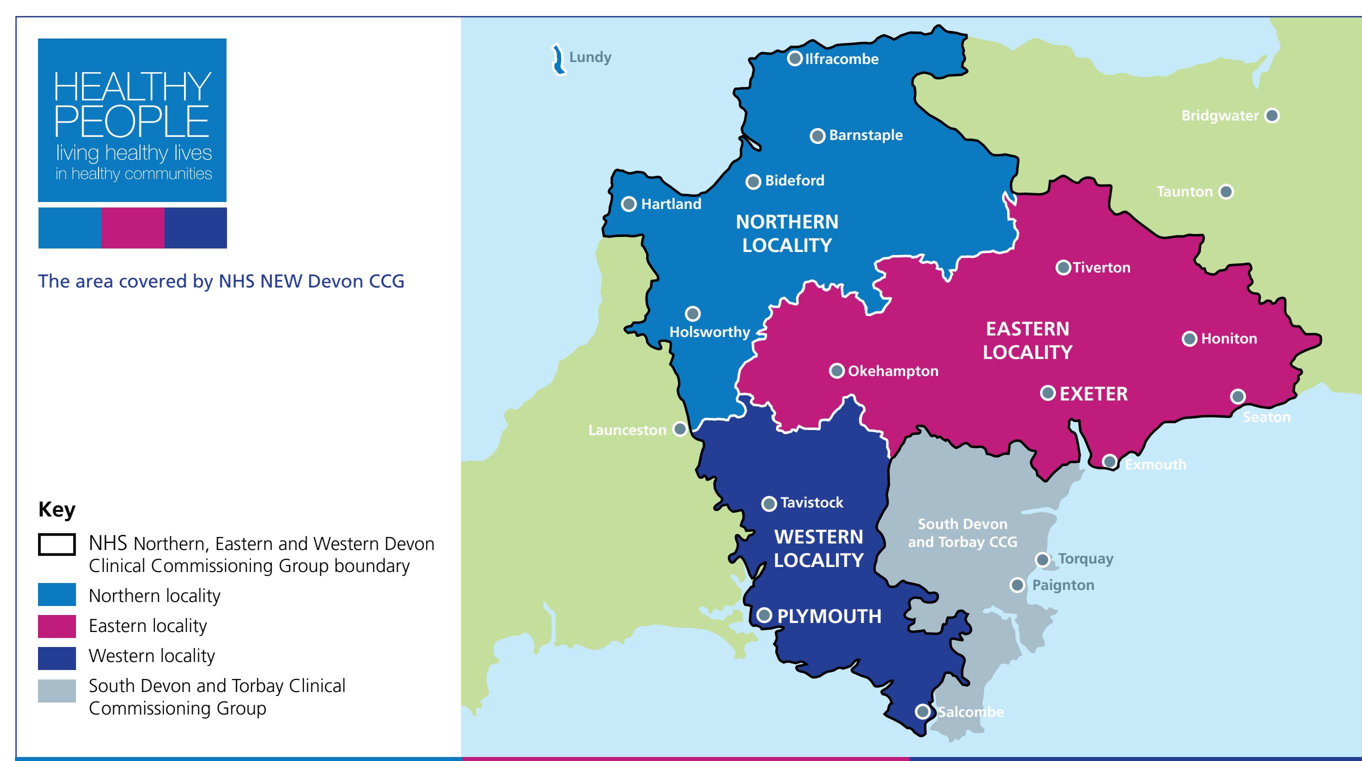
This strategic framework has been developed for the areas of Devon that are covered by NHS Northern, Eastern and Western Devon Clinical Commissioning Group, which leads the commissioning of the majority of local healthcare. Approximately 11per cent of the overall £1.1 billion resource is spent on community services - those health and integrated care services that take place in or close to people's homes and communities. Community services have a key role now and in the future.

As we look ahead we want to build on the many strengths of current services and to develop them further so that they can and do stand the test of time. This is why we have engaged so many local people in thinking about their future – and why we are checking our proposed way forward again through 'Integrated, personal and sustainable: community services for the 21st century'. We know that there are important decisions to make now to set the path for the coming years.

In addition to our local engagement there is national policy and guidance that is relevant to community services. This sets a direction of clear and simple pathways of care, focusing on outcomes and quality for patients whilst achieving the efficiency and effectiveness that will enable sustainable care and support.

Community services are of course part of a much wider system of health and social care and in looking at community services we have also been paying attention to this. The role of General Practice, the value of connections with acute and specialist healthcare, the possibilities for extending the integration of health and social care, the role of all agencies in adopting a greater health and wellbeing focus - have all been at the centre of our thinking.

In this framework we describe how community services could be, an approach to making this happen, and the inputs that will be needed to make a difference. We also set out the important experiences that people should be able to expect as a result of this work, and a number of guiding principles that have been identified as important.



The area covered by NHS NEW Devon CCG

Integrated, personal and sustainable - how this could be

People told us they wanted 'healthcare which does not stop at the boundaries', services that 'see me as a person, not a condition' and 'safe and secure services with future proofing in mind'. These and many other views and insights set a vision for 'integrated, personal and sustainable' community health and integrated health and care services. These views also framed the following six strategic priorities.

Help people to stay well

As well as a focus on caring we would expect the emphasis of community services to move increasingly towards prevention and maintenance of health. This includes recognising the importance of support for people with complex needs to help them to live well and to maintain independence.

Integrate care

The need for care and support to be wrapped around individuals and their families has been stressed time and again in local discussions. This means we would expect services to be joined up and integrated - removing and minimising the impact of organisational boundaries on great care.

Personalise support

Personalisation, choice and control over individual care was highlighted as important. Personalisation includes, and is much more than, personal health budgets and means advancing a flexible model of support which can increasingly be tailored to individuals.

Co-ordinate pathways

The value of pathway-based approaches to care with co-ordination through prevention to crisis and ongoing care has been identified time and again. This includes paying particular attention to pathways which reflect the natural flows of patients through different health and care services.

Think carer, think family

The key role of carers and the need to support carers' health and wellbeing - in addition to that of patients and the population is essential as more services are focused in people's homes and in the community. We want to commission mainstream services which are fully carer-aware.

Home as the first choice

There is growing understanding of the need to shift the model of services with less inpatient beds but a greater number of more responsive care packages at home. There is now a clear impetus for action to progress this at an early point to enable new models of community services to develop.

A shared direction

Over the last year in Northern, Eastern and Western Devon we have been:

- Listening to views of patients, carers, communities and their representatives
- Engaging with clinical and senior leaders involved in health and social care
- Reviewing needs, evidence and other details relevant to community services

This has been central to our community services programme which is designed to set the direction and delivery arrangements for the future - so that community services can and do realise their true potential for individuals, families and communities.

We are now ready to propose a way forward. *'Integrated, personal and sustainable: community services for the 21st century'* is a summary of extensive work on community services. A more detailed document and further information is available on https://www.newdevonccg.nhs.uk/involve/community-services/101039.

Designing community services for the population - how this could be

Community services are those services which take place at home or nearby. They include nursing care and support, multi-disciplinary and integrated teams that help people with complex needs and a range of clinical and other services in community hospitals and local care settings. There are many good services but we know that more can be achieved if community services are to realise their true potential.

The latest health and wellbeing profile for NHS NEW Devon CCG shows that compared to England there are:

- Fewer children below age of 14
- More young adults aged 20-24
- Fewer working age adults 25 -50
- More older adults over age 60

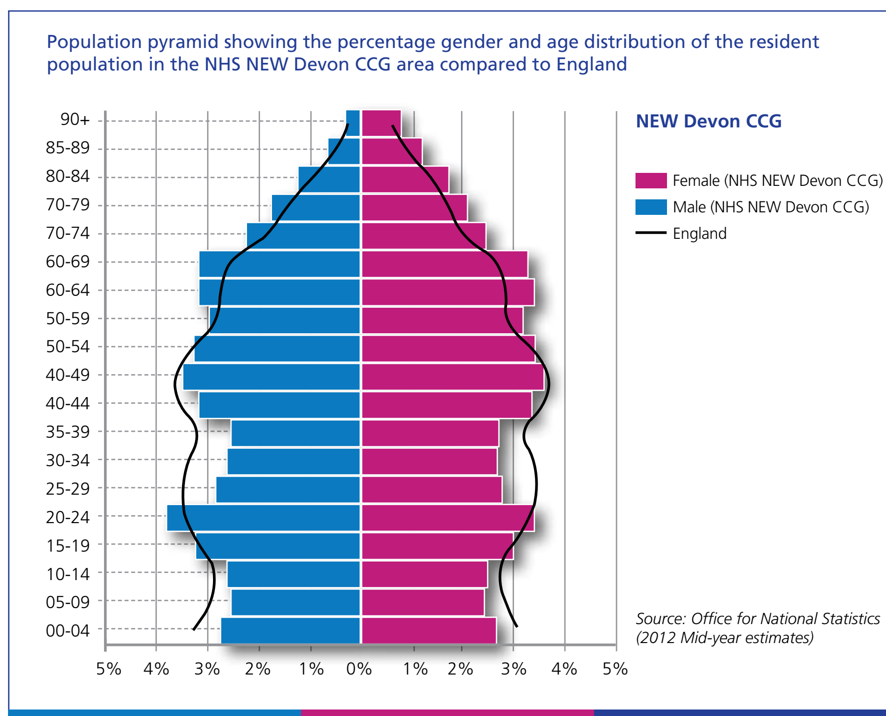
The proportions of older adults are already higher than England and rising. By 2021, the population in the NHS NEW Devon CCG area is expected to grow by 6 per cent with a 9 per cent rise in 60-74 year olds and a further 26 per cent increase (over 22000 people) in those aged 75 and over. There are new houses and communities being developed too. We need to plan ahead.

Social isolation is an issue raised in many conversations and we know that in both urban and rural settings this can be a real issue, especially for older people. This can impact on health and wellbeing. Community services of the future have a role towards addressing this.

'As more people live into older age we need services which support people to remain as well as possible for as long as possible in their own homes and communities. The ambition is to increase the healthy years of life and reduce the social isolation.'

NHS England chief nursing officer

Population pyramid showing the percentage gender and age distribution of the resident population in the NHS NEW Devon CCG area compared to England



Source: Office for National Statistics (2012 Mid-year estimates)

Locally relevant plans

In looking ahead, it is essential that we plan and prepare now for an increasing older population and their carers.

Age can bring an increased complexity of physical and mental health needs and frailty affecting the pattern of services required - especially in the oldest age groups.

We know that already people over 65 years in the NHS NEW Devon CCG area account for 72 per cent of all unscheduled days in a hospital bed (this is 10 per cent higher than the rest of England).

We also know that the impact of aging in the population is likely to bring an increase of up to 2 per cent a year extra activity in already busy acute hospitals locally.

Local Public Health audits have shown that around one third of people in community hospitals were fit and waiting for discharge.

Yet many older people would prefer to be at home. We need to plan and design services that will support this with home as the first choice for care.

Achieving the best from national and local policy - making it happen

There is a wealth of national and local policy which sets the foundations for excellent services - achievable even in the face of rising needs and the realities of financial austerity. The best care is not always the most expensive care. There is increasing evidence and examples of improving services for people while strengthening quality, efficiency and effectiveness too. This is how we can make it happen.

A view from here

Views gathered through local engagement in community services compare well with national and local policy direction.

Hundreds of people took part in discussions over the last year including:

- Attending local health summits to directly give their views
- Joining focus discussions such as a long term conditions event
- Participating through bodies that represent a range of groups
- Joining senior leaders in events and workshops
- GP Member Practice and clinician to clinician discussions.

We heard that: prevention services are as important as crisis services; the person needs to be put first; we need to remember personalised care is not - one size fits every person. Further information is available on:

https://www.newdevonccg.nhs.uk/involve/community-services/101039.

Integrated

We are already well on the path to integration of health and social care in Devon and Plymouth. The national Better Care Fund announced in 2013, is a pooled health and social care budget and is a helpful catalyst for taking this integration to the next level.

Starting this year and scaling up from 2015/16 onwards this is set to unlock the true potential of 'out of hospital' care and therefore community services - and to positively shift resources to where they can bring most benefit.

Locally we are looking to this pooled fund to enable integrated multi-disciplinary teams in each locality, to strengthen home care and to move more care out of hospital.

Personal

The King's Fund's recent review of community services in England described the important role of these services in transforming care. The report noted a range of changes are necessary including: simplifying community services; building multi-disciplinary teams supported by new models of specialist input; and reaching out to the wider community to improve prevention, supporting isolated people and to create healthy communities.

Our local engagement reflected the value of services that are tailored to enable personalised approaches to care and support.

Sustainable

Creating services that are strong and ready to stand the test of time is of utmost importance. It is recognised that change cannot wait and we need to prepare now for quality and affordable services in the future. Community services have a clear part to play in responding to the growing scale and complexity of needs, and in shifting from a focus on buildings to designing services around people - and engaging communities in sustainable services.

'...it is more important than ever that commissioners, providers and citizens are open and honest with one another about what can be achieved and work together to find solutions.' Think Local, Act Personal Partnership.

Preventive and personalised support - making it happen

Making an impact

The management of complex long term conditions needs to happen every day at home and in the community to help people to live well. This needs a new approach by all services to 'make every contact count' and embed prevention into day to day activities.

Thinking differently

'We need pathways which start and end with wellness'

Outcomes

- Enhancing quality of life for people with long term conditions and care and support needs
- Helping people recover from episodes of illness
- Reducing emergency admissions to hospital and delayed discharges from hospital.

Community health and integrated health and care services are ideally placed at the heart of communities to tailor care and support services to the people who use them; and to harness the true power of communities in wellbeing, the maintenance of health, and mobilising community assets to support people to live well and at home.

Many more people are living with one or multiple long term conditions and complex health needs. In this section we are focusing on targeted support to prevent or delay deterioration of health and wellbeing, address heath inequalities and reduce the risk of admission to hospital or residential care. This will need the following key changes:

- Change the way facilities are used, with some community hospitals becoming hubs for health and wellbeing rather than maintaining their traditional inpatient focus. This new approach would bring more prevention, wellbeing and pro-active support into localities
- Develop personalised care planning for people with complex needs which include plans for prevention, self-management and support to maintain independence and, wherever possible, avoid a crisis
- Establish a framework for services that enables increasingly flexible and bespoke support so that individuals can be more in control, including through personal health budgets as these become established
- Build on existing targeted services that support people at high risk through information, self-management, 'making every contact count' towards prevention and establishing named clinical leadership throughout the whole pathway of care
- Use technology effectively to enable preventive and personalised support. Bring this into mainstream services where the benefits of technology are known and are relevant to the needs being addressed.

To fully make a difference to community wellbeing, particularly in the older age groups, there are real benefits in harnessing the power of communities. We want to explore innovative opportunities with communities as a key part of taking this programme forward.

INTEGRATED, PERSONAL AND SUSTAINABLE

Pathways for people with complex needs - making it happen

Making an impact

NHS England advocates a pathway approach especially for older people who are most likely to suffer problems with co-ordination of care and delays in transitions between services.

Thinking differently

'See me as a person - not as a condition'

Outcomes

- Enhancing quality of life for people with long term conditions and care and support needs
- Helping people recover from episodes of illness
- Reducing emergency admissions to hospital and delayed discharges from hospital
- Improved patient and service user experience.

With more people living with multiple long term conditions and complex needs, it is essential to design the right model of care and treatment. It is increasingly recognised that all elements of care and organisations providing this are interdependent and that services and a pathway approach will achieve the best outcomes and reduce or avoid fragmentation and gaps in care that are sometimes experienced.

As well as personalised and preventive approaches to pro-active care already described, the pathway addresses help in a crisis and ongoing care with a focus on much of this care being community based and helping people to remain at home or nearby. We propose the following key changes:

- Create a model of service that offers a robust alternative to hospital stays both in preventing admission and reducing length of stay with effective community interventions including early specialist assessment when necessary
- Establish clinically led integrated multidisciplinary teams wrapped around a cluster of general practices that have a role in the whole pathway extending the skill base of teams to support more people out of hospital
- Design a small number of strategically located enhanced community hospitals, offering clinical assessment, inpatient care, outpatient care and diagnostics to enable more people requiring hospital appointments or admission to receive this in the community
- Arrange a consistent approach to supporting people living in care homes when they need healthcare to help them to remain in their care home where possible, rather than being moved or admitted to hospital
- Ensure strong co-ordination of the pathway with mental health expertise, particularly in the care of older people with dementia and other mental illness who require physical healthcare; and similarly with end of life expertise.

There are a number of local examples of strengthened community services including hospital at home, the development of local specialist clinics, and the use of technology to reach out to people at home. We want to build on the current work of complex care teams and see health and social care teams as part of a co-ordinated pathway within each locality geography.

Urgent care in the community - making it happen

Urgent care in community settings needs to be a consistent, high quality and resilient service which can be and is used as a first choice for routine urgent care. As part of a wider network of expertise it needs to be designed so that the majority of patients can be seen, treated and their care completed in a single attendance.

People with urgent needs can be supported in a range of ways. National review information indicates that patient priorities include: quick access and simplicity, being in control, and local services which are high quality and safe. Yet the reality is often an unclear system with variations in terms of service, name, location, opening hours which is thought to be increasing overall urgent care demand all over the country. In the NHS NEW Devon CCG area we propose a redesigned model with the following key changes:

- Facilitate prevention and a range of approaches to take services to patients including the use of technology, home visiting and other routes to accessing urgent support such as NHS 111 and near patient testing
- Establish a small number of hospital-based urgent care centres, replacing the current pattern of minor injuries provision, where possible within 30-40 minutes' drive time of communities accompanied by appropriate outreach support. Different approaches would need to apply in rural and urban centres
- Align the urgent care centres with primary care out-of-hours services including co-locating these on the same site where this is achievable, ideally linked with other facilities such as x-ray, to deliver a more comprehensive community service
- Arrange expert senior clinical leadership of the community service within the urgent and emergency care network arrangements in each locality plus shared information technology; protocols and governance for the most effective care.

This is a very different community model from that presently in place in that it enhances urgent care outside of large hospitals, and does this in a way which is connected to emergency and urgent care expertise to bring a convenient and reliable service that meets the needs of our population.

Making an impact

NHS England highlighted four improvements in urgent care: consistent, high quality and safe services; simplicity which enables good choices by patients and clinicians; right care in the right place with the right skills; efficient delivery of services.

Thinking differently

'I want healthcare which does not stop at the boundaries'

Outcomes

- Right care, first time with care completed in one visit
- Reducing emergency admissions to hospital
- Patient and service user experience.

Community specialty services – making it happen

Making an impact

We propose an in-depth piece of work designed to map the full scope of these services in Northern, Eastern and Western Devon.

It will also engage with professionals, commissioners, clinicians, patient and stakeholder representatives to consider current and future needs, the opportunities and challenges ahead and the relevant policy frameworks. This will provide a basis for proposing the strategic direction and future pathways for these services.

Outcomes

- Reducing emergency admissions to hospital and admissions to care
- Effectiveness of reablement
- Patient and service user experience.

There are a whole host of community specialty services. These are typified as those uni-professional services that take place in clinics or home. They particularly support people who may be vulnerable due to age, whose conditions require more specialist input. Working with patients in the community and linking with all parts of the health and care system, these services have an important role.

Specialty services include services such as: podiatry; tissue viability; musculo-skeletal physiotherapy; bladder, bowel and pelvic floor services; specialist nursing such as cardiac nursing and others. Generally, these services have many distinct individual features while also some core features in common including:

- Their role in supporting individuals who require specialist professional input due to specific needs from a patient group who are also often vulnerable due to age, long term conditions or following an episode of ill health
- Some services are small in volumes but complex in the nature of what is delivered, for example chronic fatigue services. Co-working in a networked approach with other specialty, acute, primary and community services is essential to assist the small resource to spread further
- The ethos of promoting and maintaining health and wellbeing is important in these services and most have established education strategies and support arrangements to reduce the impact of risk behaviours on the individuals themselves and others.

It is important these services are taken into account in this community service programme.

We will be undertaking further co-production work to look at these services in more depth. This will take place from the point of publishing this document and with a report on initial proposals available in July 2014.

A new model of care - making a difference

This programme builds on the strengths and proposes change to improve community services. It is centred on getting care in the right place at the right time and to the right standard for individuals, families and communities. It covers personalised and preventive support, pathways for adults with complex needs, community urgent care and specialty services in the community. The notes below describe some of the differences we would expect.

Community hospitals

Community hospitals/local care centres have an important role in the future although we expect this role to be different.

We see a number of hospitals becoming hubs for health and wellbeing - largely without beds but with a range of innovative services including clinics, prevention and wellbeing support, tailored particularly for people with complex needs.

We see a small number of others as clinical care facilities that offer enhanced outpatient services such as urgent care and diagnostics; with inpatient care consolidated into fewer settings than at present. Some may provide more specialist services.

In progressing change of this nature as it is agreed in principle, we would wish to discuss detailed implementation with primary care, providers, clinicians, partners and communities.

At home: integrated care and support every time

Home - and a person's own bed - becomes the focal point of care. Fully integrated multi-disciplinary teams - supported by specialists working in a co-ordinated way - enable more people to remain in their own homes and with the right mix of care and support in communities to achieve this. The role of district nursing, therapists, clinicians and others reflects latest national policy and skills are deployed to maintain more people at home. Learning from current successes - such as hospital at home and complex care teams - enables the spread of this learning and rapid implementation.

In each community

New partnerships in communities become established - beyond health and social care. These partnerships involve patients, primary care, community leaders, the voluntary sector, local charities and business. They also include other key departments and agencies at a local level for example education, police, fire and rescue services. They focus on harnessing the assets and power in communities to shape future care. In some areas community hospitals will also change their role to community health and wellbeing hubs while in others a more networked approach may be developed.

In each locality

The model of urgent care and pathways for adults with complex needs includes a range of Better Care Fund schemes and the development of a small number of strategically located enhanced clinical and integrated care facilities across the geography. This would bring more care out of busy acute hospitals and nearer to people's homes - and work to current day quality standards and outcomes. Strong networks and connections reflecting patient flows would support this.

Supporting future change - making a difference

To support change and transformation we need to take into account a range of important factors. These include: quality standards, the money, the workforce, technology and facilities for services, the actions and governance which will achieve transformation and the support during the period of transition to maintain quality safe services in the interim.

Quality and outcomes

There is something very powerful in describing community services as the 'golden thread' which holds seamless and high quality pathways together. Involving communities in defining this high quality can enable services and their delivery to reflect the experiences and outcomes that are important to people. Our engagement in co-production has helped us to progress this with six strategic priorities as described earlier. We have also been developing principles and experience outcomes to act as a guide to commissioning decisions.

The money

We spend 11 per cent of our commissioning resource on community services and the Clinical Commissioning Group has stated in its 2014/15 plan that the proportion of spend on community care and support will increase, showing a commitment to this model of care. However, as we all know, costs are rising and pressures on care are greater so we need to make every pound count. Add to that the fact that the local health economy is identified as one of 11 challenged communities nationally in relation to financial sustainability, anything new we do must, of course, be affordable.

Community services workforce

The workforce is central to the delivery of good care and we would wish to engage and work with the many community services clinicians, professionals and staff in the detailed design for the future. There is a need to consider new guidance and policy such as: the exciting developments in nursing roles; the benchmarks and staffing levels that will be required for the future; and the most effective ways of maintaining workforce skills. New models of care will bring new opportunities for skills development in the areas of wellbeing and prevention as well as clinically enhanced care.

The role of facilities and technology

During the stakeholder engagement phase, we were urged to make the best use of community hospitals and this framework aims to achieve this by thinking differently about the role of these important facilities. The clinical commissioning group does not own the buildings but would wish to see them used imaginatively and will work with providers, property services and communities in relation to this.

Technology is another feature yet to be fully embraced. Access to patient records by different teams, remote consultations, alarms and sensors to assist people at home, electronic appointment bookings, and many other developments all bring possibilities. We will be interested in innovative approaches to the use of technology in the delivery of effective home based and local care.

Towards a future pattern of provision

In addition to preparing community services for the future, we need to consider the arrangements for their provision. These arrangements will need to deliver the ambition of integrated, personal and sustainable care and support already described. Our proposed pattern of provision from 2015/16 until 2018/19 is described here for each of the making it happen sections of this framework.

We want to give current and prospective providers, local authorities, commissioners, key stakeholders and the public locally an opportunity to express their views before decisions are made on procurement (contract award) approach at the meeting of the Clinical Commissioning Group Governing Body on 16th July 2014. We have used the sound basis of NHS Procurement, Patient Choice and Competition (no 2) Regulations and associated guidance by Monitor to underpin our approach.

Current community services contracts in the Eastern Locality, South Hams, West Devon and Plymouth in the Western Locality, are all due to end in 2015/16. We therefore must plan ahead for provision of services in these areas from 2015/16 until no earlier than 2018/19.

- It is clear that we need to design community services with integration high on the agenda. We are therefore committed to ensuring that the future pattern of provision supports our drive towards integration with both Devon and Plymouth local authorities
- Breaking down barriers and simplifying and streamlining care for patients, particularly older people, across a patient's pathway is also crucial. We are therefore proposing to commission patterns of provision centred on locality geographies where appropriate for maximum care pathway co-ordination
- There are clear benefits of enabling enhancement of community services through clinical specialist input so that more care can and does take place outside of large hospitals. This requires taking positive steps working with the acute sector to maximise the shift of care to community settings
- We need to start now to fundamentally re-design towards a sustainable system that is centred on, and extends beyond, traditional health and social care. This includes adopting approaches which harness the power of communities and the voluntary sector and positively enable personalisation and flexible provider responses to flourish.

Towards a future pattern of provision

Personalised and preventive support

This is a developing set of services that will promote greater flexibility and innovation. We propose a competitive approach to facilitate a range of providers including the community and voluntary sectors to best serve needs.

Services for adults with complex needs

Integration and co-ordination of services with clear pathways of care centred on natural locality geographies. This underpins a no-competition proposal for these services, and re-procurement in each locality geography.

Community urgent care services

For community urgent care services we are proposing competition to achieve an alliance approach to harness the range of relevant expertise into a single arrangement for Northern, Eastern and Western Devon.

https://www.newdevonccg.nhs.uk/involve/community-services/101039.

Next steps and your views

Starting now we will:	In the first 12 months we will:
Communicate the contents of 'Integrated, personal and sustainable: community services for the 21st century' widely and invite and obtain feedback on the proposed direction for services by 8th July 2014.	As we know there is a clear impetus for action we will ensure an early focus on implementation on areas already in progress and also on more specific options and proposals as these are developed and agreed.
Engage local Health and Wellbeing Boards and local Healthwatch in Devon and Plymouth and consult with Devon Health and Wellbeing Scrutiny Committee and Plymouth Scrutiny Committee.	Some work is well advanced already and we are working with a number of communities to shape new models. This co-production will continue to develop, grow and guide local change in relation to this framework.
Further involve clinicians, commissioners, partner organisations, providers and their staff particularly through engagement of CCG localities, member practices, clinically focused care design groups and local authority colleagues.	Advance our work with local authorities on integrated health and wellbeing, commissioning and delivery to progress the model of integration Northern, Eastern and Western Devon.
Engage key groups who have an interest in this work including: carers, lay and professional stakeholder reference groups, council members, the voluntary sector, equality contacts, safeguarding leads and others.	Implement changes already underway with the support of communities, including the first of the new Health and Wellbeing hubs that are currently being designed.
Conduct in-depth work during the period between now and 8th July 2014 in relation to the contents of this framework including outcomes, impact assessments and the proposed approach to future provision.	Work towards early release and shifts of resources from current to new models of care with a clear and transparent programme, implementing this from the second half of 2014/15 and through 2015/16.
Review responses and decide the next steps towards 'Integrated, personal and sustainable: community services for the 21st century' at the Clinical Commissioning Group Governing Body meeting on 16th July 2014.	Progress the work to achieve sustainable delivery of services once decisions are made in July 2014 regarding the scope and nature of contract award processes.
In relation to future work as regards specific proposals we will begin a staged programme of publication - between June and September - for each of the care sections and localities - each with an eight-week period for comment.	Act on other changes that reflect national policy such as advancing our work on personalisation and personal health budgets, implementation of the Better Care Fund and greater integration.

Principles that will act as a guide

Early on in this programme, we established a large stakeholder reference group bringing together leaders and clinicians to add their experience and expertise. Taking into account the initial public engagement, this group set out ten principles for commissioning of community services. These have since been interpreted as 'I' experience statements and provide a framework for improvement through community services.

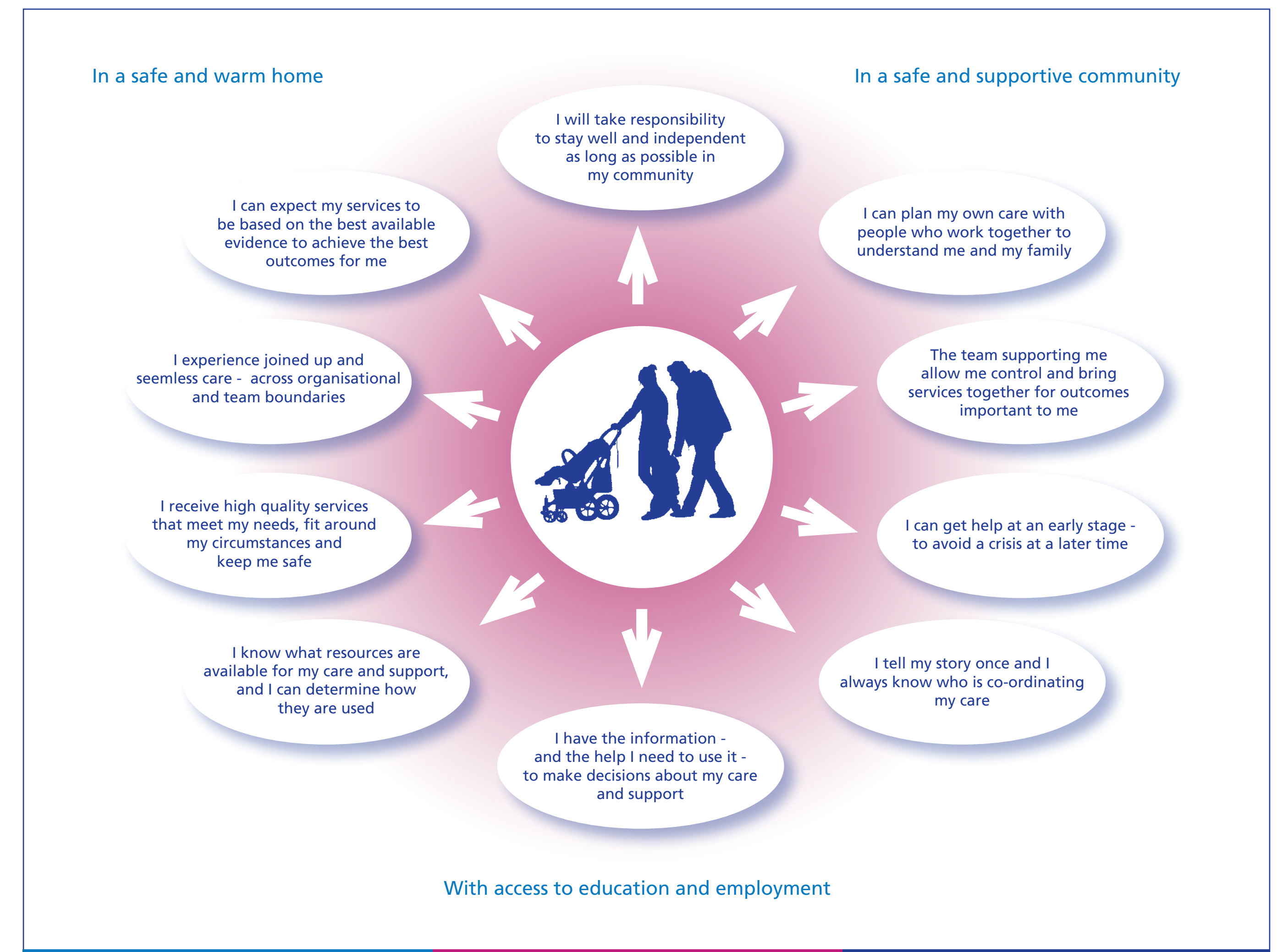
Community services commissioning principles

These principles will be an important marker to guide planning and decision making on the strategy and delivery arrangements for community services - and then at key milestone points in this journey of transformation so future services achieve the desired results:

- Integrated and seamless delivery
- Clear pathways and access
- Consistent outcomes
- Evidence-based foundations
- Individuals and carers at the centre
- Personalised and localised models
- Honest and open relationships
- Care which reflects health needs
- Sustainable, agile and flexible responses
- Shifts of resources and innovation.

Implications for experience

Built from these principles and the themes from engagement, these 'I' statements set out what individuals should be able to experience. They were developed with colleagues in Devon County Council and Plymouth City Council, and South Devon and Torbay Clinical Commissioning Group. Localities have also developed more detailed 'I' outcomes to reflect specific locality priorities identified through engagement. All of this will guide our work.



Please tell us your views

We would like your views to share with the Clinical Commissioning Group Governing Body and locality boards. At this stage we are asking you to comment on a strategic framework. Our approach to local implementation will be through co-production and should it be required for a specific change, further engagement and consultation. This means there will be opportunities to influence community services as more specific details become available.

Our questions for you

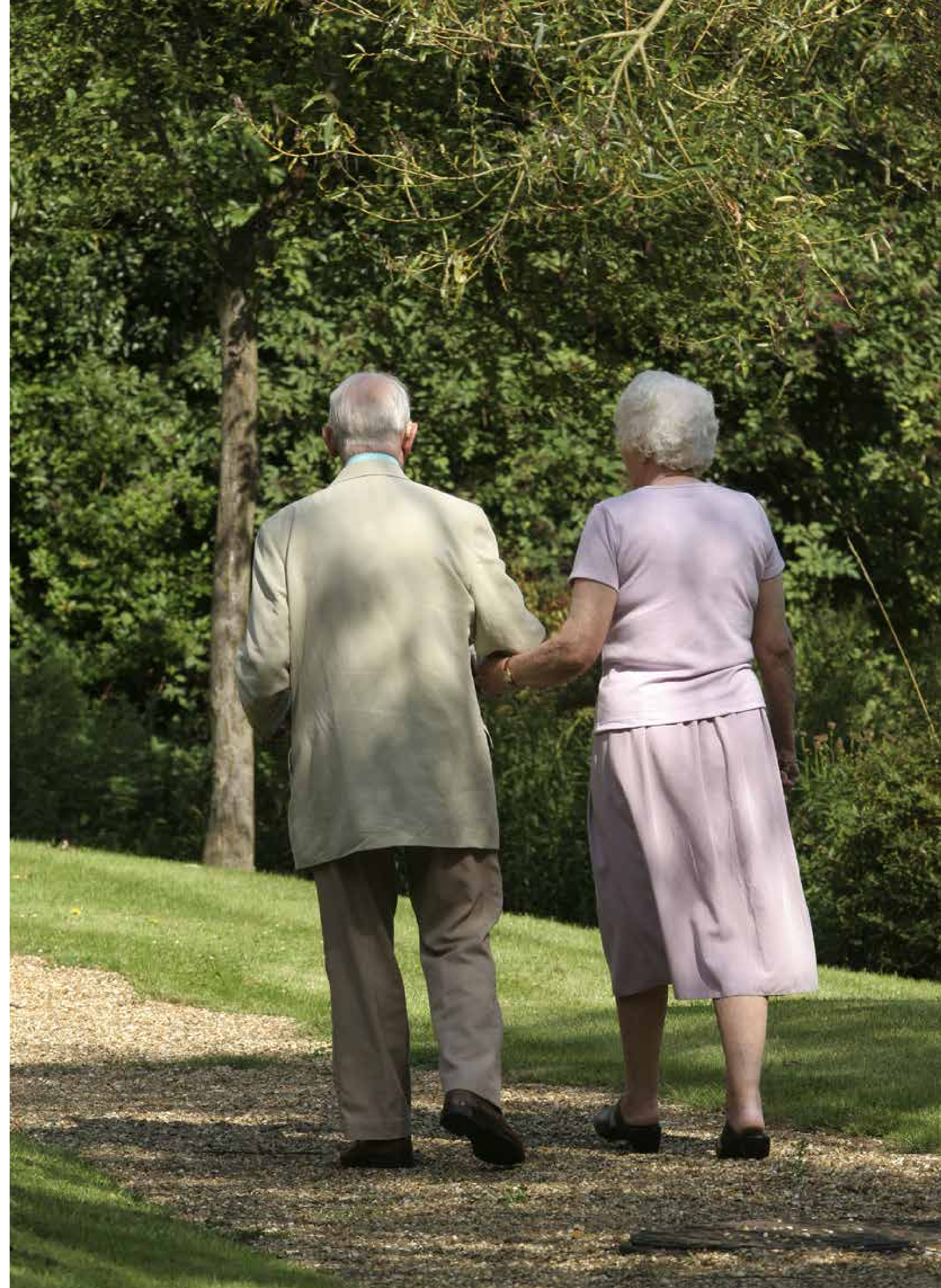
General questions:

- What are your views on the direction of travel?
- What are your views on the level of ambition in this framework?
- What do you like most about the proposed way forward?
- What is your main concern about the proposed way forward?

We would particularly welcome your responses to these questions for the framework overall as well as in relation to the following sections:

- Preventive and personalised support
- Pathways for adults with complex needs
- Urgent care in the community
- Community specialty services
- Towards a future pattern of delivery

When and how to comment	
When?	Anytime during the eight weeks from now until 8th July 2014 - although it would be helpful if we could have your comments as early as possible in this time period.
How?	There are a number of ways you can comment: Fill in the online form on https://www.newdevonccg.nhs.uk/involve/community-services/101039 or send an e-mail or written response to:
	Community Services, NHS NEW Devon Clinical Commissioning Group, County Hall, Topsham Road Exeter, D-CCG.Community@nhs.net
	Telephone one of our community relations managers to discuss your views by contacting Keri Ross on 01392 267680 or Sally Parker on 01752 398737
	Join in meetings or focus discussions that will be held over this time period as published on https://www.newdevonccg.nhs.uk/involve/community-services/101039
Need any help?	If you need this document in a different format or language then please let us know using the contact details above.



Integrated, personal and sustainable

May 2014