Bristol Clinical Commissioning Group
AGENDA ITEM NO: 11

Bristol Health & Wellbeing Board

Health and Social Care Commissioning 2014 and beyond

Report co-ordinator	Kathy Eastwood, Service Manager: Health Strategy, Bristol City Council
Date of meeting	5 September 2013

1. Purpose of this Paper

1.1 To facilitate discussion on Commissioning Plans across the local Health and Social Care system to ensure strategic alignment, focus on agreed priority areas and to explore whether opportunities for joint commissioning are fully taken-up.

1.2 To enable formal agreement of the Clinical Commissioning Group draft Three Year Plan 2013 – 2016 *"Better health and sustainable healthcare for Bristol."*

1.3 To enable formal agreement of the areas for spend for inclusion in the section 256 agreement between the Clinical Commissioning Group (CCG) and the Council.

2. Context

2.1 The central purpose of the Health and Wellbeing Board is to bring commissioning organisations together to get more out of the health and care system and better outcomes and experience through better integration. This is through collective leadership and connecting NHS and local government activity, with all public and VCS (voluntary community sector) resources to improve health and wellbeing in our communities.

2.2 The Health and Wellbeing Board is required to "sign-off" the Clinical Commissioning Group commissioning plan. This

should be informed by the JSNA and Joint Health and Wellbeing Strategy. It is recognised however that this year these have been developing in parallel.

3. Commissioning Papers

3.1 Attached are several documents (listed under appendices) that contain information about the Council and the CCG commissioning plans. Some of this is in presentation format and some of it is a narrative.

3.2 At the meeting there will be further material that links all these items up into one presentation. This will also contain information on commissioning from NHS England and on some areas of "wider determinants of health" from the Councils teams.

4. Key risks and Opportunities

4.1 There are significant opportunities for better integration of services through joint commissioning.

5. Recommendations

It is recommended that:

5.1 The HWB discuss the commissioning plans and agree that they are well aligned across organisations.

5.2 The HWB establish any further joint commissioning opportunities, as appropriate

5.3 The HWB formally agrees the Clinical Commissioning Group draft Three Year Plan 2013 – 2016 *"Better health and sustainable healthcare for Bristol."*

5.4 The HWB formally agrees the areas for spend for inclusion in the section 256 agreement between the CCG and the Council.

6. Appendices

Appendix A	Clinical Commissioning Group draft Three Year Plan 2013 – 2016 *"Better health and sustainable healthcare for Bristol."*
Appendix B	Health and Social Care Commissioning Intentions for 2013/14
Appendix C	Commissioning for children and maternity services (slides)
Appendix D	Funding Transfer from the NHS to Social Care 2013/14 (Section 256)
Appendix E	Public Health Commissioning (slides)
Appendix F	NHS England Commissioning Intentions
Appendix G	Community Investment Funds – Commissioning Intentions
Appendix H	VAAWG Commissioning Intentions
Appendix I	Preventing Homelessness

Bristol Clinical Commissioning Group

Three Year Plan

2013 – 2016

Better health and

Sustainable healthcare for Bristol

Version Control

Version	Editor	Changes	Circulation	Date
0.4	Jo Underwood Jo Wilson	• Judith Brown's amendments	Mary Connor, Judith Brown, David Tappin, Claire Thompson	26/06/13
0.5	Jo Underwood	• Exec Summary • Section 7 • Section 8 • Section 14	As above	03/07/13
0.6	Jo Underwood	• Header & footer • 8: Cancer • 10: Information Technology • 11: Financial Plan • 12: QIPP • 15: Equality & Diversity	As above + Leadership Team	04/07/13
0.7	Jo Underwood	• 8: some edits + public health leads • 9/10: separate out Corporate Governance from Clinical Quality & Transformation section. Added resilience sub-section to Section 9. • 13: QIPP • Document development version numbers (0.7 to Board seminar)	As above + Governing Body	04/07/13
0.8	Claire Thompson	• 15: Workforce data inserted (Catherine Thomas) • 9: Additional delivery theme & updates • 12.4: replaced table • 10: transformation section • 11.4 health technologies inserted • 3.1 evidence based commissioning • 1.0 presentation changes • 6.2.2 addition of diabetes	As above	12/07/13
0.9	Emma Daly & Claire Thompson	• Updating Table of Contents • 8.4 EPRR • Restructuring quality & transformation elements • Updating of table 3 section 11 • Insertion of research chapter • Insertion of patient story 6.8 • Amendment to healthcare system diagram section 8	As above	18/07/13
1.0		• Changes to executive summary • Glossary	Claire Thompson, Mary Connor, Anthony Pearce	31/07/13
1.1	Mary Connor	• Update 12.3 re: Programme Budgeting table.	Anthony Pearce Claire Thompson, Mary Connor,	01/08/13

Document development and sign off

Draft	Group	Date	Decision
0.1	Author	10/06/13	Initial draft for discussion
0.2	Editing group	14/06/13	Further discussion and editing
0.3	Editing group	24/06/13	Further discussion and editing
0.4	Editing group	27/06/13	Further editing ready for Leadership Team review
0.5	Leadership Team	04/07/13	Advice on content and overall message
0.7	Board Seminar	09/07/13	Discussion and steer on content
0.8	Editing group	TBC	Further draft following Leadership Team and Board Seminar
0.9	Final draft	End July	
1.0	Governing Body	06/08/13	Final document review
1.x	Editing group	TBC	Further draft following Governing Body advice
2.0	Governing Body	September	Final sign off

Contents

1 Foreword

Bristol Clinical Commissioning Group (CCG) is passionate about improving the quality and effectiveness of care for our patients now and in the long term, hence our overarching vision:

'Better health and sustainable healthcare for Bristol'

As a new organisation we are determined to place the patient, their families and carers at the heart of our commissioning decisions and to embrace the diversity of our local communities. We therefore have an absolute focus on patient and public engagement and the equalities agenda.

We have listened to our patients, member practices and partners to develop our own local priorities whilst also taking account of national and regional objectives.

The Government's long-term plans for the future of the NHS are set out in the NHS White Paper, 'Equity and Excellence: Liberating the NHS' and the subsequent Health and Social Care Act 2012. The Bill signalled the biggest re-organisation of the NHS in its history, and will have a significant impact on almost every organisation that delivers NHS care. The Bill stipulated that leadership, governance and commissioning of NHS services would transfer from Primary Care Trusts to Clinical Commissioning Groups.

From April 2013 therefore, Bristol CCG became the statutory body responsible for commissioning local health services for this population. This document is our integrated plan for the period 2013/14 to 2015/16. It explains what Bristol CCG is, what we aim to achieve, and how we will go about improving health and services for the population of Bristol over the next three years.

We are committed to delivering the improvements outlined within this plan and will review it regularly to ensure that we are on track. The plan will only be revised as necessary in light of changing circumstances.

Finally I would like to thank all the staff of the CCG, and our member practices and partner organisations who have contributed to this document, and who continue to work to deliver the ambitions within it.

Dr Martin Jones
Clinical Chair, Bristol CCG

2 Executive Summary

Our vision is to deliver better health and sustainable healthcare for Bristol. In order to do this our most fundamental of values is to keep the people of Bristol – patients and their carers and families – at the heart of the decisions we make. People in our city do not enjoy the same fortunes or outcomes across the board so in this plan we are committed to pursuing and promoting equity of access and equal opportunity for all, working closely with our partners in Bristol City Council and other organisations. This integrated working is the cornerstone of planning services to meet the needs of our growing population of children and young people, as well as to ensure a seamless transition to adult services.

We have a set of key Bristol-wide outcomes to deliver by 2016 including:

OUTCOMES	• Frail and elderly patients' long-term conditions managed closer to home • Earlier cancer diagnosis – achieve national outcome standards • Reducing inequalities • Patient experience – patients know what to expect and receive it.

Our objectives will be delivered through a set of eight 'Delivery Themes'. These are:

DELIVERY THEMES	1. Urgent Care system including frail and elderly patients 2. Long Term Conditions (including a specific focus on dementia) 3. Elective Care 4. Children and Maternity 5. Mental Health 6. Cancer 7. Learning Difficulties 8. Medicines Management

Within these, there are eight delivery priorities for the CCG, with the exception of the first, applying to adults & children alike:

DELIVERY PRIORITIES	1. Commissioning access to Geriatricians in a community setting 2. Risk stratification and advanced care planning/care co-ordination 3. Integrated primary care input to Emergency Departments (specifically North Bristol Trust) 4. Commissioning alternatives to acute hospital beds 5. Assertive 'pull' through the system to reduce the time people spend in acute beds 6. Robust re-ablement and rehabilitation services 7. Investment in out of hospital care and seven day working 8. Provision of real-time information for decision-making

3 Commissioning Responsibilities

Bristol CCG is responsible for commissioning emergency, urgent care, including ambulance services and out-of-hours services, and planned care for anyone present in our geographical area.

We are responsible for commissioning healthcare services to meet the reasonable needs of patients registered with Bristol general practices and unregistered patients living in the area, except for those services that the local authorities or NHS Commissioning Board are responsible for commissioning, such as general practice and very specialised services. The areas that the CCG is responsible for include:

- Community Health services
- Maternity Services
- Elective hospital care (planned care)
- Rehabilitation services
- Urgent and emergency care including A&E, ambulance and out-of-hours services (unplanned care)
- Mental Health services
- Older people's healthcare services
- Healthcare services for children and young people
- Healthcare services for people with learning disabilities
- Continuing healthcare
- Termination of Pregnancy services
- Infertility services
- Wheelchair services
- Home oxygen services
- Treatment of infectious diseases

We are also responsible for meeting the costs of prescriptions written by our GPs.

The CCG has joint commissioning arrangements in place for children and young people's services, intermediate care, learning difficulties and drug and alcohol services. Given the scale of the challenge to commissioners across health and social care in the coming years we are likely to change the ways in which we commission care to integrate services more around the needs of the patient.

3.1 What is Commissioning?

The word 'Commissioning' is frequently used but often without the knowledge or full understanding the term. To better understand Commissioning, the following definition provided by The Audit Commission is useful. This reads:

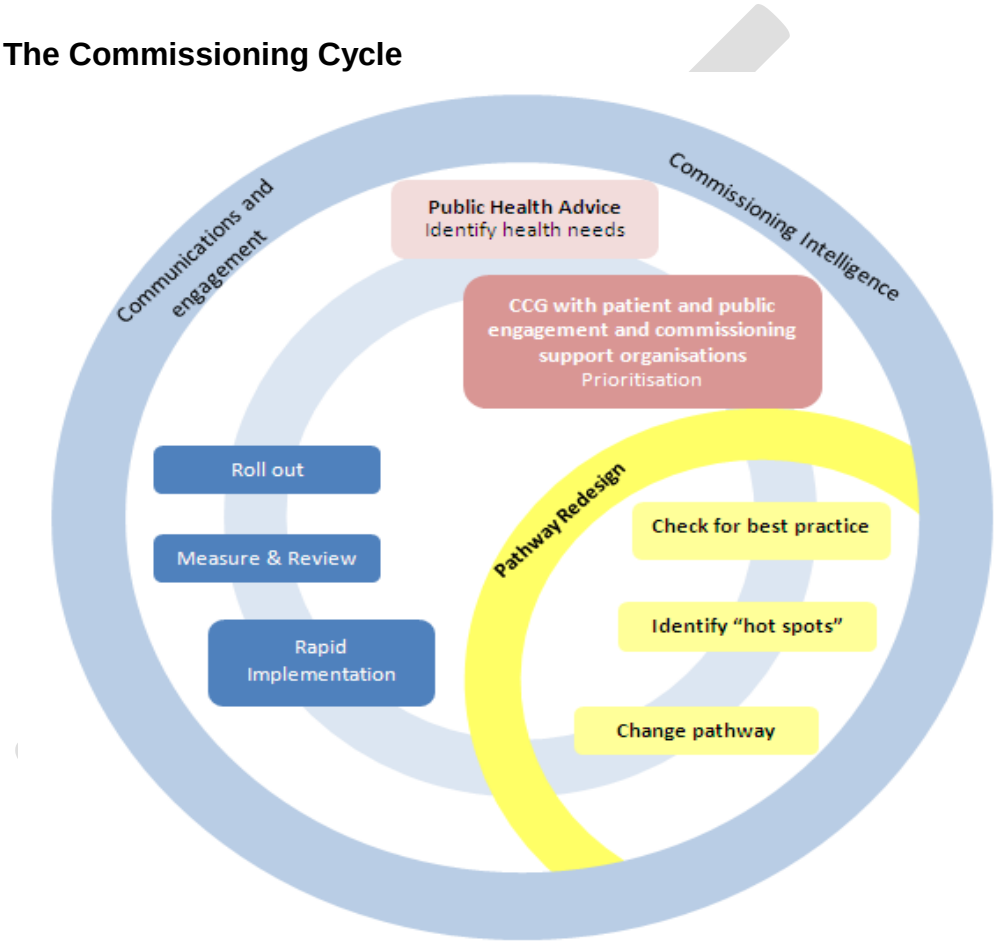
"The process of specifying, securing and monitoring of services to meet people's needs at a strategic level. This applies to all services, whether they are provided by the local authority, NHS, other public agencies or by the private and Third Sector."

Audit Commission; Making Ends Meet, Oct 2003.

Commissioning of NHS services is all about the CCG working with people in the community, Local Authorities and other organisations to identify and understand patients' needs so that services can be designed to meet those needs. This is done by working within a structured and planned process that is continuous and on-going to ensure that services are improved and developed against past experience and current need.

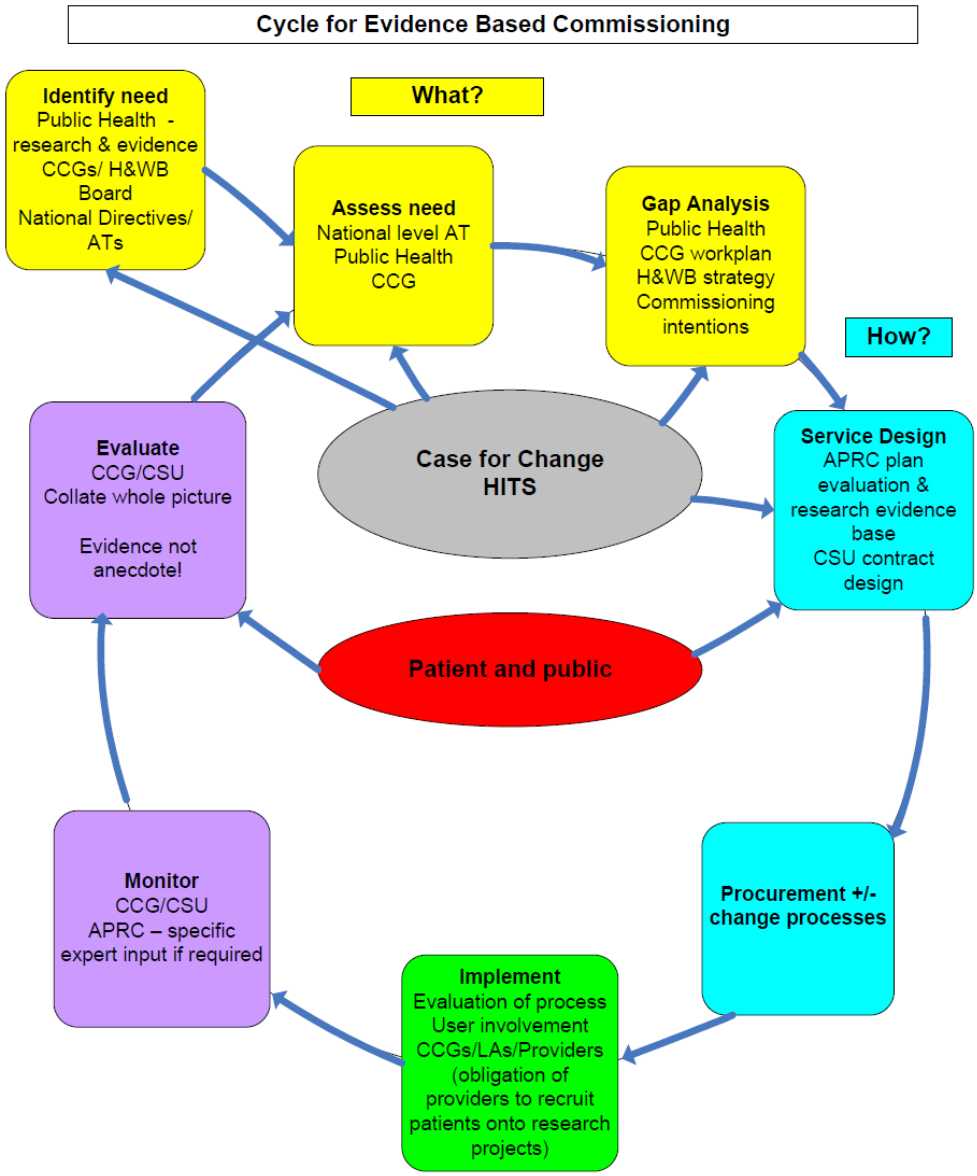
The CCG also decides how best to provide these services and the process for making this happen. GPs – being in touch with patients every day – are ideally placed to talk to patients, their carers and families and understand what their needs are with respect to keeping healthy and receiving the best treatment when and where it is needed. The diagram below is a summary of what is a complex process that will take time to establish and deliver.

The Commissioning Cycle



Bristol CCG will commission services which meet the needs of the population of Bristol based upon information contained within the Bristol Joint Strategic Needs Assessment (JSNA), the trends identified by GPs and their teams in member practices, and the feedback we receive from people who live in Bristol and use the services currently in place. The CCG also reviews existing services and monitors the performance of the providers of these services in order to gain an understanding of what is working well and what might be an area for service improvement.

Locally we have reviewed this process and adapted it to be solidly rooted in the evidence base for change, using networks including Avon Primary Care Research and the health integration teams (HITs). This is represented in the diagram below:



3.2 About Us – Bristol Clinical Commissioning Group

Bristol is the largest city in the south west and the seventh largest in the country. The registered population of Bristol CCG is 470,000 and is considerably larger than the average national CCG footprint of 261,000. This population is served by a total of 56 GP practices. These practices are grouped into 'localities' with distinct local needs and ambitions.

The health and social care economy for Bristol is fairly complex with the CCG's registered patients living within four different Local Authority boundaries. The majority of the registered population (95%) live within the City of Bristol Local Authority.

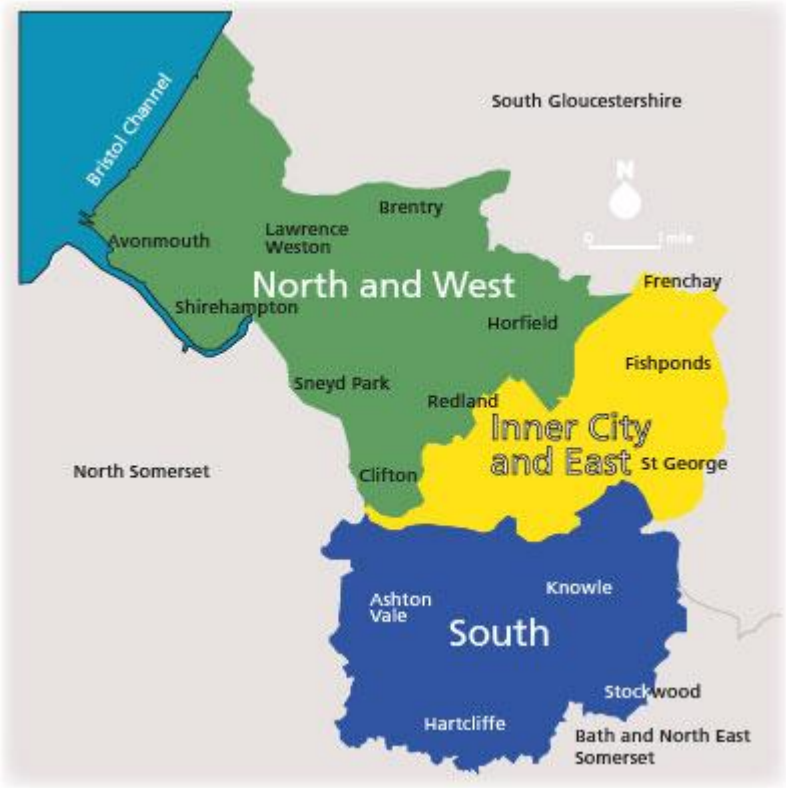
The CCG's main acute provider is University Hospitals Bristol NHS Foundation TrustT (UH Bristol), although this Trust only takes about 60% of Bristol CCG admissions. In turn, Bristol represents 61% of UH Bristol's total admissions. A very large proportion of the remaining admissions are to North Bristol Trust,

whose two campuses, Frenchay and Southmead, are each only around four miles from UH Bristol's city centre location.

Bristol CCG's 58 GP Practices are grouped into three distinct Localities:

- South;
- Inner City & East; &
- North & West.

These Localities are shown in the map of Bristol CCG below:



3.2.1 Inner City and East Bristol

Covers: Broadmead, Ashley, Easton, Lawrence Hill, Fishponds, Eastville and St George.

Population: 140,893 (based on the number of people registered with our practices).

There are 15 GP practices in the locality, including the Homeless Health Service.

3.2.2 North and West Bristol

Covers: Lockleaze, Southmead, Henbury, Lawrence Weston, Avonmouth, Horfield, Henleaze, Westbury-on-Trym, Bishopston, Redland, Stoke Bishop, Clifton, Cotham and Redland.

Population: 184,525 (based on the number of people registered with our practices).

There are 22 GP practices in the locality.

3.2.3 South Bristol

Covers: Brislington, Hengrove, Stockwood, Filwood, Knowle, Windmill Hill, Hartcliffe and Withywood, Bedminster and Bishopsworth.
Population: 157,613 (based on the number of people registered with our practices).
There are 19 GP practices in the locality.

Each locality is similar in size to some neighbouring CCGs, and is characterised by markedly different health and commissioning needs and priorities, driven by the diversity of Bristol's population.

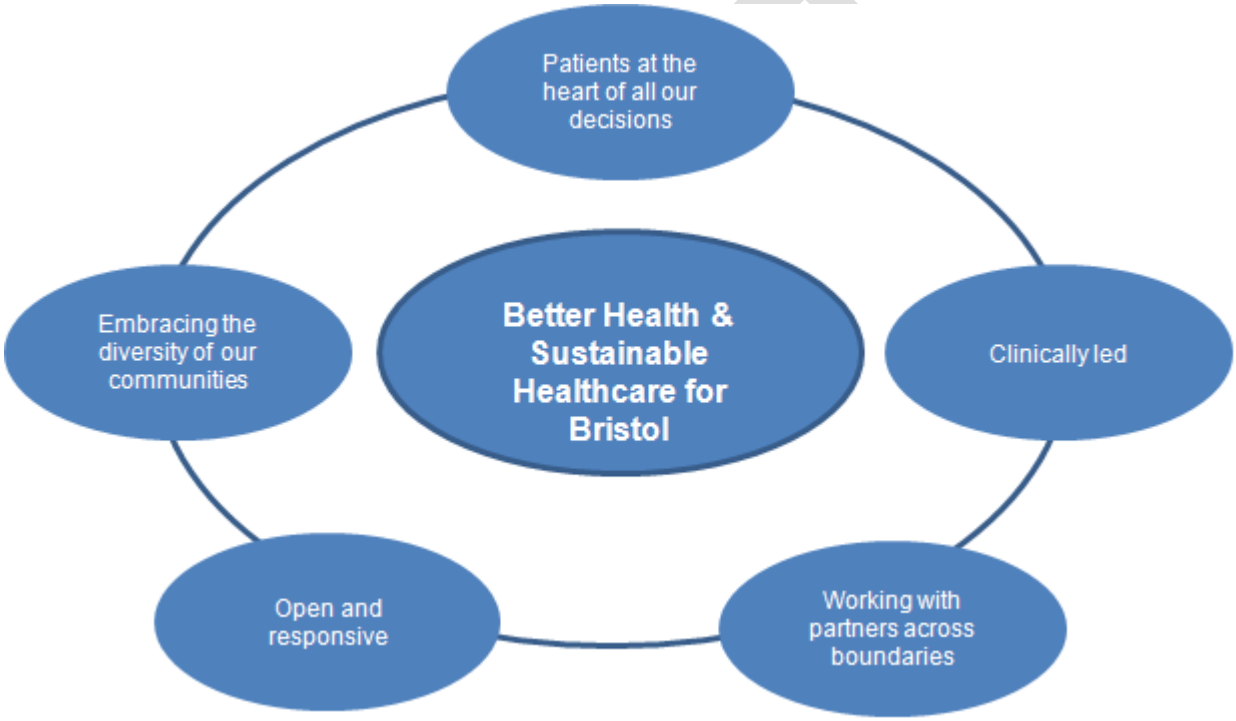
4 Our Mission, Purpose and Values

Our Mission is “better health and sustainable healthcare for Bristol”.

Our purpose is to:

- Improve the health of people in Bristol
- Improve the patient experience and access to care
- Work with Bristol City Council to reduce health inequalities across Bristol
- Work with our partners to ensure that there is a sustainable and affordable healthcare system in Bristol

There are five values that lie at the heart of the way we work with patients, the public, partners and our staff, and these are depicted below:



5 The National Context

5.1 The NHS Constitution

We recognise our obligations to patients as set out in the NHS Constitution. Our patients have a right to:

- Non-emergency treatment starting within a maximum of 18 weeks from referral
- Be seen by a specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected
- Choice of a number of hospitals for elective care
- View their personal health record
- Be treated with dignity and respect, including single sex accommodation
- Have complaints dealt with efficiently and investigated properly.

For further information on the NHS Constitution please see http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/nhs-constitution-interactive-version-march-2012.pdf

5.2 The NHS Mandate

In November 2012 the Government published its first mandate with the NHS Commissioning Board. The NHS Mandate is structured around the five domains in the Outcomes Framework (see below) where the Government expects the NHS Commissioning Board to make improvements.

Through the Mandate, the NHS will be measured, for the first time, by how well it achieves the things that really matter to people. It can be downloaded from http://mandate.dh.gov.uk/2012/11/13/nhs-mandate-published/

5.3 The NHS Outcomes Framework 2013/14

The NHS Outcomes Framework describes the health outcomes required from NHS organisation under 5 domains. These requirements are reflected in the CCG and JSNA priorities for the plan period and various initiatives have been developed to help us achieve these outcomes. The diagram below demonstrates how our Delivery Themes (see Section 6) and management approaches link to the framework:

Outcomes Framework		Bristol CCG
Effectiveness		
Domain 1	Preventing people from dying prematurely	Delivery Themes 1,2&4: urgent care system and frail older people; long term conditions; Children
Domain 2	Enhancing quality of life for people with long term conditions	Delivery Themes 2&4: Long Term Conditions; Children
Domain 3	Helping people to recover from episodes of ill health or following injury	Delivery Theme 1&4: urgent care system; Children
Patient Experience		
Domain 4	Ensuring that people have a positive experience of care	Quality and Governance
Safety		
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	Quality and Governance

5.4 Everyone Counts: Planning for Patients 2013/14

Although the *NHS Outcomes Framework* and *NHS Constitution* set out the goals and responsibilities for commissioners, NHS England recognises that the approaches for delivery will vary and local commissioners will have freedom to develop services that work in their community.

There are five areas that *Everyone Counts* asks commissioners to focus on in order to deliver for the public:

- Support for routine care 7 days a week
- Greater transparency on outcomes
- Mechanisms to enhance patient feedback
- Better data collection to drive evidence-based medicine
- High professional standards, safer care

It also describes tools and levers to support commissioners, including:

- The NHS Standard Contract
- Commissioning for Quality and Innovation (CQUIN)
- Quality premium
- Financial planning and business rules

6 The Local Context

We are one CCG with three strong and empowered localities. Our 2013/14 commissioning intentions support integrated commissioning, the Joint Strategic Needs Assessment (JSNA), the draft Joint Health and Wellbeing Strategy and stakeholder engagement. This section explores the drivers and projections for health and wellbeing in Bristol in order to set out the CCG's strategic priorities to 2016.

6.1 Understanding our population

The following section draws data and analysis from the Bristol Joint Strategic Needs Assessment 2012 and NHS Commissioning Board benchmarking support pack for Bristol CCG, 2012.

Bristol is a rapidly growing city. It is a diverse city with a relatively young population and a strong local economy. On a range of health indicators Bristol ranks as one of the healthiest of the Core Cities (and of other comparable cities), even though Bristol may not compare so well to the England or Southwest averages. The population growth means that the health needs in Bristol are growing and changing. Meeting these growing and changing needs, especially given current financial constraints, requires everybody's combined efforts. Health is "everybody's business" not just that of the health and social care sectors alone.

For Bristol overall, health and wellbeing has gradually improved across many indicators. However, the main story is in the differences within Bristol. The overall citywide picture can hide the differences in experiences for different areas and population groups within the city. There are areas of Bristol that are very affluent, and areas that rank amongst the most deprived in the country. Child poverty in Bristol is significantly higher than the average rate for England, and there are stark health inequalities between different areas.

6.1.1 Our Population

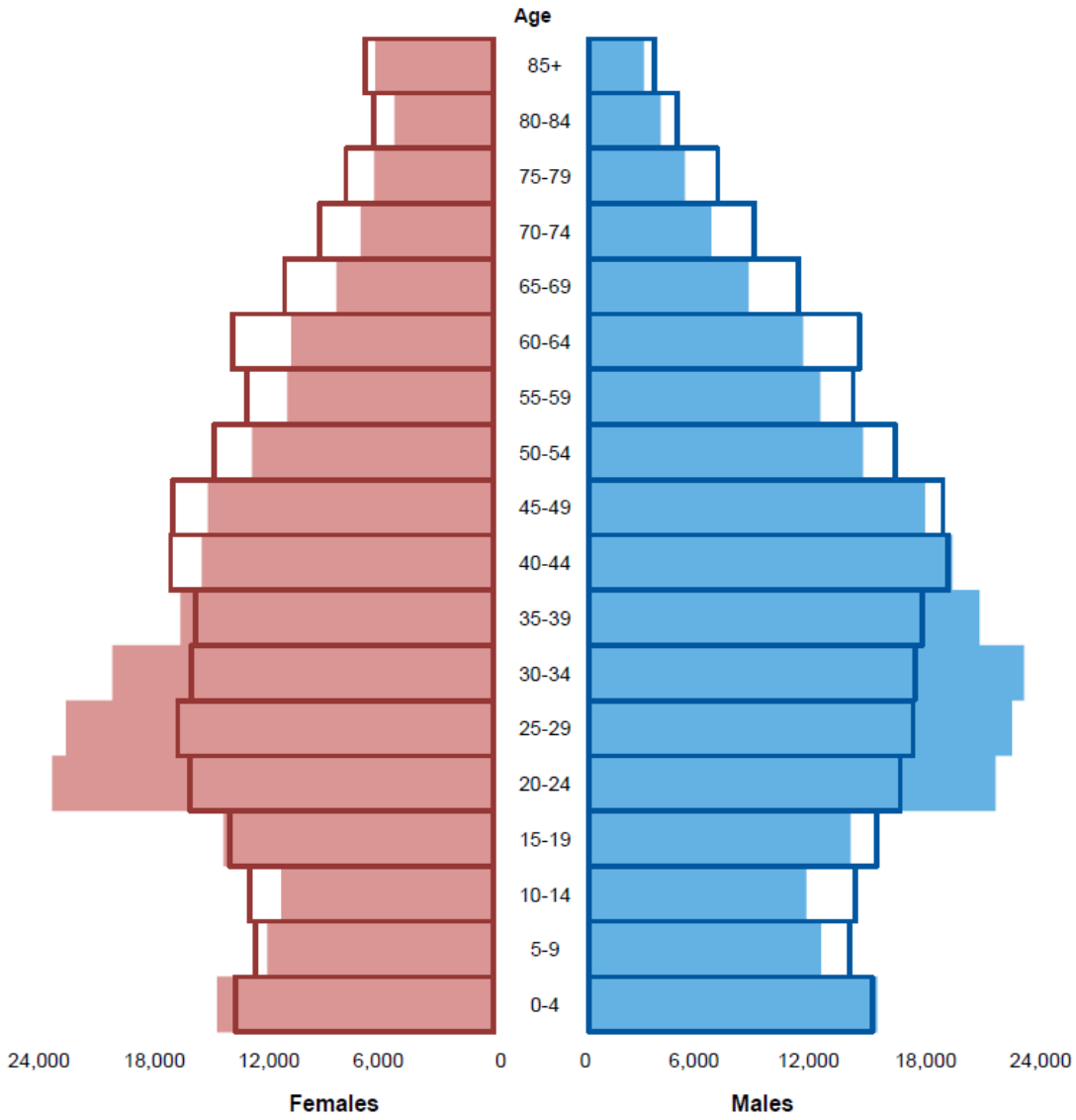
Population growth and change is probably the most significant issue for Bristol's Health and Care Services. Bristol's population is currently estimated at 428,100[1], and in the last decade Bristol is estimated to have grown much faster (9.7%) than the England & Wales average (7.1%), and 3rd fastest of the Core Cities.

Growth has been focussed in the central areas of Bristol, reflecting that the citywide picture can obscure differences within it. For example, since 2001 Bristol overall had a 9.7% growth, but the central wards of Cabot (62%) and Lawrence Hill (44%) saw much greater increases, with these two wards accounting for almost a third of the population increase across the city[22]. However, new government projections estimate that Bristol's population will now increase broadly in line with the England average (8.1% over 2010-2020).

[1] This is the population of Bristol Unitary Authority. The population of Bristol CCG refers to the volume of people registered with a Bristol GP, which is slightly higher at 470,000. The data in this section is drawn from both Unitary Authority and Registered Population statistics and is labelled accordingly.

6.1.2 Population by age

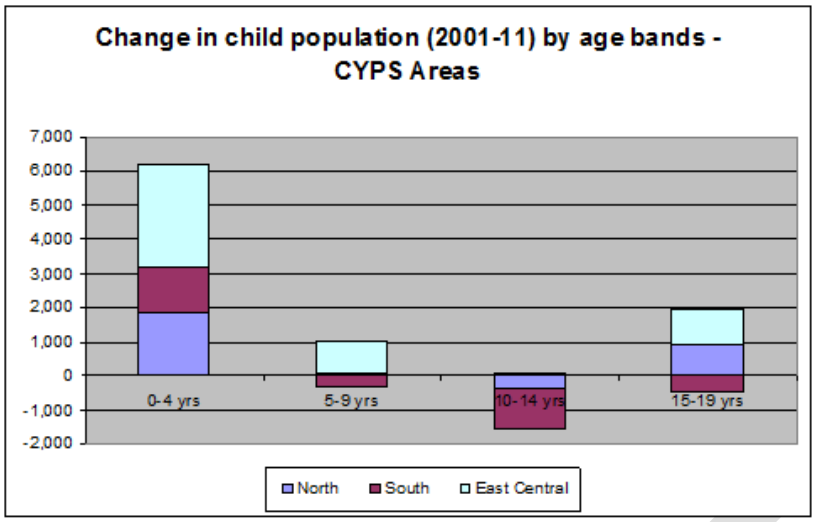
Bristol CCG has a younger than average age profile with more people under the age of 4, and between the ages of 20 and 40. The chart below shows the number of people registered with this CCG's practices by sex and 5-year age band. The darker outlines show the profile of the England population.

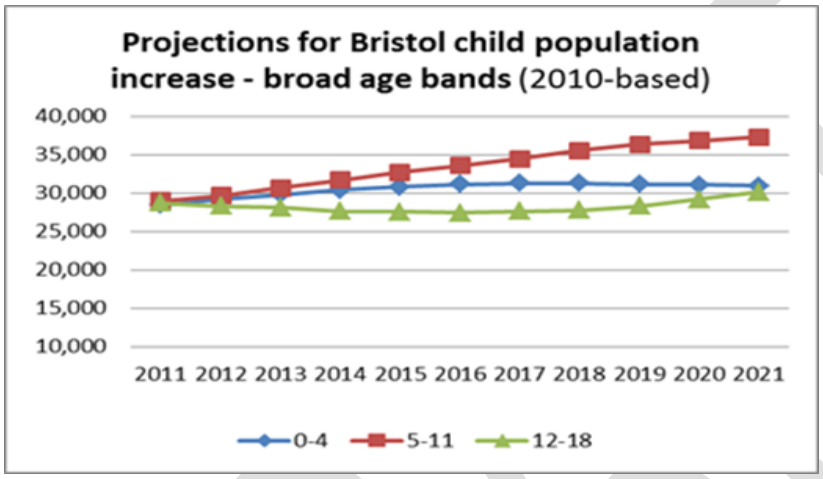


(Source: NHS Commissioning Board, 2012 using Registered Population)

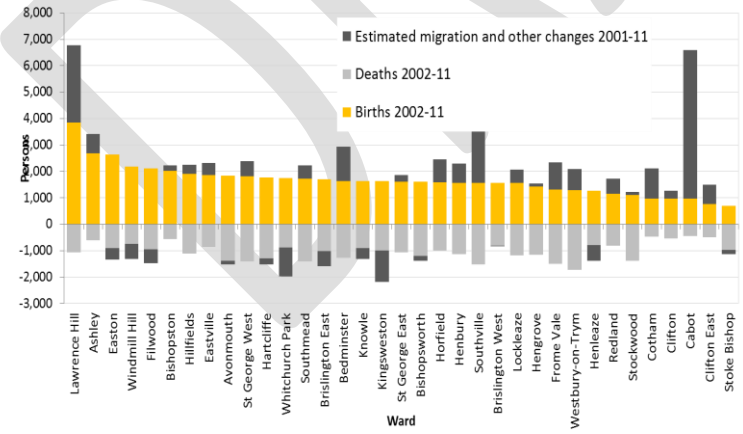
Bristol is unusual in that it is seeing a rapid and continuing growth of the child population of the city.

More detailed analysis of this situation has been undertaken by the local authority as part of drawing up a Child population JSNA, which the CCG is a key partner in. This draft report and summary actions are being worked on, but what is very evident is that there is a need for a joined-up strategic approach across the sectors of health, care and education. This further supports our aim to deliver more integrated services.





These tables show a large rise in the number of children particularly in the 0-5 year age groups, and projected impact over the coming years.



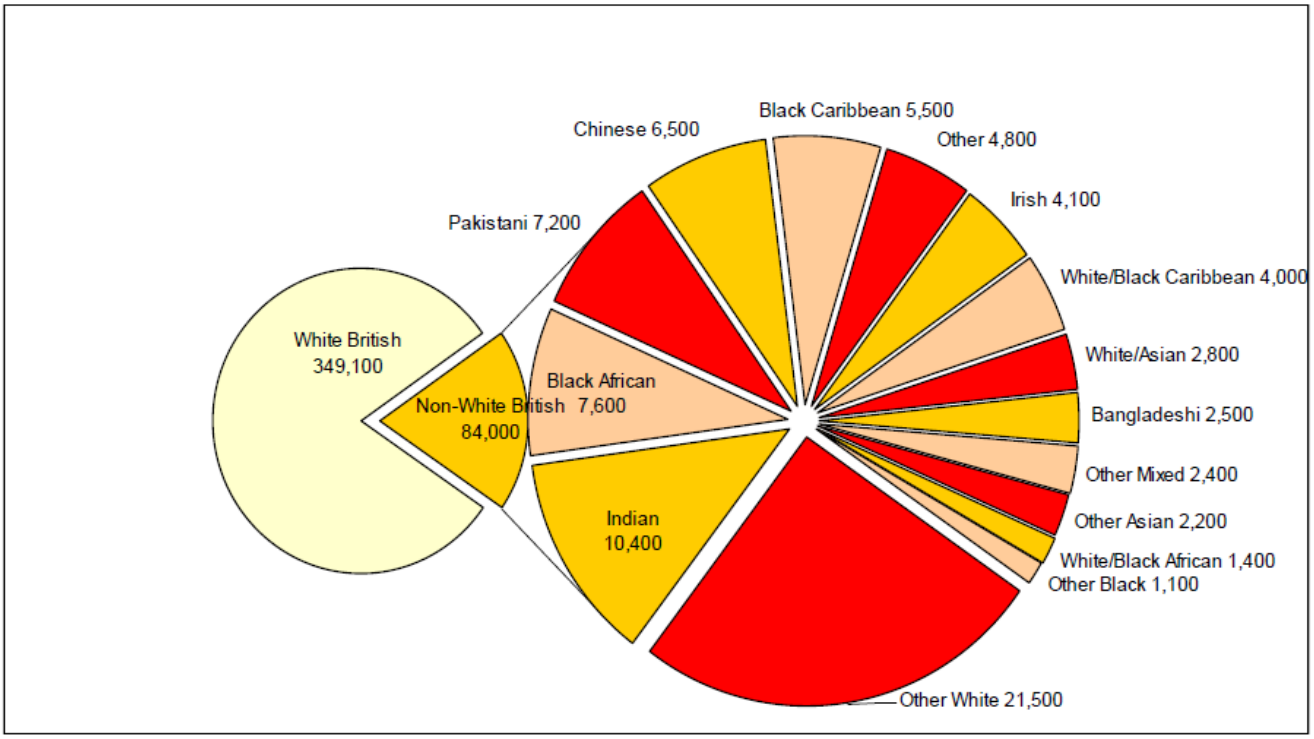
The increase in Central wards is driven largely by international migration and higher birth rates of the new communities, creating distinct needs.

6.1.3 Population by ethnicity

The estimated Black and Minority Ethnic (BME) population of Bristol is 16% or 68,600 people. For children the proportion is much higher, with 26% of Bristol school pupils coming from BME groups (over 28% of Reception Year children). Also, 6% (26,100 people) of the local population now are non-British white (including recent immigrants from Eastern Europe) which is a very significant increase, and over a quarter of children born in Bristol are to mothers who were born outside the UK. The BME population continues to be highly concentrated in Inner City wards, but East Bristol is becoming increasingly diverse too.

The diversity of Bristol's population is illustrated below.

Population by Ethnic Group in Bristol (2009)



Source: ONS Population Estimates by Ethnic Group, Crown Copyright 2011 (Experimental Statistics) [Population of Bristol 2011 report]

(Source: JSNA, 2012 using Unitary Authority population)

6.1.4 Future population change

Throughout the 1990's Bristol had a relatively stable population, but since 2001 the population is estimated to have increased by 13.2%, more than twice the England average. However, future population projections for Bristol are now in line with the national picture, and mid-table for Core Cities and regional neighbours (2008-based projections were much higher). Over a 10-year period (2010-2020), the population of Bristol is projected to increase by 34,500 people, to a total population of 460,800. This projected increase of 8.1% is very similar to the estimated England average of 8.4%.

The table below shows growth projections for Bristol compared with other Core Cities, local commissioners and England as a whole:

Local Authority	2010	2015	2020	Change 2010-2020	
				Number	% increase
England	52,213,400	54,468,200	56,606,600	4,393,200	**8.4%**
South West	5,252,300	5,418,500	5,574,200	321,900	**6.1%**
Core Cities					
Manchester	470,200	507,000	535,300	65,100	**13.8%**
Nottingham	301,000	319,400	334,100	33,100	**11.0%**
Birmingham	1,031,900	1,089,000	1,141,900	110,000	**10.7%**
Leeds	780,900	817,700	848,800	67,900	**8.7%**
Bristol	426,300	445,600	460,800	34,500	**8.1%**
Sheffield	542,500	561,000	576,800	34,300	**6.3%**
Liverpool	440,400	450,100	458,600	18,200	**4.1%**
Newcastle	282,900	287,700	289,900	7,000	**2.5%**
West of England					
North Somerset	210,300	223,400	236,000	25,700	**12.2%**
South Glos	265,900	277,500	287,600	21,700	**8.2%**
Bristol	426,300	445,600	460,800	34,500	**8.1%**
B&NES	177,200	179,700	180,600	3,400	**1.9%**

Source: 2010-based Sub-national Population Projections for Bristol, Office for National Statistics
[Note – the 2010 estimate here is based on the new methodology, not the official ONS 2010 estimate for Bristol]

(Source: JSNA, 2012 using Unitary Authority population)

In terms of age group, the highest growth rates over the ten-year period are projected to be for children (+17.6%) and people aged 65-74 (+13.7%), although the highest increase in numbers is in young working age (25-44). The percentage of young people aged 16-24 is projected to decrease by almost 5% between 2015 and 2020. Population projections by broad age group are shown in the table below.

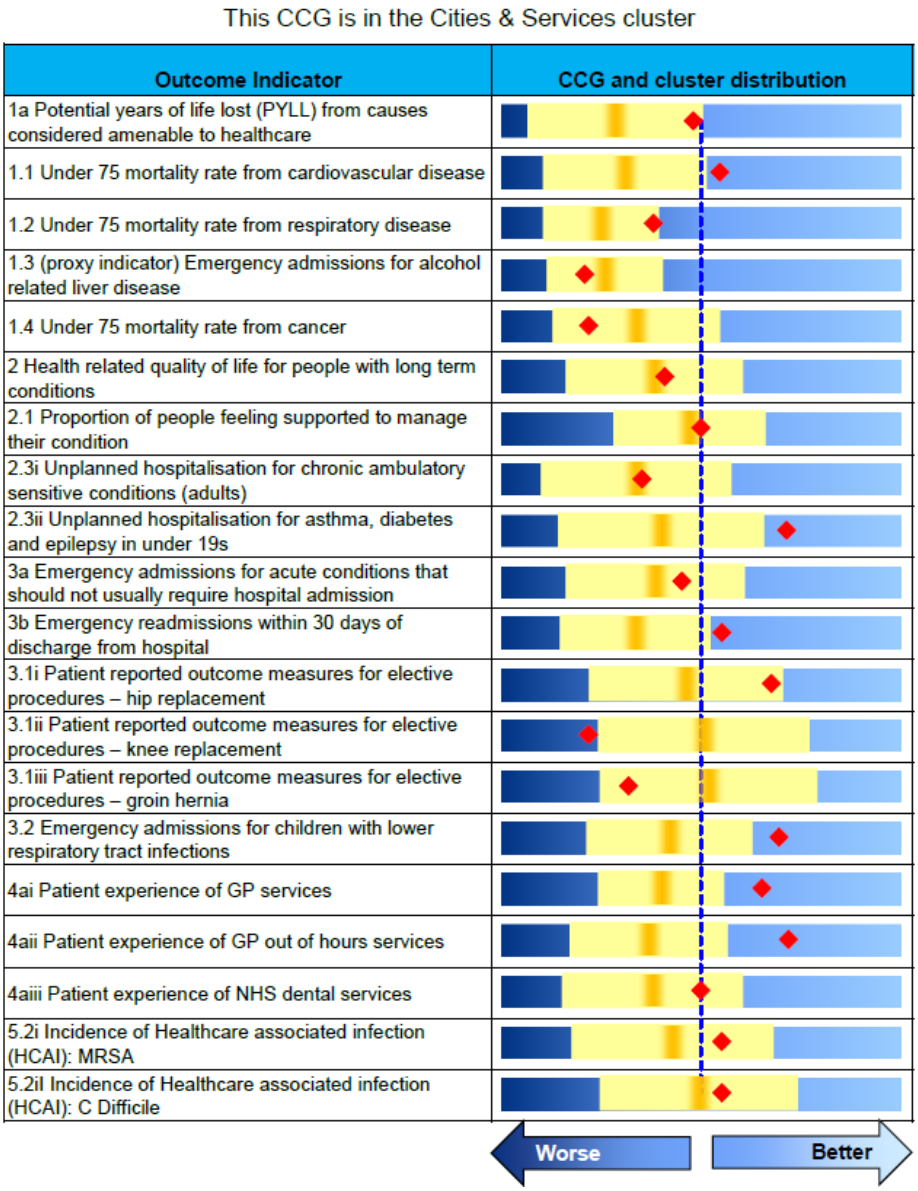
Persons	2010	2015	2020	Change 2010-2020	
age 0-15	72,300	78,500	85,000	12,700	17.6%
age 16-24	67,800	67,800	64,500	-3,300	-4.9%
age 25-44	143,100	150,800	157,300	14,200	9.9%
age 45-64	88,200	90,900	94,000	5,800	6.6%
age 65-74	27,000	29,700	30,700	3,700	13.7%
age 75+	27,900	27,900	29,400	1,500	5.4%
All Ages	**426,300**	**445,600**	**460,800**	**34,500**	**8.1%**

Source: 2010-based Sub-national Population Projections for Bristol, Office for National Statistics
[Note – the 2010 estimate here is based on the new methodology, not the official ONS 2010 estimate for Bristol]

(Source: Bristol JSNA 2012 using Unitary Authority Population)

6.2 Health Outcomes in Bristol

Many of the big health issues for the city mirror national challenges. For example, cancer is still the biggest killer of people under 75 (38%), followed by cardio-vascular diseases (23%). Obesity is a major contributing factor to poor health outcomes, as is smoking and the rise in alcohol consumption. Mental ill health has a major impact on wellbeing. Appropriate support for older people with dementia is a growing issue, as is support for people with Long Term Conditions and the need to better integrate social care and health services. Greater integration is key to ensuring that services are planned and commissioned around the needs of the patient. We will also better integrate services for children with adult services to improve the transition of care. The current financial challenges highlight other issues such as the need to improve the directing of people (in non-emergencies) to access primary care (eg GPs) rather than more costly secondary care services (eg hospitals).

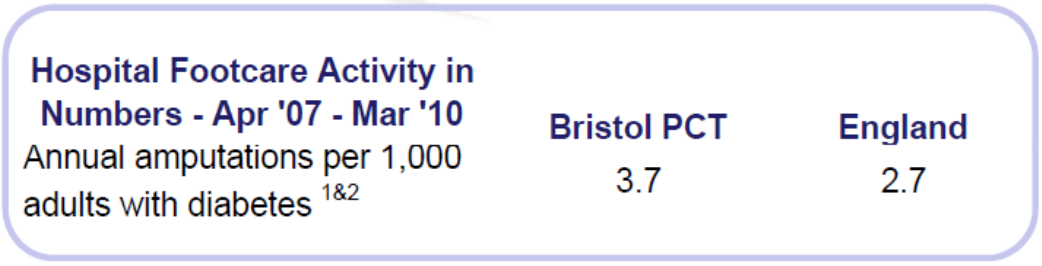


(Source: NHS Commissioning Board, 2012 using Registered Population)

The chart above shows the distribution of the CCGs on each indicator in terms of ranks. This CCG is shown as a red diamond. The yellow box shows the

interquartile range and median of CCGs in the same ONS cluster[2] as this CCG. The dotted blue line is the England median. Each indicator has been orientated so that better outcomes are towards the right (light blue).

The CCG has also already recognised that outcomes for diabetic people in our CCG are significantly poorer than should be expected (see below).



Data sources: 1 Hospital Episode Statistics, The NHS Information Centre for Health and Social Care
2 Quality and Outcomes Framework, The NHS Information Centre for Health and Social Care

6.2.1 Emergency Occupied Bed Days

In 2012 the Kings Fund published a report on Urgent Care and Older People. They benchmarked hospital length of stay by CCG for over-65s, and Bristol ranked 147 out of 150 CCGs. The top and bottom of the benchmarking table is illustrated below:

Rank	PCT code	PCT name	Average emergency length of stay (Days)	Difference from top quartile
1	TAL	Torbay	5.9	
2	5PJ	Stoke on Trent	6.9	
3	5PH	North Staffordshire	7.1	
147	5QJ	Bristol	11.2	2.8
148	5A3	South Gloucestershire	11.3	2.9
149	5NT	Manchester	11.6	3.2
150	5N4	Sheffield	12.4	4.0

6.2.2 Opportunities for the CCG based on Outcomes Benchmarking

Therefore in terms of outcomes/indicators worse than peer group, key health priorities to be addressed by Bristol CCG are:

- Emergency admissions for alcohol
- Under 75 cancer mortality
- Knee and groin procedure Patient Reported Outcome Measures
- Hospital emergency length of stay/occupied bed days for over 65 year olds
- Clinical outcomes for patients with diabetes

In addition, the CCG could improve outcomes in the following areas:

- Under 75 mortality from respiratory disease

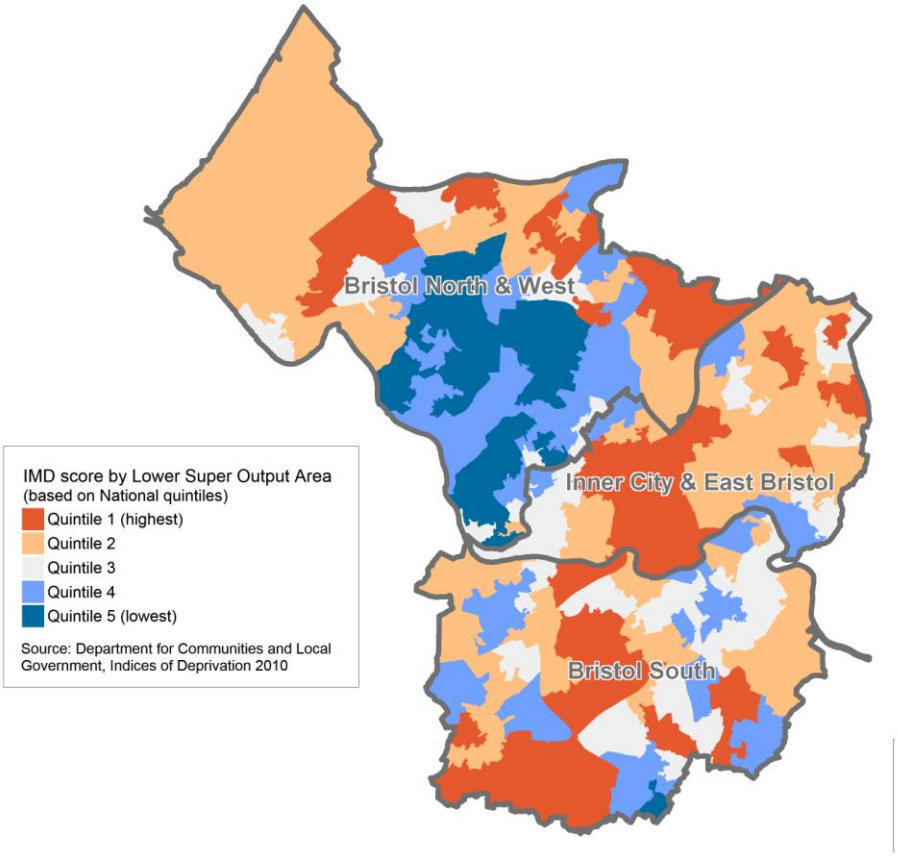
[2] ONS = Office of National Statistics, which groups or clusters CCGs that have similar characteristics in terms of population.

- Health related quality of life for people with long term conditions
- Unplanned admission for chronic ambulatory sensitive conditions
- Emergency admissions for acute conditions that should not usually require hospital admission

6.2.3 Health Inequalities in Bristol

Despite the general city-wide improvement in health and wellbeing outcomes, there are clear and persistent health and wellbeing inequalities across the city, including a persistent inequality in life expectancy between the most and least deprived areas (with a gap of about 9 years between the wards with the highest and lowest life expectancy estimates). Inequalities in health and wellbeing outcomes between the most affluent and most disadvantaged areas are longstanding, deep seated and have proved difficult to change. Bristol has distinct geographical concentrations in deprivation and affluence (which in some areas, especially in North Bristol, sit side by side.).

The map below shows the levels of deprivation in Bristol CCG localities, based on the Index of Multiple Deprivation 2010 (IMD2010)



6.2.3.1 South Locality

There are concentrated and persistent areas of deprivation in South Bristol. Almost half the areas are more deprived than the national average and the health of South Bristol is generally worse than the Bristol average. For Filwood ward (Knowle West), there are poor health outcomes on most indicators. South Bristol has areas of persistent unemployment, high numbers of children with Special Educational Needs and high numbers of

disabled people. Premature mortality due to cancer is also highest in the South.

Population growth is much lower than the Bristol average, and in some small pockets of outlying areas of South Bristol the population actually fell slightly between 2001 and 2010. The South of Bristol has a much lower proportion of black and minority ethnic (BME) residents than the Bristol average.

6.2.3.2 Inner City & East Locality

There are concentrated and persistent areas of deprivation in the Inner City, with a changing profile in East Bristol.

In the Inner City almost half the children live in families receiving means tested benefits. The overall Bristol population growth has largely concentrated in the Inner City, with a young and increasingly diverse ethnic population. 3 of the 4 Inner City wards have the highest proportions of BME residents in Bristol, and for children these proportions are much higher, with 80% of pupils in Lawrence Hill being BME, and 60% in Easton and Ashley. Most of the Inner City has very high rates of child poverty, and high levels of overcrowding.

Inner City wards, particularly Lawrence Hill, have low health and wellbeing outcomes on most indicators, and premature mortality rates are consistently higher in the Inner City than elsewhere in Bristol. Estimates of smoking, alcohol consumption and numbers of adults in drug treatment are higher in the Inner City than Bristol overall. However, there are also some positive indicators that may protect health. For example, the Inner City wards on average have higher rates of mothers initiating breastfeeding and lower rates of mothers smoking during pregnancy than in Bristol as a whole (even though deprived areas usually have poorer outcomes on these indicators).

Across East Bristol the age profiles vary over wards. Population estimates indicate a 40% increase in the under 1 population since 2001, with a decline in the over 75 population. Most areas in East Bristol are more deprived than the national average, and over the last few years most have increased in relative deprivation, especially concentrated in the Greater Fishponds area. However, this is not one of the most deprived areas in Bristol.

6.2.3.3 North & West Locality

Overall, this is a relatively affluent area with generally positive health outcomes, and high levels of educational attainment. Taken as a locality as a whole, Bristol North and West has much lower levels of deprivation, child poverty, obesity, smoking, etc.

However, there are significant levels of deprivation across the North of the area, which has a population profile more similar to South Bristol. Consequently there are significant health inequalities, as overall indicator rates can mask localised differences.

Population growth in North and West Bristol is lower than the Bristol average, and this area has the highest life expectancy estimates, and a relatively low proportion of BME residents.

6.2.4 Primary Care in Bristol

The Annual GP Patient Survey issued by the Department of Health received 14,500 responses from Bristol patients in 2010-11. The responses revealed that more patients in Bristol are satisfied with access to Primary Care services than the national average. In particular, the proportion of patients able to book an appointment in advance, and those satisfied with their practice opening times were significantly higher than the national average, as shown in the chart below. Responses given to other indicators, such as ability to see a GP within 48 hours, and percentage of patients satisfied with phone access were slightly above the national average, though not significantly so.

Managing conditions in primary care where possible ensures continuity of care as well as keeping financial spending to the minimum necessary. The GP Practice Profiles illustrate that practices within Bristol PCT make significantly fewer GP referrals to secondary care than national average, which appears consistent across all specialities with the exception of general medicine (significantly higher) and urology[3] (no significant difference).

6.3 Summary of Key Outcomes for the CCG

Based on the information about our population's current and future health needs, we have identified the following set of outcomes to deliver by 2016:

6.3.1 Key clinical outcomes by 2016

- Bristol escapes the bottom quartile for diabetic amputations, based on current metrics as a baseline
- Frail and elderly patients' long-term conditions managed closer to home
- Earlier cancer diagnosis – Bristol achieves national outcome standards
- Ambition to reduce emergency occupied bed days by 30%

6.3.2 Key community outcomes by 2016

- Reducing inequalities – the CCG recognises the need to address inequalities and to deliver equitable services to all. The reduction in health inequalities within Bristol, and between Bristol and the rest of England, will be a key indicator of the CCG's success.
- Prevention as well as cure – we focus on preserving health and well-being in our local communities as well as enhancing people's experiences when they become patients.
- Patient voice – this is integral to everything we do. 'Patients and public are part of us.'

[3] Note that these national comparators exclude locally provided services such as the community urology service and therefore our referral rate for urology would benchmark higher than national average

- Patient expectations – these are managed because patients know the bigger picture of our priorities and constraints. They understand why and how we have to prioritise, and how this might impact them.
- Patient experience – patients know what to expect and receive it. There is a consistent patient experience across all clinicians and institutions.
- Patients as consumers – the delivery of health services keeps pace with how our population consumes other local services.

6.3.3 Key organisational outcomes by 2016

- The governing body commissions with clout – it leads and co-ordinates the Bristol health community and acts as a functional, trusting team.
- The management team and staff want to come to work – they feel valued, are empowered to make appropriate decisions, and achieve work-life balance.
- Member practices offer challenge and support – the CCG and practices learn how to challenge constructively, the CCG has a relationship with all practices, and the CCG nurtures talent in the practices as part of its succession planning.

7 Quality and Transformation

Improving quality is inherent in all we do. As a clinically led organisation the improvement of services and outcomes through transformational change is key to our culture, as is delivering this in a sustainable way – namely by all our staff having the skills and confidence to make improvements, wherever they work.

7.1 Approach to Transformation

We recognise the need for transformation that supports real and sustained change for improvement, through clinically led commissioning. We will use the NHS Change Model (below) as a framework to support the process of improvement, acknowledging that wider engagement within the organisation is critical to ensure that all staff are supported to make changes for the better.

1. ***Our shared purpose*** *Connects us with our core NHS values collectively work together to take action on what we hold in common. Spending time on shared purpose is vital to ensure effective foundations are in place before progressing to other parts of the process.*
2. ***Leadership for change*** *The approach, skills and behaviours needed to lead significant change.*
3. ***Spread of innovation*** *Accelerate the speed of spread and adoption of innovation to deliver required cost savings while improving quality of care*
4. *Improvement methodology ensures that the change will be delivered in a planned, proven way that follows established methods.*
5. ***Rigorous delivery*** *An effective approach for the delivery of change and the monitoring of progress towards planned objectives are essential to making that change a reality.*
6. ***Transparent measurement*** *At the start of any change it is important to plan for expected benefits and return on investment.*
7. ***System drivers*** *The broad conditions for change need to be aligned to support what is being done.*
8. ***Engagement to mobilise*** *To affect large scale change it is essential that large numbers of people and resources are engaged and mobilised in an effective, collaborative and strategic way.*

We have invested in a Director post for transformation and quality, with the CCG transformation team providing the 'hub' for improvement efforts. Additional resource is available from the South West Commissioning Support Unit transformation team, whom we commission to run specific projects and to work across the wider health community. The 3 Bristol localities provide the 'grassroots' input to commissioning so it is critical that we develop the capacity, awareness and skills of staff in the localities and member practices to deliver change programmes.

All staff groups have a part to play; it is recognised that within the CCG and member practices there are individuals with a range of skills and experience, who have already established their own 'toolkit' of methodologies and techniques that they are familiar with and confident in using. Staff who require refresher training or wish to be trained in new approaches and techniques will be offered opportunities to do so, to increase capability and capacity. Transformation opportunities will take different forms and be of varying size and scale, from small tests of change within a practice, to larger scale, pan Bristol change. The CCG Transformation Team will support staff to build further capability, as required.

The team will also further develop relationships with external partners, such as University Hospitals Bristol, North Bristol Trust, the CSU and Bristol Community Health to align improvement efforts. The involvement of patients and service users is also key. Opportunities to develop similar relationships with equivalent teams within the Local Authority will also be investigated. Relationships with local academic institutions, the Avon Primary Care Research Collaborative and the Academic Health Science Network will promote better application of research into practice.

The CCG workplan & overarching delivery themes (as outlined in this plan) will inform the priorities for the transformation team

7.2 Embedding & sustaining change

Key elements of our strategy to ensure that transformational changes are maintained are:

Leadership: The CCG Director of Transformation & Quality is key in leading and promoting this agenda but it would be expected that other directors have responsibility; in addition, by providing senior leaders with a grounding in improvement methodologies/ principles this will offer additional capability for promotion, both within and outside the organisation.

Build into plans: To ensure effective service transformation, reference to improvement principles, methodologies and outcomes must be built into all plans and embedded in all streams of work, not seen as something separate. This should be a formal requirement and expectation. Proposals should be scrutinised to ensure there is clarity on what quality outcomes will be delivered, how this will be done and how they will be measured.

Monitoring: The progress of all transformation projects will be tracked and achievement towards milestones documented. It is recommended that quarterly

reports will be presented to the Governing Body. The role of the CCG Steering Groups is being reviewed, but it would be appropriate and beneficial for these groups to have oversight of progress of projects relevant to their areas and receive monthly updates (highlight reports). The monitoring and management of project progression will be carried out within a framework that reflects PRINCE2 principles.

Staff: The importance of developing skills at all levels has already been referenced; in addition empowering staff to feel able to test out ideas, within a supportive infrastructure, contributes to sustainability of transformation. To ensure transformation becomes embedded within the organisation's culture and development, competencies will need to be built into new role descriptions and become part of the appraisal process. Robust learning and development plans for teams and individuals should be created that include prioritised learning requirements, how these can be met, resources needed, timescales and evaluation process. All of this will be aligned with the CCG's organisational development strategy.

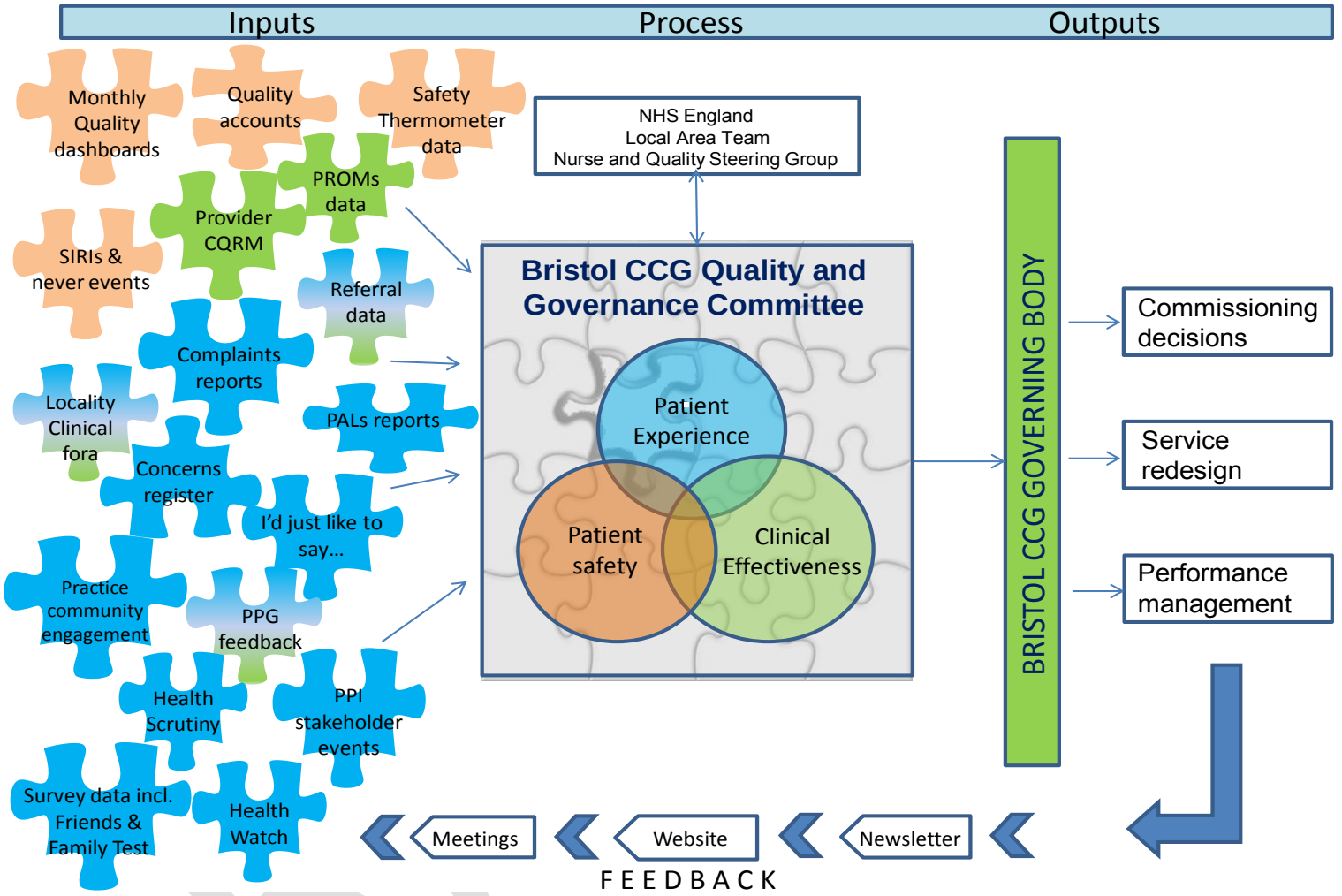
7.3 Listening to our public and partners

Irrespective of the findings of the Francis report[4] and our new statutory duty of candour, the CCG is committed to transparency and putting patients' needs first in all we do. Bristol CCG's Quality and Governance Committee is responsible for this and for ensuring there is a robust process for listening to the public. This process is depicted overleaf. The purpose of the process is to ensure that information gathered from multiple sources is turned into well triangulated intelligence – to improve services where this is needed, and to celebrate success where this is achieved.

(This section & safeguarding to be revised & edited by Richard Lyle for September issue)

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf

Bristol CCG – Quality review framework overview



7.4 Safeguarding

7.4.1 Safeguarding Children

For children and young people, the key legislation includes the Children Act 1989 and the Children Act 2004. Sections 11 and 13 of the 2004 Act have been amended so that the NHS Commissioning Board (CB) and CCGs will have identical duties to those of PCTs, i.e. to have regard to the need to safeguard and promote the welfare of children. The revised version of Working Together (HM Government 2010) will set out expectations as to how these duties should be fulfilled.

The CCGs and the NHS CB will have a statutory responsibility to ensure that the organisations from which they commission services provide a safe system that safeguards children. Bristol CCG will have a statutory duty to be members of Local Safeguarding Children Board (LSCB).

The accountability framework being developed by the NHS CB will set out in more detail how the NHS CB and CCGs will work together to minimise risk, improve outcomes for children and develop and sustain effective partnerships, and ensure they are able to access the necessary clinical expertise and advice.

Bristol CCG is committed to developing capacity to better support their statutory responsibility to promote the safety and welfare of children. As a CCG we will be required to provide assurance that safeguarding children activity within all commissioned services meets national safeguarding children standards and demonstrate a model of continuous improvement.

The Board of the CCG includes a Director of Transformation & Quality who will be the executive lead for safeguarding children providing a clear line of accountability for safeguarding arrangements, properly reflected in the CCG governance arrangements. This post will be responsible for assuring the quality of care across all health providers.

Bristol CCG plans to train staff in recognising, acting upon and appropriately reporting safeguarding concerns. The governance arrangements the CCG will have in place will ensure rigor and challenge of health providers and ensure scrutiny and oversight of significant safeguarding children incidents and resulting provider action plans. The CCG will participate and actively contribute to the work of the Local Safeguarding Children Board including multi- agency serious case reviews. The CCG will ensure that the lessons learnt from such reviews are embedded in health practice to promote the safety and wellbeing of children accessing health services.

7.4.2 Safeguarding Adults

The prevention of abuse of adults at risk is the collective responsibility of all sections of society. Safeguarding Adults is everybody's business. However, those agencies, professionals, independent sector organisations and voluntary groups working with, or in contact with, people who are potentially Adults at Risk, hold a particular responsibility to ensure safe, effective services and to facilitate

the prevention and early detection of abuse from whatever quarter, thus ensuring that appropriate protective action can be taken.

Therefore safeguarding is a core responsibility within NHS Commissioning and is an integral part of every aspect of NHS Bristol CCG's work.

Safeguarding adults involves a range of additional measures taken to protect patients in the most vulnerable circumstances, patients that are currently defined within No Secrets as 'vulnerable adults'. This may be due to illness, impaired mental capacity, physical or learning disability or frailty brought about by age or other circumstance.

The term vulnerable adult refers to any person aged 18 years or over who is or may be in need of community care services by reason of mental or other disability, age or illness, and who is unable to take care of him or herself against significant harm or exploitation (Lord Chancellors Department, 1997 and reiterated in No Secrets, 2000) " No Secrets" 2000 will remain the framework policy guidance that underpins local Bristol policies until 2013 when the government is expected to agree new legislation and guidance.

It is recognised that this definition is inclusive of many health service users, and nationally there is a move to include markers of poor quality care within safeguarding concerns - such as the development of serious pressure ulcers and repeated falls, and in the future this might be widened to other markers - such as weight loss and missed medication doses. The key principle is that of significant harm, which itself is a subjective term.

The CCG is an active partner in the Bristol Safeguarding Adults Board. The BSAB has recently published revised policies and procedures document 'No Secrets in Bristol 2012' that outlines the multi-agency, city wide approach to addressing adult safeguarding issues. These policies and procedures underpin the CCG's approach to adult safeguarding.

NHS Bristol CCG also promotes this agenda through its contribution to the Adult Safeguarding Team and its support of the wider quality agenda associated with registered care homes and domiciliary care within the city.

Further work is being undertaken to improve and integrate existing safeguarding, care quality and performance systems as part of an overarching governance framework to monitor the quality of local provision. This framework will provide assurance that adult safeguarding concerns are identified and dealt with robustly and lessons learned implemented.

Following the Winterbourne View Serious Case review there have been a range of recommendations that cut across all commissioning responsibilities, as well as those specifically for learning disability services. The NHS is developing a Protocol to ensure all areas of the organisation and its commissioned NHS services are aware of their responsibilities and report and act as required. Scrutiny of commissioning decisions and evidence that appropriate levels of due diligence have been undertaken prior to commissioning care are being built into current commissioning practice supported by appropriate contractual and performance management frameworks and documentation.

8 Delivery Themes

In order to deliver against our key outcomes we are organising our work into eight delivery themes:

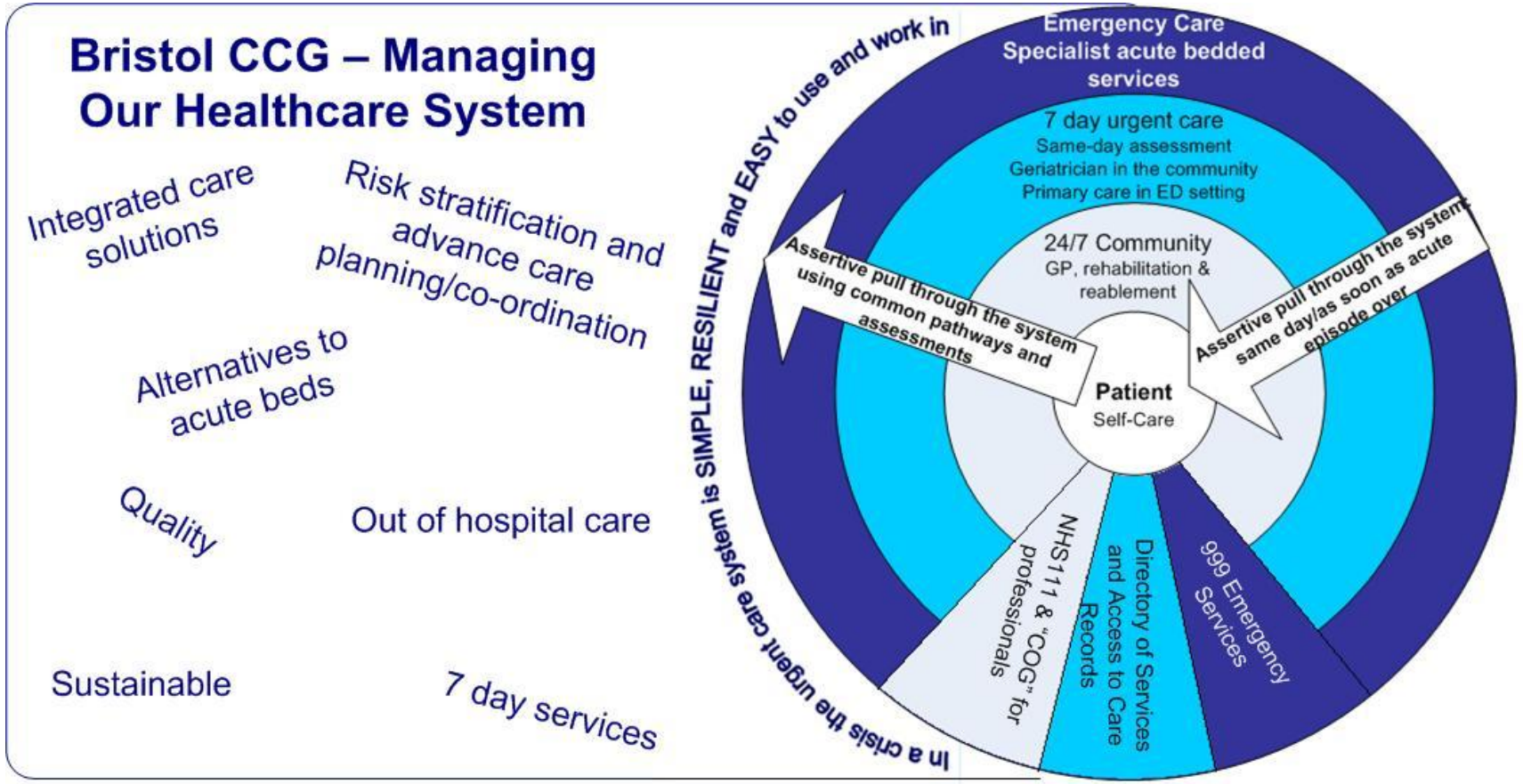
- Urgent Care system management including Frail and elderly patients
- Long Term Conditions including alcohol dependency and mental health services
- Elective Care
- Children's and Maternity
- Mental Health
- Cancer
- Learning Difficulties
- Medicines Management

As well as a dedicated Children and Maternity theme, meeting the needs of children and young people is embedded within the remaining seven themes. Local authority public health leads are identified for each theme; just one aspect of our integrated approach.

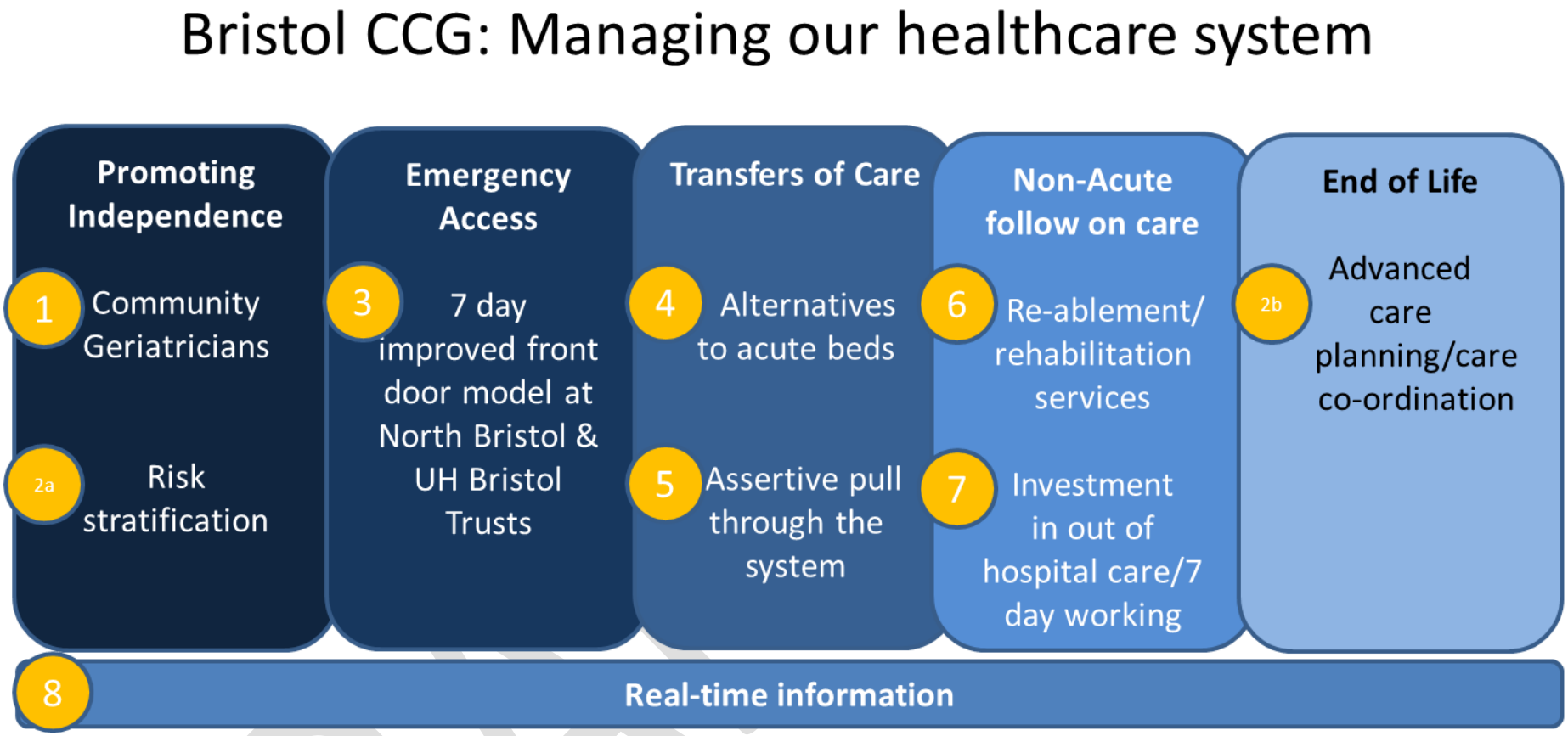
The following sections provide an overview of the strategic delivery themes, indicators and three-year intervention plan for delivering transformational change. Patient stories are also provided to illustrate the intended impact of the work we will do.

8.1 Urgent Care System Management including frail and elderly patients

Over the last few years the Bristol and wider healthcare system (spanning North Somerset and South Gloucestershire) has struggled to achieve key performance targets in urgent care and patients have not received optimum services as a result. During 2012 we worked with our strategic partners to define a vision for our urgent care system: that it will be **simple, resilient and easy to use and work in.** This whole-system vision is shared across the wider health community and is illustrated in the diagram below.



Effective management of the urgent care system is not just about ambulances and emergency departments. It starts with high quality GP services and preventative care, and continues post- crisis with the provision of adequate and appropriate rehabilitation, re-ablement and enablement services. Following advice from the Emergency Care Intensive Support Team, and later on from the Kings Fund in its report *Urgent and Emergency Care: a review for NHS South of England*, Bristol CCG has identified eight Development Priorities. These are mapped below along the system pathway for urgent care & are included in Bristol CCG's plan overleaf for improvement of the urgent care system.



Delivery Theme 1: Urgent Care system including Frail and Elderly Patients

Strategic Ambitions

- More primary and community care closer to home
- Integrated service model led by primary care drawing in specialist expertise
- Reduce acute hospital capacity through reduced occupied bed days
- Seamless care for patients indicated by reduction in unnecessary hospital admissions
- A compassionate and co-ordinated system allowing people to die where they choose (children and adults)

Indicators

- Reduction in A&E attendances for primary care conditions
- Advanced care plans for 90% of Nursing Home residents
- Preferred place of death recorded and delivered
- Reduce rate of unnecessary hospital admissions (ambulatory care sensitive conditions)/increase same-day urgent care rate
- Reduction in non-elective hospital bed days >14 days

Clinical Lead: Dr Peter Goyder	Lead Officer: Martin Jones	Public Health: Chris Hine

Interventions

- **Community Geriatricians including Cossham 'Tepid' clinic**
- **Risk stratification (see Long Term Conditions)**
- **Advanced care planning/care co-ordination (see Long Term Conditions)**
- **Alternatives to acute beds including review of community hospital beds**
- **Reablement/rehabilitation – improve provision in a community setting**
- **Assertive pull through the system**
- **Real-time information**
- **Urgent care demand management: NBT Front Door**
- 7 day working – in primary care and in commissioning activities
- Support to care homes
- Develop Joint Health & Wellbeing Strategy
- Re-commission community equipment store
- Mainstream carers' break project
- New joint care home contract and joint domiciliary care specification
- Clinical education programme (IC&E)
- Greater focus on urgent care in primary care (direct access phone number, standardise practice offering, including sick children)
- Test and implement redesigned older people's pathway

8.2

Hip Fracture
Emily's Story

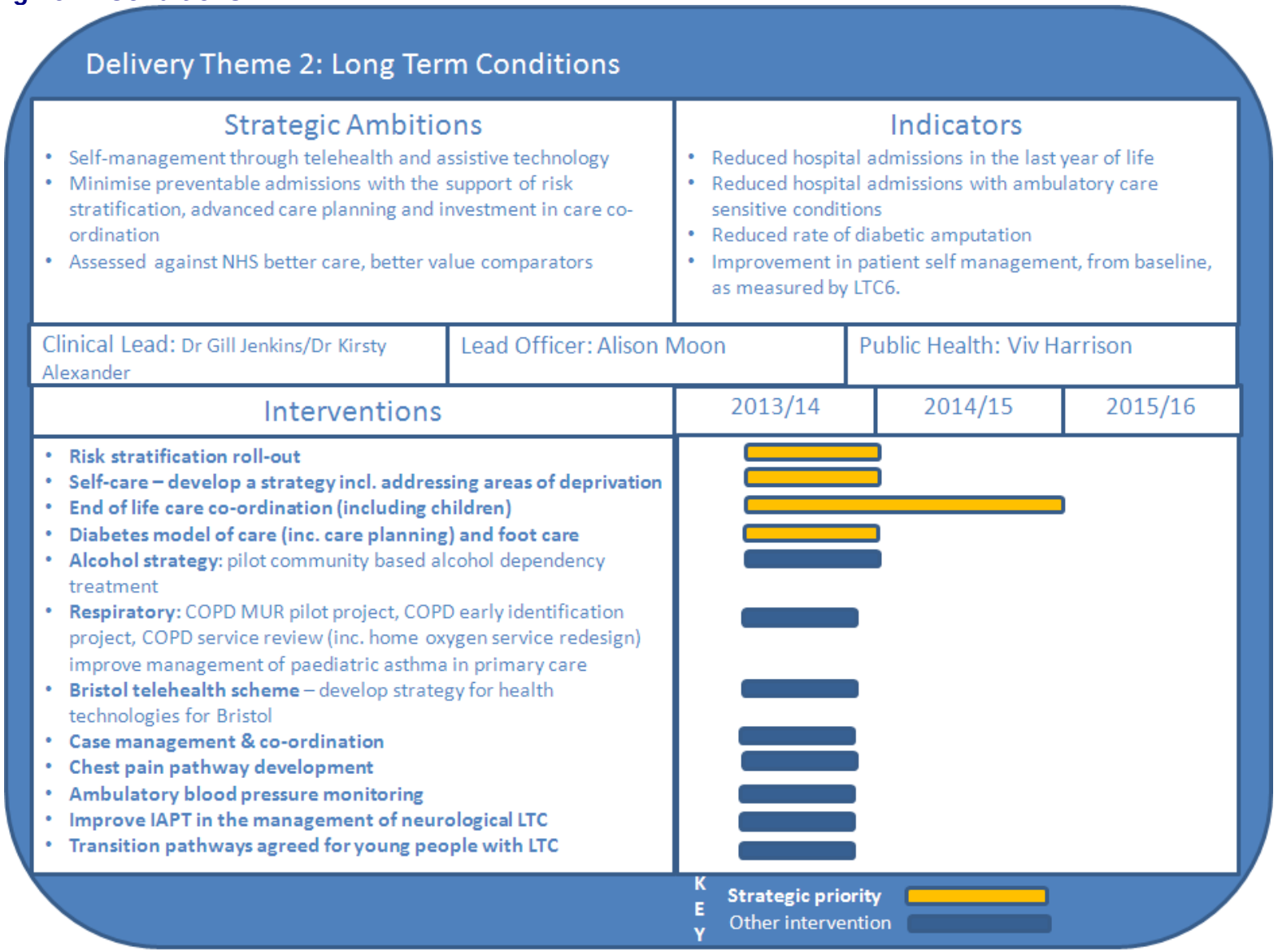
Now

Emily is 92 and independent but frail. She tripped over her cat and fell, hurting her hip. Her daughter found her on the floor a couple of hours later and called an ambulance. Emily was transferred to hospital and was diagnosed with a fractured neck of femur. She was transferred to the orthopaedic team who made a decision to operate the next day. She was found to be dehydrated by the anaesthetist who delayed her surgery until she was fit. Emily developed a chest infection and did not have surgery until the fifth day. She was eventually discharged to a care home three weeks after her fall.

Future

Emily was identified by her practice nurse as being at risk of falls so she was wearing an alert necklace when she fell. 20 minutes later her daughter arrived and called 999. The ambulance crew suspected a fractured neck of femur. They started intravenous fluids and pain relief and informed the A&E department that they would be arriving shortly. On arrival blood tests were sent, Emily had a pressure area assessment and she quickly went for an x-ray which confirmed the fracture. Emily had a femoral nerve block in the A&E department that allowed her to be more comfortable without strong painkillers. She was then seen by an Orthogeriatrician – who assessed her needs and planned her care over the next few days, and by the anaesthetist. She was transferred to the operating theatre and had surgery within 10 hours of her fall. She was transferred back to the dedicated rehabilitation orthopaedic ward. She was on her feet quickly and went home from hospital 5 days after her fall with some increased social support.

8.2 Long Term Conditions



8.3

Long Term Condition
Patricia's Story

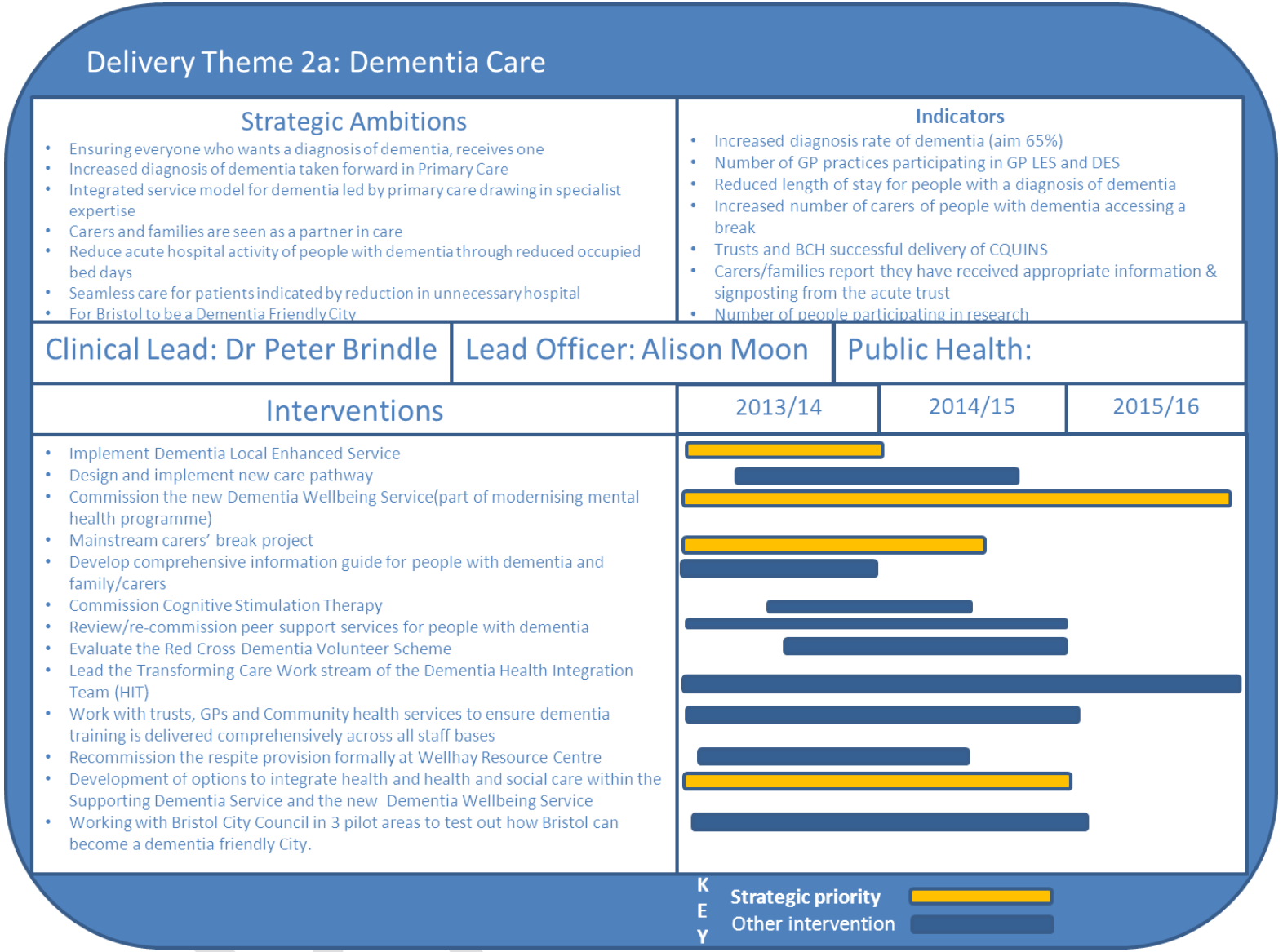
Now

Patricia is 69 and has had severe COPD for 20 years. She frequently has infections and is often admitted to hospital. Following a cold she becomes increasingly breathless, coughing up sputum and finding it harder to breathe. By 7am on the Friday she has become extremely scared and dials 999. An ambulance arrives promptly and takes her to A&E. Although she is seen quickly by the A&E department and given nebulisers she remains breathless. Despite a request to be discharged she is persuaded to be admitted. Two days later on Monday her records are reviewed by the Consultant Respiratory Physician who agrees that she is no more breathless than usual and she is discharged home on the Tuesday.

Future

Patricia's practice based respiratory nurse has flagged her to the health community as having severe COPD. They have documented her normal clinical state and her plans for exacerbations. Patricia also has clear guidelines to follow and holds antibiotics that she can start. Despite starting this treatment after a bad Thursday night she dials 999 on Friday morning. The ambulance crew attending have access to her diagnosis and normal findings. They assess that she is in need of a further assessment, give her nebulisers, and through the Professional SPA ascertain that she can be seen in the Respiratory Hot Clinic at 9.30 am. They organise appropriate transport for her. She is seen by a Respiratory consultant in the clinic who agrees a treatment plan with her. She is discharged home with daily visits, and access by phone to the community respiratory nurses. She is pleased to not need a further hospital admission

8.3 Dementia


Delivery Theme 2a: Dementia Care
Strategic Ambitions
Ensuring everyone who wants a diagnosis of dementia, receives one
Increased diagnosis of dementia taken forward in Primary Care
Integrated service model for dementia led by primary care drawing in specialist expertise
Carers and families are seen as a partner in care
Reduce acute hospital activity of people with dementia through reduced occupied bed days
Seamless care for patients indicated by reduction in unnecessary hospital
For Bristol to be a Dementia Friendly City
Indicators
Increased diagnosis rate of dementia (aim 65%)
Number of GP practices participating in GP LES and DES
Reduced length of stay for people with a diagnosis of dementia
Increased number of carers of people with dementia accessing a break
Trusts and BCH successful delivery of CQUINS
Carers/families report they have received appropriate information & signposting from the acute trust
Number of people participating in research
Clinical Lead: Dr Peter Brindle
Lead Officer: Alison Moon
Public Health:
Interventions
2013/14
2014/15
2015/16
Implement Dementia Local Enhanced Service
Design and implement new care pathway
Commission the new Dementia Wellbeing Service(part of modernising mental health programme)
Mainstream carers' break project
Develop comprehensive information guide for people with dementia and family/carers
Commission Cognitive Stimulation Therapy
Review/re-commission peer support services for people with dementia
Evaluate the Red Cross Dementia Volunteer Scheme
Lead the Transforming Care Work stream of the Dementia Health Integration Team (HIT)
Work with trusts, GPs and Community health services to ensure dementia training is delivered comprehensively across all staff bases
Recommission the respite provision formally at Wellhay Resource Centre
Development of options to integrate health and health and social care within the Supporting Dementia Service and the new Dementia Wellbeing Service
Working with Bristol City Council in 3 pilot areas to test out how Bristol can become a dementia friendly City.
KEY
Strategic priority
Other intervention

Dementia Care: Thomas's Story

Now

Thomas 85, lives with his wife Elsie. Thomas has been becoming more and more forgetful over the past 4 years. The couple have visited the GP previously, but had generally been offered reassurance that this was probably just his age. Over time Thomas has become so forgetful, the last time he went out he forget where he lived. They return to the GP who carries out some blood tests then refers Thomas to the memory clinic.

Thomas is diagnosed with vascular dementia, as there is no specific drug treatment available for this, Thomas is discharged back to his GP, with some information about the memory cafes, advice about his blood pressure, and other general support available. Over time Thomas starts to become aggressive and Elsie is feeling isolated and is struggling to cope. She also feels that she cannot go to her local shops with Thomas anymore as they do not understand his behaviour and the assistants get impatient. One day Thomas lashes out at Elsie and she calls the GP. She diagnoses a severe UTI and admits him to hospital. Although the UTI is successfully treated, Thomas remains disorientated in his new surroundings and stays in hospital for a long time. Eventually Thomas returns home and the district nurse visits him, followed by the social worker and a community psychiatric nurse. Elsie and Thomas end up telling their story several times over in one day. Once Thomas is better Elsie says she does not need any help and the services leave.

Unfortunately Thomas becomes unwell again ends up back in hospital. This happens several times and during the last admission Elsie realises she can not cope anymore, and after many weeks, Thomas is discharged from hospital into a care home.

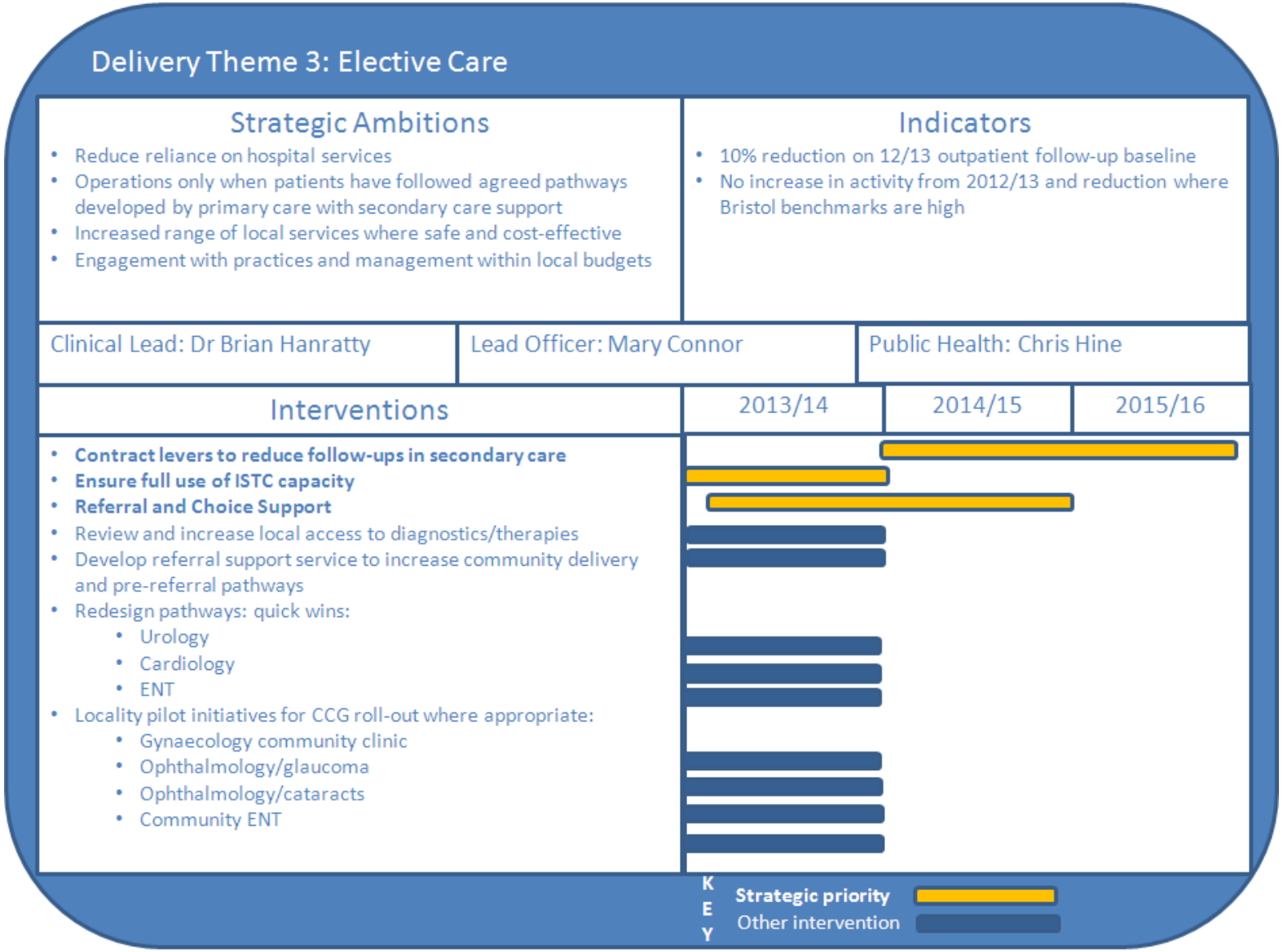
Future

Thomas 85, lives with his wife Elsie. He has become more and more forgetful over the past 2 years. He goes to his GP who has been trained and understands dementia, who performs some blood tests and arranges a brain scan. The GP discusses Thomas's history and the test results with the memory nurse that works with his practice and together they agree that Thomas has Vascular Dementia. Thomas and Elsie are given a comprehensive information pack and asked to return for a follow up appointment in a few weeks with the practice nurse who is also experienced in managing dementia. Thomas agrees to have his information passed to the Dementia Wellbeing Service, who will contact him and Elsie by telephone every 6 months or as required, and will also talk to him about options for post diagnostic support. This includes a range of things including cognitive stimulation therapy. Thomas has also started to think about the things he can do to plan for the future and how he might want to be cared for.

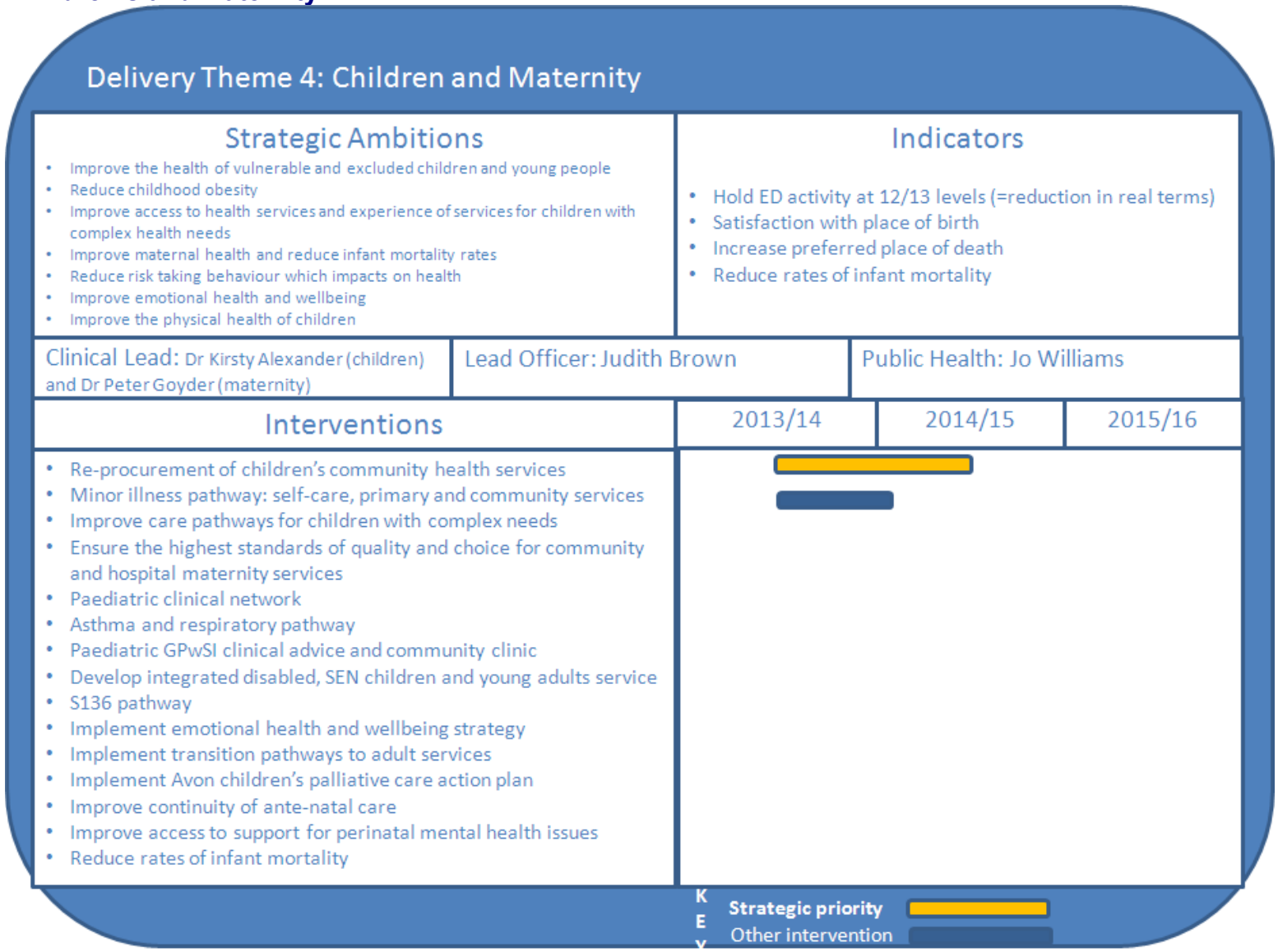
Elsie is happy to go out to the shops with Thomas, as her area has become "dementia friendly" and shop assistants understand what dementia is. However, during one of the calls from the Dementia Wellbeing Service Elsie explains she is starting to feel tired and stressed. The service arranges for a volunteer to come in and provide some help, for Elsie to access a carers break and for Thomas to see the GP as there is concern he may have a minor infection. They also liaise with Health and Social Care to arrange for an assessment of Thomas's and Elsie's needs.

Elsie knows exactly who she can contact if there is a problem and is feeling more confident that Thomas can continue living at home, as there is now a package of care in place to support them. As Thomas becomes more unwell there is a coordinated plan put in place, across health, social care and the Dementia Wellbeing Service to ensure that Thomas can remain at home, as long as possible and that Elsie is well supported.

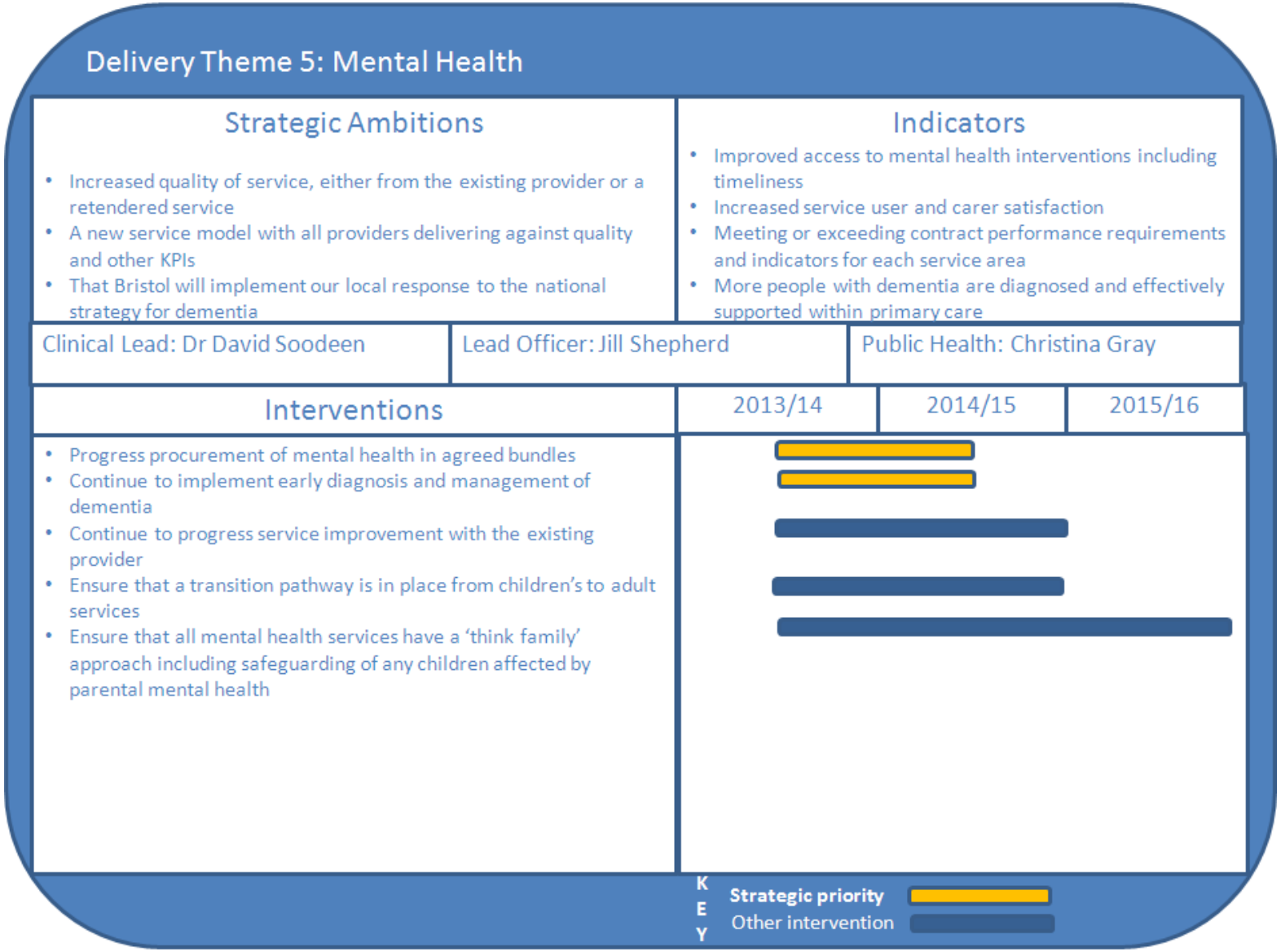
8.4 Elective Care



8.5 Children's and Maternity



8.6 Mental Health



8.4

Substance Misuse
Darryl's Story

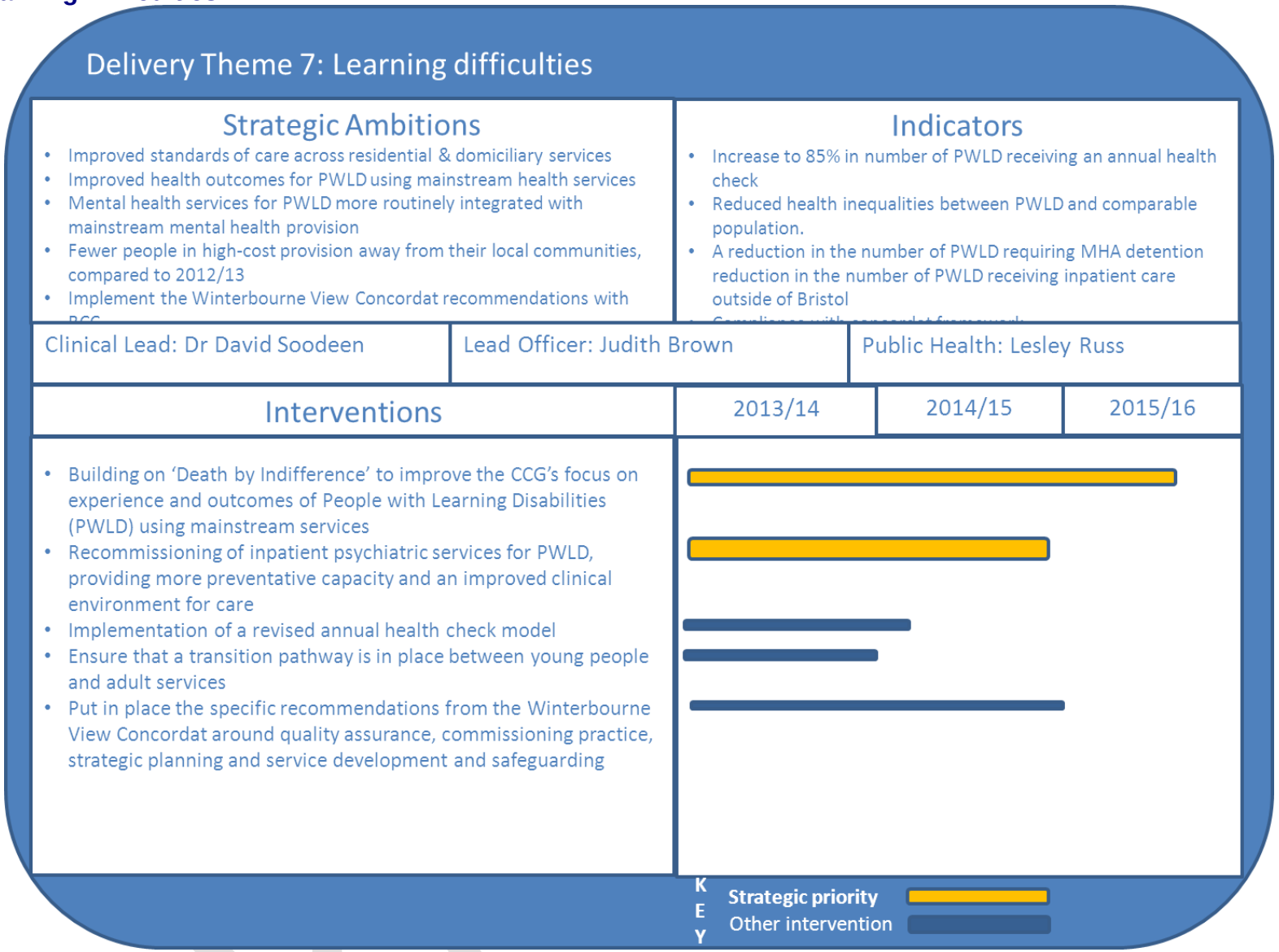
Now

Darryl is 44 and has been homeless for 11 years. He has no family support, drinks 90 units of alcohol a week and has widespread lower limb ulcers. He is generally difficult with people and uses hospital as a refuge. He attends A&E late of an evening having "collapsed" knowing that he will be admitted overnight before discharging himself the next morning. He has had 50 admissions to any one of the three hospitals in the region over the past year with another ninety attendances. He is also well known to his GP practice who see him a couple of times a week. He has been labelled as being an alcoholic with personality disorder. He has never engaged with mental health or alcohol services as they will not see him when drunk, and he is not able to attend appointments due to his chaotic nature.

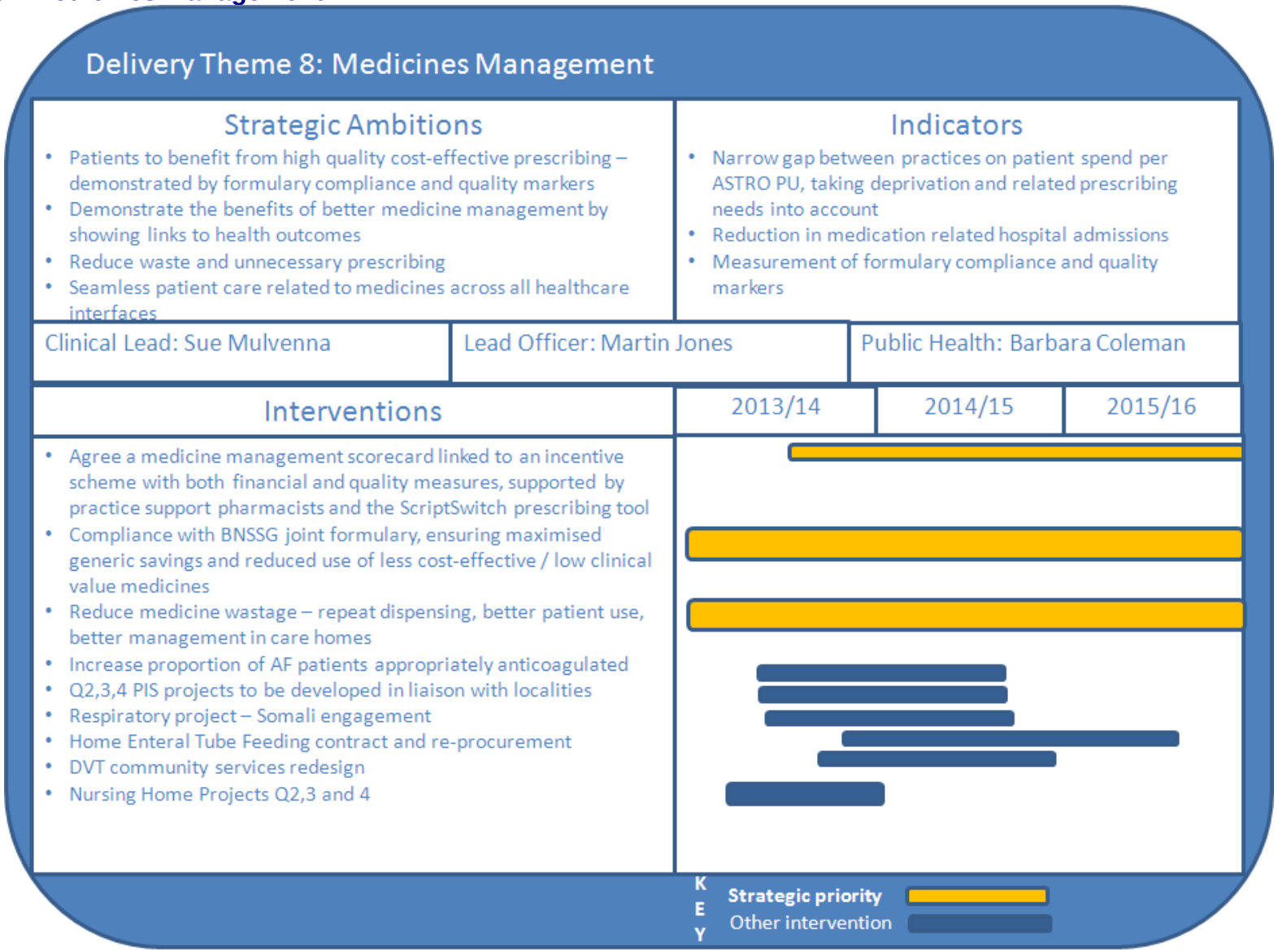
Future

In the new system Darryl is reviewed by the A&E team who ask for an assessment by the mental health team. He is seen by the acute mental health Liaison Team who assess him and identify a number of key issues that are medical, psychological and social. They assign a key worker who is able to link with him and find him in the community. The key worker is able to support Darryl by helping him access support for his health and housing including taking him to appointments. They also work to help him manage his behaviour and if he does not attend agreed meetings will find him to look at the problems. After the first three months with his new key worker Darryl has only had five admissions and is starting to develop some structure in his life.

8.8 Learning Difficulties



8.9 Medicines Management



Medicines Management
Ronald's Story

Now

Ronald is 86, has glaucoma in his left eye and lives alone. He has his medicines in a dosette box, which the community pharmacy delivers on a weekly basis. He is also prescribed Xalatan (latanoprost) eye drops for his glaucoma, which are delivered on a weekly basis with his other medicines. Ronald stopped using the drops last year as he found it too difficult to use them. He didn't want to disappoint the doctor, so when the eye drops arrived from the pharmacy he put them away in his fridge (as instructed) and didn't mention to anyone. Ronald's eye sight gradually worsens with time and tasks such as reading start to become a problem. Medication waste through unnecessary prescribing of eye drops is also an issue in this case.

Future

Ronald is 86, has glaucoma in his left eye and lives alone. He has his medicines in a dosette box, which the community pharmacy delivers on a weekly basis, along with his Xalatan (latanoprost) eye drops for his glaucoma. A medication review undertaken by the Medicines Optimisation Pharmacist based within the GP practice shows that Ronald has had 52 prescriptions, each for two bottles in the last year. The Pharmacist telephones the Community Pharmacist to discuss this issue as these drops last for 28days once opened. The Xalatan drops are taken off of the weekly prescription and put on a separate 56 day prescription, prescribed generically (as latanoprost) with a quantity of two bottles. The directions are also made clearer from 'one a day' to 'Put ONE drop into the LEFT eye once a day in the EVENING' after checking the instructions on a scanned letter from the eye hospital.

Next time Ronald sees his GP, a flag on the clinical system prompts a discussion about eye drops. Ronald says he stopped using the drops last year as it was too difficult to use them. He used to always put them in both eyes and thought one bottle was for the left eye, and one bottle for the right eye. He has all the bottles in his fridge and says he is happy to return them. He commented that he didn't want to disappoint the doctor and was a little embarrassed to talk to anyone about the difficulties he was having. The GP explains to Ronald that if his eye drops are not used every evening, he will gradually lose the sight in his left eye. The GP asks Ronald to persevere and prescribes a device to help administer the eye drops, explaining that it will help. The GP then puts a note on the clinical system to not issue any more latanoprost prescriptions until after the next medication review.

Ronald takes his prescription into the community pharmacy and the pharmacist shows him how to use the new device with his eye drops. Ronald is happier following his visit to the GP and pharmacist; he is better able to use his eye drops and feels supported knowing where he can go for advice if needed. Ronald's eyesight is once again being preserved, as he is now using his medication properly. Prescribing the eye drops generically (not by brand) and reducing the number of bottles provided to a suitable amount has saved more than £1100 a year.

9 Research and Development

9.1 Summary

Research and evidence needs to be at the heart of our core business, underpining decision making across all key workstreams. The CCG aims to lead the field in terms of supporting research excellence and routinely using robust evidence in decision making. Our commissioning will be evidence-based and we also aim to ensure that patients in the Bristol CCG area are provided with opportunities to participate in well designed research studies where available.

9.2 Background

Research management, research governance, research evidence and service evaluation activities are coordinated and supported by the Avon Primary Care Research Collaborative (APCRC) on behalf of the CCG. The APCRC is a well-established team of R&D professionals with wide-ranging experience and a strong reputation for customer-focussed service. The APCRC have close links with research colleagues in the two local Universities, at the Public Health department of the Council and in local NHS Trusts. The team has a voice locally, regionally and nationally and contributes to Primary Care discussions via a wide range of research related fora.

In recent years the APCRC has been at the top of the league table in terms of the generation of 'Research Capability Funding' (RCF), which is allocated according to the quantity of high quality, NIHR funded research that is undertaken locally and hosted at the CCG. The RCF is reinvested in new research and new researchers each year, thus creating a 'Virtuous Circle' of success.

9.3 The Future

The APCRC team are uniquely well placed to support the CCG over the next three years and

i. To encourage and the use of Research and Evidence in relation to all nine key delivery streams;
ii. To put Research and Evidence at the heart of CCG core business.

9.4 Supporting Key Delivery Themes

The R&D team will support the nine key delivery themes described in the CCG plan. This support may be via development and hosting of NIHR funded research in that area, via evaluation or audit work, via Health Integration Team (HIT) work under the umbrella of Bristol Health Partners, or as part of our knowledge mobilisation and best evidence work stream. The table below shows some of the existing and planned R&D team support for each of the nine key deliverables identified in the CCG 3 year plan, concentrating on research work, evalution work and work with Bristol Health Partner HITs.

How the R&D service up supports the nine Key Delivery Themes in the CCG 3 year plan

Key CCG Delivery Theme	Research projects – current and planned	Current evaluation work	Work with Bristol Health Partners and HITs
Urgent Care System Management including frail and elderly patients	• Research work on effectiveness of care bundles as a means of improving hospital care and reducing hospital readmission in patients with COPD *under consideration by funder* (UoB) • Planned large programme grant in the area of reducing unplanned admissions, due for submission within the year • Both will be hosted at Bristol CCG and will generate RCF funding • Various completed research in this arena	• Evaluation of a Frail Older people self-assessment tool • Evaluation of NHS 111 • Supporting the evaluation of 'consultant link' • Supporting development of service spec and evaluation plan for tepid clinic for frail older people	• Bristol CCG is host to the ITHAcA HIT focussed on Avoiding Hospital Admissions
Long Term Conditions	• New research bid around New Forms of Consulting (email etc.) is in development (UoB), will be hosted at Bristol CCG if funded • Physio Direct research – recently completed, led by UoB • We are participating (across BNSSG) in research on 'National Guidance for measuring assistive technology'	• Carers' breaks evaluation (complete) • Supporting the evaluation of the integrated rehabilitation care pathway	
Dementia	• We have incorporated requirements around research and evaluation into the Dementia service specification	• Supporting the evaluation plan and subsequent commissioning of an independent evaluation of a new Dementia Care pathway within Bristol	• Dr Peter Brindle an active member of the Dementia HIT
Elective Care	• As Above: • Research work on effectiveness of care bundles as a means of improving hospital care and reducing hospital readmission in patients with	• Evaluation of secondary care referral management • Evaluation of the Vascular on -call rota	• Bristol CCG is hosting the Avoiding Hospital Admissions HIT

	COPD *under consideration by funder* (UoB) • Planned large programme grant in the area of reducing unplanned admissions, due for submission within the year •		(ITHACA)
Children's and Maternity	• TARGET – programme Grant based at UoB • FAST HTA grant led by UWE Both Hosted at Bristol CCG and thus generating RCF funding	• Supporting evaluation of pilot mindfulness course for adolescents • Supporting the audit current standards of continuity of care in community maternity services • Supporting the evaluation of a pilot of	• SHIPP HIT • RUBICON (respiratory Infestions) HIT • Child Injury prevention and Injury Care HIT (SHIPP and RUBICON hosted at Bristol CCG)
Mental Health	• MIR study (HTA rapid trials study) led by UoB (antidepressants) • PANDA study – Programme grant led by UoB (indications for prescribing antidepressants) • Script in a Day (Research for pt. benefit grant) led by local GP All three hosted projects by Bristol CCG and thus generating RCF funding	• Ensured that requirements around research, evaluation and evidence are incorporated into all service specs as part of the Modernising Mental Health programme • We have been supporting the Improving Care in Self Harm HIT to ensure they evaluate their work	• Improving Care in Self Harm HIT
Cancer	• DISCOVERY programme grant on Early Diagnosis – led by UoB and hosted by Bristol CCG so generating RCF	• We will be supporting the evaluation of an End of Life Care Coordination centre	
Learning Difficulties	• Hosted a Confidential Enquiry into suicide rates amongst patients learning difficulties	• Evaluation of the ARTSHINE work	
Medicines Management	• MIR study (HTA rapid trials study) led by UoB (antidepressants) • PANDA study – Programme grant led by UoB (indications for prescribing antidepressants)	• We have supported a cohort of Medical Students to undertake an audit into repeat prescribing in Primary Care	

In addition to these specific examples of R&D support, we are also involved in three activities that cut across all nine key delivery themes:

(i) In future we will strive to ensure evaluation is included in every commissioning cycle. All service redesign, service recommissioning or service decommissioning, across all key themes, will be based on evaluation evidence.

(ii) we are devising means of ensuring exchange of knowledge between practice and academia. We aim to influence the development of research ideas by our academic colleagues, and help disseminate the results of research directly back into practice. Key examples are the Management Fellowships (see below), and forthcoming Evidence Apprentice schemes funded from RCF.

(iii) we have successfully incorporated requirements around research and evaluation into the Dementia service specification. We will mainstream this, and ensure that these requirements are included in all new service specifications in future

9.5 The Research and Evidence Charter

In addition to supporting the key delivery themes, at a more general level the R&D team will be seeking Bristol CCG Board Approval to sign up to the *Research and Evidence Charter,* as described by the Association of Medical Research Charities (AMRC) in their document of May 2013[5]. The AMRC document acknowledges that research and the use of evidence are integral to NHS core business and suggests practical ways forward to make this vision a reality. Approaches specific to the roles of commissioners are summarised in their vision of a Research Charter (page 30/31).

The charter sets out seven steps that commissioners can take to ensure that their commissioning decisions are informed by the latest research findings. These steps are shown in the figure overleaf. At Bristol CCG we have already fully achieved some of these steps, and efforts are well advanced in terms of ensuring that all seven steps are met, established and mainstreamed into the routine business of the CCG.

Signing up for the charter is a recognition of the benefits to patients and the wider NHS of research and the use of evidence, and is a public commitment to upholding and taking forward work in this arena.

[5] AMRC – Our vision or research in the NHS, May 2013, The text is available at this website, via the PDF links on the right of the page: *http://www.amrc.org.uk/news-policy--debate_our-vision-for-research-in-the-nhs*

Our Research Charter for NHS England and Clinical Commissioning Groups

NHS England and Clinical Commissioning Groups have a duty to promote research and the use of research evidence

To achieve this duty they should:

- Appoint an individual at board level with responsibility for research
- Include participation in NHS research in provider contracts
- Develop a balanced scorecard of measures to assess research and the use of research evidence in delivering care and report on these quarterly at board meetings
- Take part in research prioritisation exercises – with NIHR NETSCC, local HEIs and other relevant bodies
- Consider relevant research findings and evaluations when commissioning services
    - Develop structures to routinely access relevant evidence and inform the redesign of services and commissioning policy
    - Routinely evaluate services and consider how quality can be improved
    - Engage with NICE, Public Health Observatories, CLAHRCs, The Cochrane Library, NIHR NETSCC, local HEIs and other relevant bodies
- Promote best practice in the handling, use and sharing of data by providers when commissioning services
- Develop a process and earmark a recurring budget to ensure excess treatment costs are managed without causing delays to research.

9.6 Other Research and Evidence Objectives

Beyond sign up to the Charter, the key objectives for the Resarch and Development team over the next three years are:

- To rework the R&D 3 year strategy, to reflect the fundamental changes in the commissioning landscape and to reflect the nine key delivery themes of the CCG. The timescale of the R&D strategy will be brought into line with the CCG 3 year plan
- Our key role is to support high quality research in the primary care arena and to encourage the dissemination of research results into practice
- We will maintain and build on our position as a leader in terms of the quantity and quality of NIHR funded research that we host at the CCG. We work very closely with researchers at the local universities to ensure NHS ideas are fed into new research as it is developed and that NHS staff are included in grant applications. The APCRC has a very strong reputation in terms of hosting grants, monitoring, reporting and ensuring financial probity.
- We will strive to maintain the ‘virtuous circle’ of the Research Capability Funding awards each year. The RCF is re-invested and used to support the development of new research ideas that are funded by the NIHR, and to support new researchers and innovative schemes. This investment benefits the research community and in the longer term benefits our patients.
- We are developing our Service Evaluation agenda. In recent years we have been striving to ensure that evaluation is built into the commissioning cycle, and is incorporated into every commissioning, recommissioning or decommissioning decision. We will be pushing this agenda in the future, with the aim of mainstreaming this, without exception, into all commissioning decision making.
- We are working hard to establish a ‘knowledge exchange’ enviroment involving academia and practice locally. One example of this is the Management Fellowships we have recently set up. These enable established NHS managers to spend up to a year immersing themselves in the research environment of the University, feeding in

NHS expertise. On their return to the NHS their research experience will feed back directly into the NHS commissioning environment. These Fellowships are funded from our RCF award. In a similar vein we will be setting up a 'Knowledge Apprentice' scheme, aimed at giving less experienced staff.

- We will be working on a 'knowledge mobilisation framework' to help us better understand how commissioning decisions are made and how we can ensure that research and robust evidence are incorporated into those decision making processes.
- We will continue to work with local, regional and national partners and initiatives to ensure that Bristol CCG is at the forefront of developments in the research arena. Our key partner organisations include:
  - Bristol Health Partners
  - The West of England Academic Health Science Network (AHSN)
  - The National Instituting for Health Research (NIHR)
  - The Western Comprehensive Local Research Network (WCLRN) and its successor organisation in this area, the Local Clinical Research Network
  - Our key research funding organisations
  - The local Higher Education Institutions
  - Local Public Health departments
  - NHS England and the local area team
  - The Health and Wellbeing Board
  - It is hoped to include The Collaboration for Leadership in Applied Health Research and Care *West* (CLAHRC) in this list, once a final decision has been reached about funding.
- Through our work with Bristol Health Partners, we will support the work of the Health Integration Teams (HITs) . We propose to offer Evaluation support to all the HITs and to offer general Research Management support to the staff involved with the HITs.
- In terms of Research Governance, we will ensure that all the research being undertaken meets the criteria set out in the Research Governance Framework. Our aim is to provide a light touch, yet effective and efficient system of NHS assurance, as well as providing research passports and letters of access where and when appropriate.

10 Organisational Governance and Resilience

Our ambitions and positive outcomes can only be achieved with strong organisation and governance of our activities.

10.1 Organisational Governance

The CCG is led by an elected Governing Body, with an elected GP Chair. The Governing Body is made up of 13 people, including clinicians and senior managers, whose key tasks include setting the CCG's vision and strategy, monitoring the implementation of the strategy, taking overall responsibility for quality and safety issues, and ensuring that public money is spent efficiently and responsibly. Each Locality has elected representatives who are members of the CCG governing body.

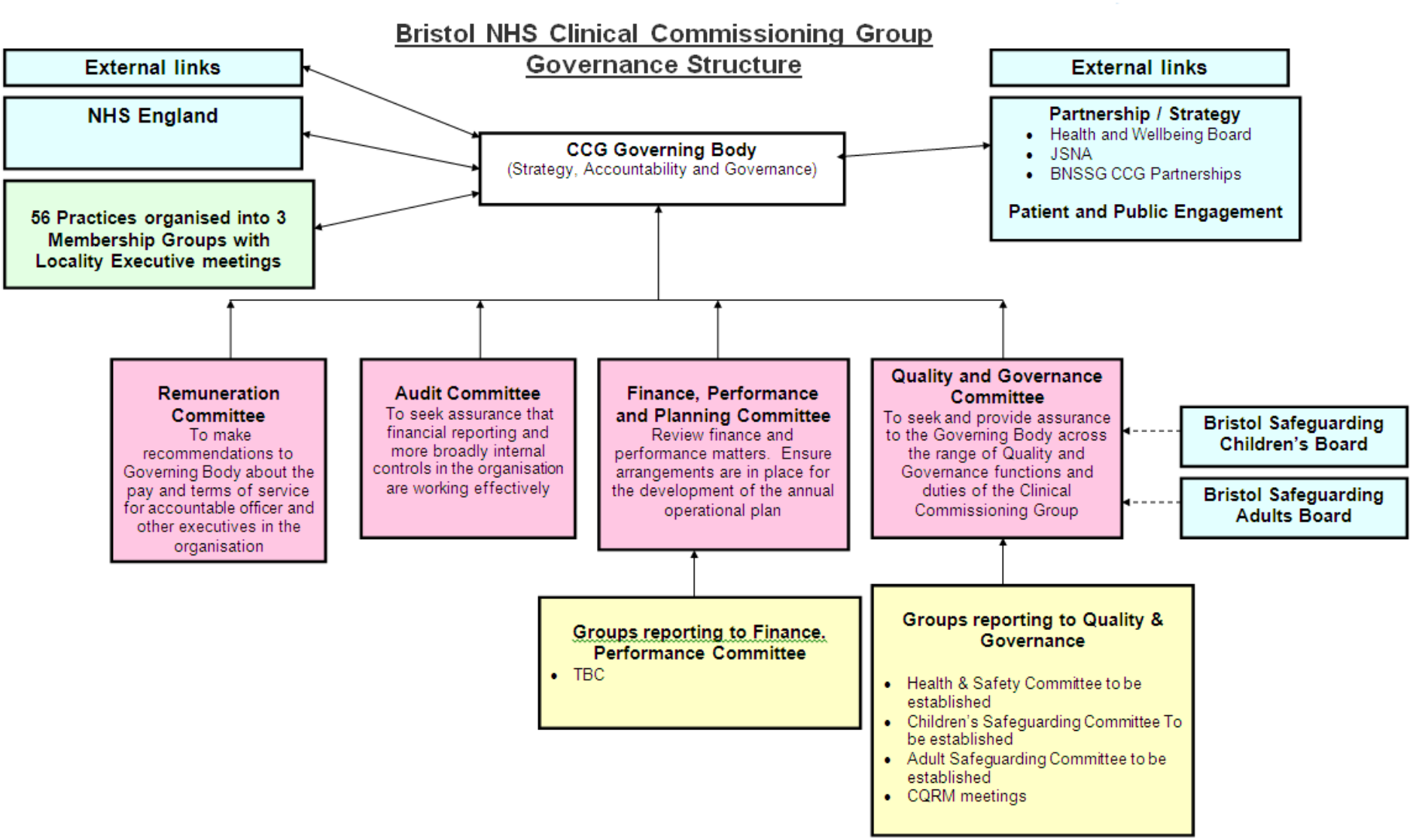
The clinical leaders on the governing body are supported by the CCG's senior management team: the chief officer, the chief finance officer, the operations director, and the director of transformation and quality. Finally, the governing body has two lay members one focusing on patient and public involvement and one on governance.

10.2 Risk Management

We recognise our statutory responsibility to patients, staff and the public to ensure that effective processes, policies and people are in place to deliver our objectives and to control any risks to achieving them. Our approach to risk management will be comprehensive, covering financial, organisational, clinical, project and reputational risks.

The CCG has a Risk Management Strategy approved by the Governing Body which provides the framework for the continued development of risk management processes throughout the organisation and describes levels of accountability, processes and frameworks.

The CCG's Governance Structure is depicted overleaf.


Bristol NHS Clinical Commissioning Group
Governance Structure
External links
NHS England
56 Practices organised into 3 Membership Groups with Locality Executive meetings
CCG Governing Body
(Strategy, Accountability and Governance)
External links
Partnership / Strategy
Health and Wellbeing Board
JSNA
BNSSG CCG Partnerships
Patient and Public Engagement
Remuneration Committee
To make recommendations to Governing Body about the pay and terms of service for accountable officer and other executives in the organisation
Audit Committee
To seek assurance that financial reporting and more broadly internal controls in the organisation are working effectively
Finance, Performance and Planning Committee
Review finance and performance matters. Ensure arrangements are in place for the development of the annual operational plan
Quality and Governance Committee
To seek and provide assurance to the Governing Body across the range of Quality and Governance functions and duties of the Clinical Commissioning Group
Bristol Safeguarding Children's Board
Bristol Safeguarding Adults Board
Groups reporting to Finance, Performance Committee
TBC
Groups reporting to Quality & Governance
Health & Safety Committee to be established
Children's Safeguarding Committee To be established
Adult Safeguarding Committee to be established
CQRM meetings

10.3 Performance Management Arrangements – CCG Contracts

The Governance Structure outlined above supports the performance management of CCG contracts with care providers.

Contract managers are required to ensure that appropriate contract management activities are in place for:

- Review of clinical quality, and issue of quality letters
- Review by external bodies as appropriate
- Information governance
- Locality, patient and public feedback and involvement
- Performance and financial reporting
- Risk and issue management

Named contract managers are accountable to the CCG Governing Body for robust contract management approaches via:

- The CCG Quality and Governance Committee
- The CCG Finance, Performance & Planning Committee

10.4 Performance Management Arrangements – Joint Contracts

Joint management of contracts is co-ordinated through the BNSSG CCG Partnership. Each contract will have a designated Co-ordinating CCG.

Contract Performance Management Groups: The co-ordinating CCG for each main provider will hold a monthly performance meeting with that provider supported by the CSU. To ease pressure on diaries it is suggested that the meetings are merged to one CPMG / CQRM with the agenda beginning with quality and safety issues and structured such that there are opportunities for members to attend for part of the meeting if this is preferred. The obvious synergy between performance, quality and financial issues means that holding the providers to account for these items in the same session is likely to be the strongest approach. 'Associate' commissioners will be welcome to attend if they wish to do so, but will not be required for the meeting to be quorate.

Coordination via BNSSG CCG Partnership meeting: Co-ordination between commissioners will occur through the BNSSG Partnership meeting, which will set aside a part of the agenda to consider issues of provider management on a monthly basis. This will give the opportunity for commissioners to co-ordinate their provider management approaches across BNSSG and to maintain a firm grip on system finance, performance and quality issues.

Contract Delivery Management Group internal to CSU acting as Technical Group: In order to provide support to these meeting the Commissioning Support Unit will operate a Contract Delivery Management Group acting as a technical group. Representatives from BNSSG CCGs or the Area Team are provided with the dates of these meetings and will have an open invitation to attend but not be required for quoracy. Contract Performance Management Groups may also

agree to establish Finance and Information meetings to support detail review of finance and activity prior to the main meetings.

Area Team engagement and involvement: The Area Team as substantial direct commissioners will be invited to the section of the BNSSG Partnership meeting where commissioners will co-ordinate their provider approaches and to be invited as associates to the provider facing meetings.

Trust Development Authority: The Trust Development Authority will be invited to the CCG Partnership meetings and Contract Performance Management Group meeting for individual providers.

Formal performance and quality letters continue: This approach will continue to be supported by the formal quality and contract performance management letters sent on a monthly basis to providers by the CSU, with CCG commissioners receiving a briefing pack to cover these and the main performance issues in advance of each provider facing meeting.

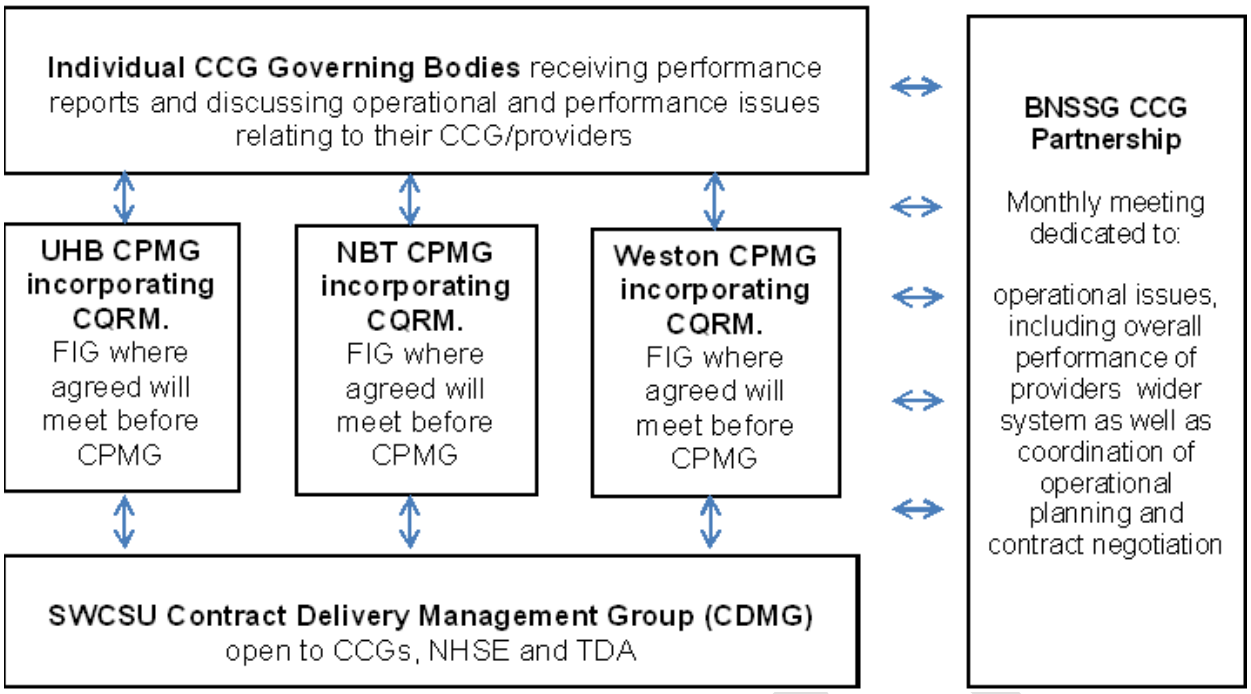
These arrangements will apply to:

1. University Hospitals Bristol NHS Foundation Trust
2. North Bristol NHS Trust
3. Weston Area Health NHS Trust

These arrangements will not apply to:

- Avon and Wiltshire Mental Health Partnership NHS Trust where BNSSG CCGs commission in partnership with 3 other CCGs and has its own governance structure already agreed. The Trust Development Authority will be invited to join in attendance. However, the CCG Partnership will consider overall performance of AWP and issues relating to BNSSG as a whole at its meetings.
- South Western Ambulance Service NHS Foundation Trust where BNSSG CCGs commission with all other CCGs in the South West. The contract management support arrangements are still being agreed and implemented. However, the CCG Partnership will consider overall performance of SWASFT and issues relating to BNSSG as a whole at its meetings.
- Other contracts subject to different models of contract management – Updates on these arrangements and issue arising will be reported and discussed at the CCG Partnership as required.

These relationships are summarised in the diagram below:



10.5 Resilience

Section 46 of the Health & Social Care Act 2012 stipulates that CCGs must take appropriate steps to ensure that they are properly prepared for dealing with a relevant emergency. This includes any emergency which might affect the CCG itself, or commissioned service provider(s), whether by increasing the need for the services that it may arrange or in any other way. Emergencies affecting the CCG are covered by our Business Continuity Arrangements, and emergencies affecting providers are covered in our Escalation and Major Incident Policies.

10.5.1 Business Continuity

The CCG is developing an effective Business Continuity Management System (BCMS) in line with the International Standard ISO 22301. This provides a framework for resilience, enabling an effective response to safeguard activities that have been identified as priority and must continue during an incident.

The BCMS will allow for the fact that in the event of a Very Serious Major incident, NHS England Area Team will expect to take responsibility for leading and directing the operations. Under these circumstances, the CCG emergency response team will liaise closely with them from the incident room that we have established as part of our business continuity planning. For less serious events, the CCG Business Continuity Plan (BCP) arrangements will dictate priorities and the CCG leadership will communicate arrangements for staff and patient safety and a series of actions that will recover critical, essential and important functions as quickly as possible. The BCMS will also allow for the CCG to be supported by and work closely with the CSU during office hours. In addition to the CCG emergency response team who will provide the immediate response, we will also set up an executive team to consider the strategic response.

Broadly, the CCG BCP is in three phases:

- Responding to a disruptive incident (incident management)
- Maintaining delivery of prioritised activities/services during an incident (business continuity)
- Returning to 'business as usual' (resumption and recovery)

The CCG BCP will be based on a comprehensive Business Impact Assessment (BIA) which will be conducted by all directorates to identify:

- critical core functions
- key staff
- resources
- information systems
- telecommunications
- equipment
- premises

The directorate level Business Continuity and Recovery Plans will be developed to identify recovery prioritisation of key functions, and will be based on the assumption that there will be sufficient knowledgeable people available to execute the Plan and support business recovery operations. These plans are designed to address a "most likely worst-case" scenario

10.5.2 Emergency Preparedness, Resilience & Response

The DOH publication "Local Health Resilience Partnerships: Implementation Information and Joint Resource Pack SW1A" (2012) describes the role of Clinical Commissioning Groups in emergency preparedness, resilience and response (EPRR) as follows;

- "Ensure contracts with provider organisations contain relevant emergency preparedness, resilience (including business continuity) and response elements.
- Support the NHS Commissioning Board in discharging its EPRR functions and duties locally.
- Provide a route of escalation for the Local Health Resilience Partnership should a provider fail to maintain necessary EPRR capacity and capability.
- Fulfil the responsibilities as a Category 2 responder under the Civil Contingencies Act including maintaining business continuity plans for their own organisation
- Will be represented on the LHRP (either on their own behalf or through representation by a 'lead' CCG)

In response to these requirements the CCG has identified the Operations Director as the accountable officer for EPRR and is establishing an Incident Control Centre in South Plaza.

The CCG is represented on the LHRP by South Gloucester CCG and participates in a BNSSG on call rota aligned with that of Somerset CCG.

The CCG has also established strong links with Bristol City Council Public Health Department in order to ensure a coordinated approach to all EPRR activity.

10.5.3 Major Incidents and Escalation

In order to discharge its duties for responding to emergencies relating to commissioned services and providers, the CCG has a joint on-call rota as noted above. A national business continuity toolkit is in development and the following BNSSG Plans are being developed:

- Mass Casualty Planning
- Major Incident Response
- Severe Weather
- Communicable Diseases
- Fuel Plan

A Bristol, North Somerset & South Gloucestershire Escalation Policy is in place and agreed across all commissioners and providers in the health and social care system. This provides the parameters for escalation, communication and de-escalation between all partners. The CCG is supported in this role by the CSU who provide an in-hours on-call escalation support rota and expertise in maintaining the system escalation policy.

10.6 Work Planning Process

Fundamental to the work planning process is the development of the CCG mission, the strategic priorities and the clinical, community and organisational outcomes. These were agreed by the CCG's Governing Body in May 2013. The process for work planning was also agreed on that date.

The CCG has established 3 clinical steering groups which form the clinical decision making "hubs" of the organisation. The steering groups bring together local and Bristol wide ideas and initiatives and also consider those relating to the wider Bristol, North Somerset and South Gloucestershire agenda.

10.6.1 BNSSG CCG Partnership

In September 2012 Bristol CCG agreed a Memorandum of Understanding with neighbouring North Somerset and South Gloucestershire CCGs. The memorandum came into effect on 1 April 2013 and formalised the existing strong joint working arrangements between the three CCGs, providing a framework in which they can:

- **Jointly Commission Services**: The CCGs have agreed to collaboratively commission services where there is a clear benefit to the population of each CCG. Collaboration will be considered on a contract by contract basis and the most effective form of collaboration will be agreed.

- **Collaborate on other commissioning activities**: The CCGs have agreed to explore collaboration across all CCG operations to support commissioning

where it is agreed that collaboration will benefit the population of each CCG. This will allow the CCGs to collectively address strategic risks that apply across BNSSG and improve their operations by, for example, increasing resilience.

This relationship, along with the role of the Steering Groups, is depicted on the Clinical Developments structure overleaf.

10.7 Commissioning Support

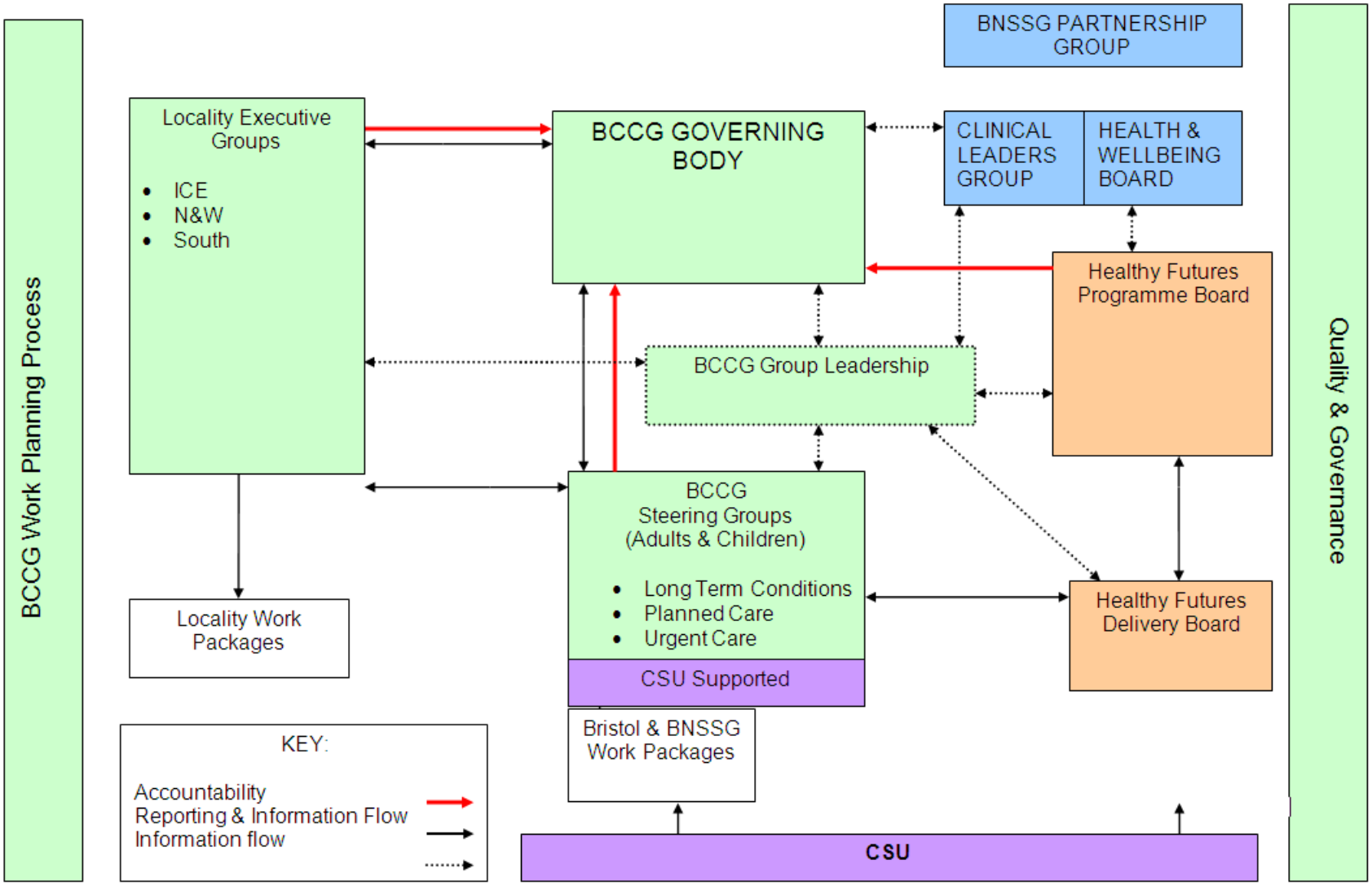
Bristol CCG contracts for this from the NHS South West Commissioning Support Unit (SWCS) which aims to provide a comprehensive service in line with the offers below:

The CCG works with the commissioning support unit to

- enable clinical leaders to transform services
- commission for better clinical outcomes from providers
- find and implement solutions to key challenges across the wider health community (QIPP, urgent care, shifting care settings)
- work with other partners to really make the new systems effective

The CCG has established a series of key performance indicators for SWCS covering commissioning strategy, commissioning delivery, service transformation, procurement, HR support, communications, business intelligence, finance and IM&T.

BRISTOL CLINICAL COMMISSIONING GROUP CLINICAL DEVELOPMENTS STRUCTURE



11 Information Technology

11.1 CCG functions in relation to Informatics

CCG functions in relation to Informatics fall into four main areas as set out below.

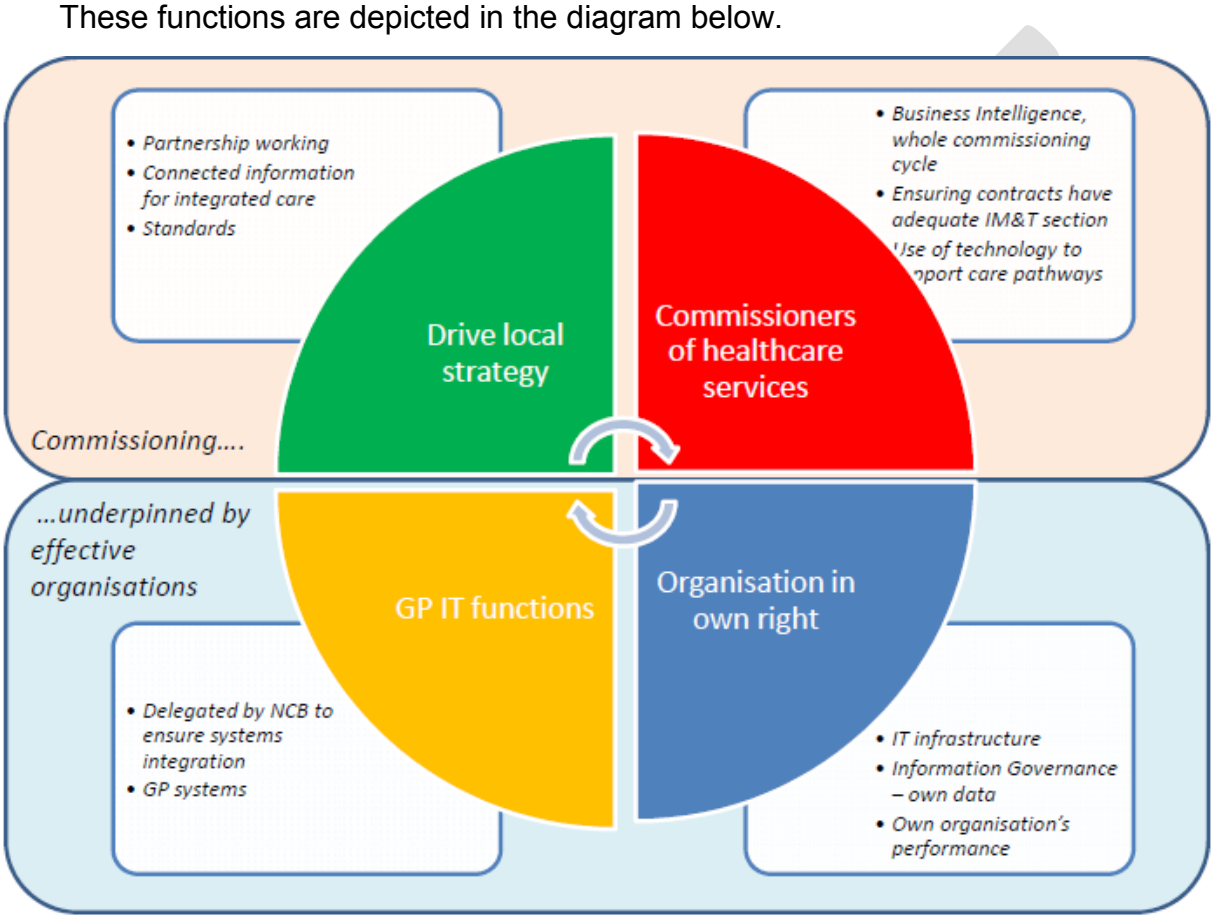
COMMISSIONING

1) As commissioners of services requiring Business Intelligence
2) As the organisations driving local strategy, partnerships, integration and public involvement, working collaboratively with the organisations shown in Figure 1

ORGANISATIONS

3) As organisations requiring Informatics support to run their own business
4) As the organisations to which GP IT functions have been delegated, to ensure these remain integrated with broader system development

These functions are depicted in the diagram below.



The CCG is supported in delivering these functions by South West Commissioning Support, and a summary of our service specification is set out below.

the vision: responsive, cutting edge IM&T support for excellent commissioning

1. Helped by technology, we'll know what patients, members and stakeholders think of the services we commission, and what they want

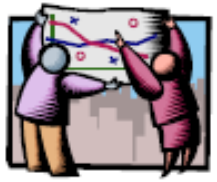
2. There'll be one version of the truth – high quality benchmarked data agreed by all and available via a single dashboard with drill-down to patient level

3. Information will support us to redesign and commission services using care pathways across organisational boundaries, rather than being a barrier

4. Technology will be used to make life easier for both patients and staff – using phone and computer where best

5. We'll have a rolling system of active risk stratification and case management

6. Systems will be interoperable with information shared appropriately, enabling easy, quality referrals, a view of where patients are in the system, and good handovers of care when patients are discharged



7. We'll be transparent, providing information to enable patients to hold us to account

8. We'll be able to monitor all our contracts easily and effectively, releasing productivity and encouraging quality & outcomes

9. We'll have a skilled workforce, committed to using IT in real time. Staff setting contracts will know how best to ensure monitoring data can easily be collected

11.2 Guiding Principles

The following principles have been established within the BNSSG collaborative IM&T strategic group, to be used in determining priorities and decisions about the way in which the IM&T strategy is delivered:

1. **Patients and clinicians working together:**
    - 'No decision about me, without me'
2. **Ensuring quality and safety**
    - Information systems (in the broadest sense of the word) should adhere to relevant safety standards
    - It is a safety issue if a clinical needle of information is buried in an administrative haystack of data
    - Information systems need to be robust, resilient and secure – this should influence decision making not only about new systems and infrastructure, but also about the retention / upgrading of existing assets
3. **Increasing convenience for patients and healthcare staff**
    - Channel shifting, moving business from face to face to online or by phone where appropriate to do so
    - Information available across care settings, with appropriate Information Governance in place
4. **Equity of access for all patients**
5. **Increasing transparency**
    - Giving patients better information to make choices about their healthcare
    - ensuring people can make the best use of the healthcare information available
    - being accountable to patients and the public for CCG decision making
6. **Maximise efficiency to make the day to day clinical business of the organisation work well**
    - A single data set, increasing confidence in the quality of data
    - New initiatives must not introduce a suffocating bureaucracy of data collection or monitoring
    - Less plethora of data, more intelligence
    - Use existing systems, focussing on interoperability rather than monolithic replacements
    - Data entered once in a timely fashion, then shared in accordance with information governance standards
7. **Influencing the national Informatics agenda**

11.3 Overarching strategy

In order to fulfil CCG functions and address service priorities, Bristol CCG has a contractual relationship with the Commissioning Support Unit for informatics support to:

- Add value to data by using technology to create, share and access intelligence

- Ensure commissioned services make the best use of available technology to deliver and monitor care across the entire pathway and in all care settings
- Engage with patients, members and other stakeholders in real time
- Run their own business

The main themes of the CCG IM&T requirements are therefore:

- Business Intelligence
- Interoperability
- Productivity
- Workforce Development

A summary is set out below of the projects/core workstreams which are being progressed.

Project	**Plan and approach to investment**
Business Intelligence (Avon Business Intelligence (ABI)) • Further developments to ABI as single gateway to information about commissioned services	• Core already funded from existing funding streams • Reinvest savings from Health Intelligence contract into developing successor to PCDR
Connecting Care • Increasing interoperability to meet service priorities	• Core already funded • Further developments require business case
Electronic discharge summaries and clinic letters	• Business case required
Referrals project (review current arrangements and propose future approach)	• Business case required
Office Productivity IT Programme, including: • Software tools • Enterprise wide solutions • Online collaboration tools • Content management	• Develop Office Productivity Strategy and business case • Develop 'Bring Your Own Device' business case (to cover costs of eg security model) and policy
Workforce development programme including: • Informatics skills for Commissioners • Use of Office Productivity tools • Clinical services awareness for Informaticians	• Undertake Training Needs Analysis (TNA) • Review possible approaches to provision (online; face to face tuition; placements etc) • Develop business case
GP IT • Review GP Systems of Choice (GPSoC) future arrangements and fitness for purpose of systems • Support system moves for overall business needs	• Progress single system platform where possible

11.4 Health technologies

Technology is being used more widely within health and social care to support patients in the community, although it is still an emerging area of innovation and learning. Some

of the ways it can be used include the monitoring of vital signs, supporting self care, providing remote consultations and maintaining a safe environment.

There is an increasing interest in health technologies nationally, as an innovative response to the growing number of patients with co-morbidities managed outside of hospital. The government is keen to promote telehealth through the 3millionlives scheme, despite equivocal findings from the national Whole System Demonstrator pilot. In addition, an enhanced service for remote care monitoring is being launched this year, to encourage GP practices to consider remote ways of monitoring patients with long term but stable conditions.

Bristol, as an early adopter of telehealth monitoring for long term conditions, has good experience in the application of health technology. Working with Bristol Community Health, Bristol CCG continues to oversee a large scale, three year programme of telehealth that has introduced home based monitoring to over 700 patients in 2 years. In addition potential opportunities for partnership working are emerging, as Bristol University, Bristol City Council and third sector organisations develop schemes that could support the delivery of the CCG's own priorities through use of technology.

The learning from these experiences has informed the development of some draft key principles in relation to health technologies in Bristol CCG.

- Application of a prioritisation framework to ensure the volume of health technology options is effectively managed to make best use of potential opportunities
- Needs focussed not technology focussed in approach. The standard of care must be at least equivalent to conventional care and should support independence rather than dependence of staff and patients
- Taking a targeted approach with effective monitoring to ensure improvement in the quality of services
- Seeking out opportunities for joint working
- Testing for practical experience when evidence is equivocal

12 Financial Plan

The Financial Framework for 2013/14 and beyond sets out financial plans that ensure all national targets and standards are met or exceeded.

The medium term financial strategy sets out the key assumptions for the CCG and demonstrates how they will be used to support delivery of the CCG strategic and operational objectives set out in the service strategy. The plan builds on the financial plans developed by NHS Bristol which are underpinned by:

- A sustainable strong position throughout the 3 years of the plan;
- Growth and inflation assumed in line with the NHS Operating Plan framework assumptions;
- Maintaining a 2% "headroom" contingency to fund cost pressures and other non-recurrent initiatives;
- Activity modelling based on the outturn for 2012/13, impact of population growth and the impact of initiatives to reduce demand and move care closer to home;
- Improved comparative benchmark performance compared to peer groups;
- Focused investment planned during the period to support the delivery of the CCG strategy with particular focus on shifting the settings of care, supporting more patients in the community, and managing the impact of demographic change on health services.

12.1 Assumptions

The key assumptions within the model are as follows:

- The 2013/14 CCG allocation at the time of writing is £519m. It is envisaged that the recurrent resource allocation will increase by 2.5% year on year in line with the national operating framework;
- Uplift to providers to inflation and other mandatory cost pressures will be 2.7% across the period;
- Providers will be expected to deliver on-going year on year efficiency of between 2.5% and 4% which will be delivered through national tariff;
- Population growth based on current experience is assumed to be 1% with a differential impact across age bandings per JSNA;
- The CCG has planned for a 2% headroom to manage in year financial risk, and to fund non-recurrent costs;
- The CCG will deliver a surplus of 1% year on year;
- A contingency reserve of 0.5% has been established.

12.2 Other Resource Issues

- The allocation is based on an assessment of historic expenditure patterns relating to CCG responsibilities and assuming that the existing recurrent expenditure continues. Transfers of resource to the NHSE and Public Health have been removed although the final allocation adjustments may be subject to modification
- The Operating Framework for the NHS in England provides flat rate growth of 2.3% in 2013/14. The DoH has deferred the application of a new resource allocation formula for CCGs whilst further review of the formula takes place.

An allocation of £7.3m to support re-ablement will also be available to the health and social care community.. Table 1 below sets out the growth allocation available to NHS Bristol in 2013/14 and the anticipated growth for the following 3 years.

- Resources to support joint working between health and social care will transfer to Bristol Council to invest in social care services and support service transformation to benefit health and to improve overall health gain. It is assumed that future resources will be transferred and managed through joint governance arrangements.
- Bristol Clinical Commissioning Group will work with Bristol Council to agree jointly on appropriate areas for social care investment and outcomes from this investment, taking into account the Joint Strategic Needs Assessment and existing commissioning plans for both health and social care.

Table 1: Description of 2013/14 allocations and growth assumptions 2014-16.

Description	2013/14 £m	2014/15 £m	2015/16 £m
Anticipated Resource Limit	508.0	519.2	530.7
Growth (Actual & Predicted) %	2.3%	2.5%	2.5%
Growth (Actual & Predicted) £m	11.2	11.5	11.8
TOTAL RESOURCE	519.2	530.7	542.5

12.3 Applications of funds

The CCG will be responsible for a range of services on behalf of the GP registered population. Responsibilities include secondary acute care, community care, mental health and continuing health care. It will also have responsibility for prescribing and some local primary care enhanced services. The CCG does not have any responsibility for the commissioning of very specialised services which the National Commissioning Board will undertake on a regional basis.

12.3.1 Assumptions on Application of Funds

The financial plan follows a number of assumptions across the range of budgets. A summary of these assumptions can is shown at Table 2 below. The principles are as follows:

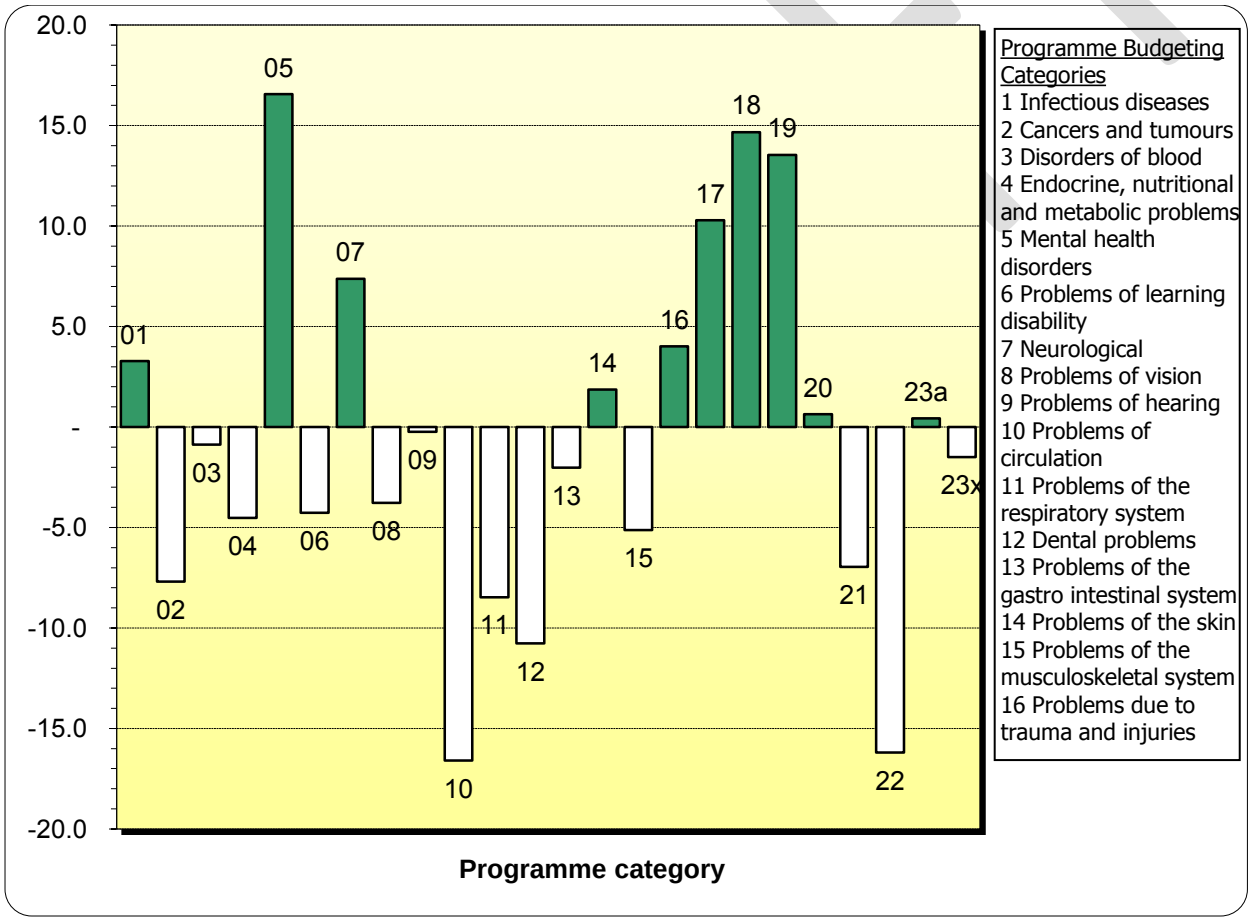
- Providers will be funded for the impact of inflation. This is assumed at 2.7% year on year up to 2016;
- The impact of inflation on primary care prescribing is assumed at an annual increase of 8%;
- All NHS providers will be expected to deliver a 4% efficiency saving year on year in line with the NHS Operating Framework;
- The CCG expects to achieve savings of 5% on primary care prescribing, after having assumed growth of 8%;
- Our population is growing and the health demand is increasing. This is assumed to be an average of 1% year on year which is applied differentially across age bandings per JSNA;
- The CCG will not increase its running costs over the 2-year period. Running costs will be funded within the £25 per head running cost allowance, with a contingency of circa £0.75m;

- The CCG will maintain a recurrent reserve of 2% of the recurrent resource limit to fund cost pressures and other non-recurrent expenditure and also retain 0.5% general contingency;
- The CCG will achieve a 1% surplus per year;
- The expenditure assumptions for our providers will include payments for achieving the national and local quality and innovation targets (CQUIN). This is assumed to be funded annually up to 2.5% of the contract value for the period of the financial plan.
- Considers the CCG position assessed against national benchmarking e.g. 2011-12 Programme Budgeting benchmarking tool. Table 3 below.

Table 2: Inflation, efficiency and growth assumptions 2013-16

Description	2013/14 %	2014/15 %	2015/16 %
Inflation uplift for providers	2.7	2.7	2.7
Inflation for prescribing	8	8	8
Secondary care efficiency	4	4	4
Prescribing efficiency	5	5	5
Expected demographic growth	1	1	1

Table 3: PCT expenditure on main programme categories - variance from National benchmark £m.



Source: Department of Health 2011-12 programme budgeting benchmarking tool version 1.0.

12.4 Investment Assumptions

The investment plan focuses on enabling more patients to be supported in the community. To support this strategy, the CCG will progress investments in community care, primary care, mental health and to further integrate working with social care over the term of the financial plan. This will enable the CCG to deliver the demand challenge that the NHS will face over the next 3 years.

These investments support the strategic intentions for the CCG.

Whilst the CCG is planning to deliver a surplus of £5m year on year, which is in accord with the current national planning assumptions, to deliver this, the CCG will need to achieve its objective of delivering an increased range of services in a primary or community setting.

Providers will be expected to deliver efficiency savings to contain expenditure within a net reduction in income of 1.3%. The CCG proposed investments in out of hospital services, will support secondary care providers to achieve this as it should enable reducing bed occupancy in the acute setting.

In summary, the total sources and applications of funds over the period of the plan are set out below in Table 3. A summary of savings and investments are also detailed below.

Table 3: Source & Application Funds 2013/14 to 2015/16[6]

	2013-14 £m	2014-15 £m	2015-16 £m
Resources			
Total Resources - 2.3% Growth	519.0	530.9	543.1
Health and Social Care Integration Funding *Estimated 1% in 2014-15 and 3% in 2015-16*	0.0	-5.3	-16.3
Total Available Sources	**519.0**	**525.6**	**526.9**
Applications			
Acute Care - 1% growth	287.0	289.8	292.7
Community Services - 1% Growth	43.8	44.3	44.7
Mental Health & LD - 1% Growth	56.8	57.4	58.0
Continuing Healthcare - 1% Growth	19.0	19.2	19.4
Free Nursing Care	5.0	5.1	5.1
Prescribing - 3% Growth	55.8	57.4	59.2
Primary Care - 1.3% Growth	10.7	10.9	11.0
Support Costs - 1%	5.1	5.2	5.3
Running Costs - 1% Growth	11.3	11.4	11.5
Contingency Reserve - 0.5%	2.5	2.7	2.7
Headroom - 2%	10.0	10.6	10.9
Investment Reserves	6.9	5.9	5.6
Additional resources available for investment	0.0	5.9	11.9
Health and Social Care Integration Funding	0.0	-5.3	-16.3
Total Applications	**514.0**	**520.4**	**521.6**
Surplus	**5.0**	**5.3**	**5.3**

[6] Note applications in 2013/14: new CQUIN (£2.5m), NHS 111 implementation (£0.8m), Mental Health Services (£1.7m), NICE & HCDD provision (£1.0m), Carers Services (£0.8m). 2014/15 programme £3.5m, 2015/16 programme £8.6m

12.5 Proposals to Apply Headroom to Support Transformational Change

As can be seen from the 3 year financial summary above the CCG is planning to provide for reserves and headroom of over £12m (2.5%). It is planned to apply £5m of this headroom to support transformational change that will support the CCG strategic objective to support reduce inappropriate use of secondary care. Proposals are in development to implement during 2013/14:

- Further expansion of the GPSU both in terms of increased accessibility across 2 sites and also explore extended opening
- To support the growing elderly population and to support care closer to home it is proposed to pilot the role of community geriatricians. This will require an increase in the short term (circa 5 years) in additional community based geriatricians. Most importantly though it will enable a different model of service to be developed
- Increased capacity in community and primary care teams to support 7 day working and advanced care planning
- Increase the provision of non acute beds – ie virtual community ward
- Review current LES arrangements for nursing and care homes linked to the wider implementation of risk stratification tools leading to advanced care planning and care co-ordination
- To pilot a number of advice and guidance services (ENT, gynae, cardiology, paediatrics) using non PBR contracting models
- Non recurrent support for modernising mental health

12.6 Financial Risk and Mitigations

The key risks to the CCG financial plan in 13/14 are as follows:

- Cost neutrality is not achieved associated with the maximum take for specialist commissioning.
- Slippage on the QIPP plan for 13/14 will exert pressure on the CCG
- Inability to contain non elective activity at 2012/13 levels
- CHC levels cannot be contained and in particular the cost of retro claims is above the level provided for in 12/13 accounts
- The potential for error in the various baseline adjustments that are taking place as we move into 13/14
- Agreement of 13/14 contracts with main providers and emerging cost pressures
- Quality and delivering the NHS Constitution commitments
- Organisational memory is lost

The risk mitigation on the QIPP plan will be via:

- contingency reserves held by the CCG
- active and targeted data validation routines to mitigate the potential impact of coding and counting creep in acute providers
- investments targeted to delivery of infrastructure changes to enhance community based services for 13/14 and beyond

The CCG will also need to be able to deal with a range of financial risk throughout the 3 year planning period. Areas of risk that may be experienced include:

- Growth funding received is less than the anticipated level;
- Transformation savings are not delivered recurrently, resulting in a secondary care cost pressure;
- Demand on acute services cannot be contained at 12/13 activity levels;
- Tariff and other inflation exceeds the planning assumptions across the period of the financial plan;
- Continuing Healthcare requests are significantly higher than planned;
- The impact of high cost drugs and new devices exceeds planned increases;
- Primary care prescribing increases in excess of the 8% growth assumption and efficiency savings of 5% are not delivered;
- The process of organisational change results in a resource gap to fund specific services

Mitigations to address risk over and above those outlined include:

- Robust performance management arrangements
- Regular review of programmes of work to respond to performance and new innovations
- More active involvement of medicines management expertise in the review of PBR drug exclusions
- Working in partnership with other CCGs and the Area Teams to consider joint initiatives to mitigate system wide risk
- Working with NHS England and other new commissioners to ensure any anomalies in baseline allocations are resolved and no organisation is left with windfall gains/losses.

12.7 Procurement

The CCG is already undertaking a very significant clinical procurement, of mental health services in Bristol. Over the coming years this approach will become increasingly common, and we already know that the following are due for re-procurement:

- Community child health services (2015)
- Commissioning support (2016)

In addition we are currently undertaking a review of all any qualified provider (AQP) services which may resulting the need for further tendering.

(more detail from Faye Robinson for September version)

13 QIPP

As intelligent clinical commissioners Bristol CCG has a clear understanding of its service priorities, clear reporting structures against activity and finance information and a sound understanding of our provider landscape and local health economy.

Our approach to QIPP is informed by our 5 values, and is driven by the understanding that reduced duplication and a positive patient experience can result in safe care and good outcomes. Improved quality can consequently equate to improved efficiency. It is critical therefore that an emphasis on maintaining and improving quality and patient safety is at the heart of the work of Bristol CCG and its partners

The CCG has strong and well engaged clinical leaders, a history of excellent working relationships with public health, social care and our wider partners and is in a strong position to progress the service transformation across the community. The governance and work planning processes set out in this plan help us to co-ordinate our planning and interventions across the four branches of QIPP:

Quality: We have strong and well engaged clinical leaders and a robust Quality and Governance Committee. Our contract management arrangements ensure regular control and oversight of clinical quality issues, and we have a proactive and wide-reaching approach to seeking and acting on public, patient and carer experience of services.

Innovation: we are active partners in the local Academic Health Sciences Network and the Bristol Health Partners, both of which promote the role of innovation and best-practice in the way we commission healthcare. As part of this the CCG is active sponsor to a variety of Health Improvement Teams seeking to test and evaluate innovative solutions to relevant local priorities, e.g. self-harm and emergency bed days.

Productivity: Benchmarking information is widely available and the CCG, working with the local CSU, is making this information available in an accessible and useful format to Locality Groups. This provides useful insight into where there are areas for improvement in terms of use of resources. Our productivity focus is very much on progressing service models which are better embedded in primary/community settings with less reliance on hospital based services. This will not necessarily result in reduced expenditure but will enable Bristol to manage the impact of population demographics in a sustained period where there will be little if any real terms increase in funding to the NHS and Local Authority.

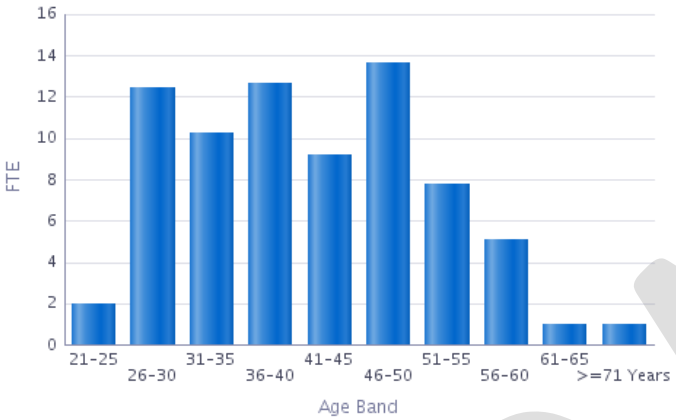
Prevention: through our partnership working with the Local Authority – via the Health & Wellbeing Board – we have a strong focus on the challenges facing Bristol over the next few years. Prevention is a facet of all of the eight delivery themes, but particularly in the Long Term Conditions, Mental Health and Urgent Care/Frail Older People themes.

14 Workforce and Organisational Development

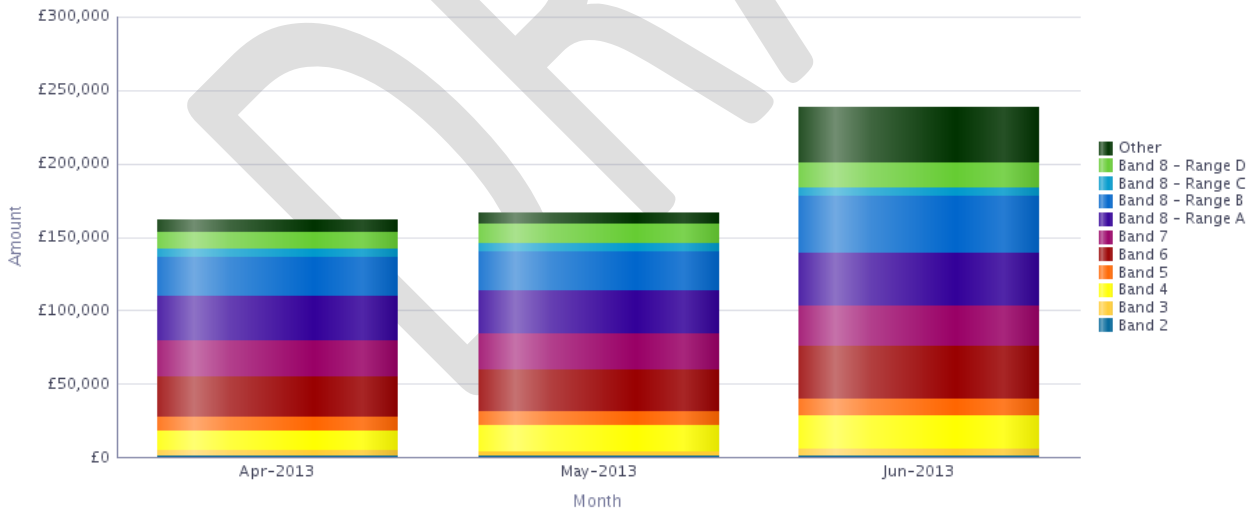
The CCG currently employs a total of 84 staff, equating to 75 WTE. The profile below shows the position relating to the workforce over the period of April to June 2013.

	Apr-2013	May-2013	Jun-2013
FTE	73	74	75
Headcount	80	82	84
New Hires	85	2	3
Leavers	1	0	1
Maternity Leave	4	4	5
Turnover Rate	1.3%	0.0%	1.2%

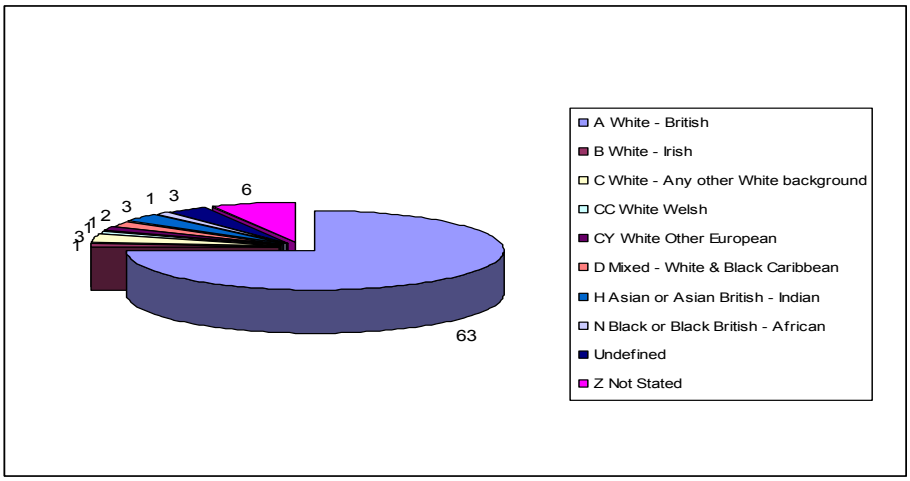
The age profile of the CCG is illustrated in the bar chart below, indicating a good spread of ages across the organisation, which supports sustainability and the potential for succession planning in the future.



The following chart outlines the pay profile of the organisation and shows a broad spread of salaries across the pay ranges.



Bristol CCG supports a diverse population within Bristol City boundaries and the following chart illustrates the ethnic profile of the workforce as at 30 June 2013.



The NHS is operating in a context which is changing at a scale and pace not seen before. The emergence of new organisations set against a backdrop of a loss of senior NHS leadership expertise and financial constraint means it has never been more crucial to harness the leadership potential and talent within the CCG in order to provide system leadership going forward.
Organisational development (OD) for the CCG will be a key enabler of the achievement of the new organisation's strategic ambitions.

The CCG considers the key drivers for sustainable levels of high performance are:

- **Agreement on direction**. This is a compelling vision outlining the mission, purpose and values of the CCG. The vision needs to be meaningful and to connect to individuals working within the CCG. It must be underpinned and supported by the culture and climate of the CCG.

- **High quality performance.** This involves having the right capabilities, effective systems and processes and a high level of motivation within the workforce.

These drivers support the need for the development and delivery of an OD strategy which supports the CCG mission, purpose and values and is underpinned by a culture of valuing all staff, empowering them to make appropriate decisions, supporting them to be a creative and enabling a work life balance

The CCG is currently developing its OD strategy the purpose of which is to set out how the CCG will develop from where it is now to where it wants to be in achieving the outcomes detailed above.

The strategy will to build on work already undertaken within the CCG and will outline:

- How the CCG will draws out maximum benefit from GP involvement in the Governing Body
- The development of a culture which has clear accountability and expectations.
    - Where innovation and excellence are tangibly supported and consistently rewarded and where poor performance is addressed through an appropriate balance of support and consequences.
    - Where there is clear alignment between staff behaviours and experiences and the value base espoused within the CCG.

- Clear timelines for progression with milestones.
- The need to consider both team and individual development
- The need to include three specific staff groups
    - The Governing Body,
    - Locality Executive Groups and Member Practices
    - Wider CCG staff.
- The requirement to align existing development opportunities for bands 4-8A

Once the strategy has been finalised the CCG will develop a detailed organisational development plan which, it is anticipated will deliver the following proposed outcomes

- The CCG is led by leaders with the appropriate skills and knowledge, who have a vision aligned to priorities, provide direction and leadership during times of uncertainty and who role model attitudes and behaviours consistent with the CCG vision and values.
- The CCG develops an organisational culture which enables individuals and teams to deliver high performance.
- Team and individual development needs are identified and met through a consistent CCG approach to organisational development

It is anticipated that the action plan will be in place by autumn 2013.

13 Equality and Diversity

Bristol CCG's Equality, Diversity and Human Rights Strategy sets out our clear intention to adopt inclusive and innovative approaches to meeting the needs of our diverse population and valuing differences of: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation. This Strategy is complemented by our Equality and Diversity in Employment Policy which is about ensuring that equality, diversity and human rights are embedded throughout our employment-related functions.

Together, the Strategy and Policy aim to support our compliance with a range of legal and regulatory requirements, in particular: the Equality Act 2010, the public sector Equality Duty, the Human Rights Act 1998 and implementation of the NHS Equality Delivery System. They also aim to move the CCG beyond basic compliance, towards being recognised by our peers and strategic partners as leaders in shaping a fair and equitable, local health economy.

To achieve this, we have committed to:

- understand the health and wellbeing needs of Bristol's diverse population and how discrimination can impact on health, wellbeing, access to services and service experiences
- commission services which are accessible to, and meet the needs of, this diverse population
- develop the required knowledge and skills to enable our workforce to commission services in this way
- plan and conduct our business in a way which tackles discrimination and promotes equality in service delivery, employment and key decision-making
- continually improve our equality-related performance by developing and delivering against Equality Objectives which address our key challenges

14 Sustainability

A number of important trends affect the human population of the planet. These have tangible consequences for Bristol and the CCG. Some of these consequences are amenable to local action to make their impact less; some of these actions we can undertake as an organisation; some we need to act with others to achieve the greatest impact:

Population growth: This also affects Bristol (migration, fertility) and has a direct impact on the use of health services we commission. We need to review the impact of this on our commissioning plans annually.

Increasing cost of fossil fuels with the added cost of the investment into the further development of non-fossil fuel energy: population growth drives the cost of fossil fuels up world-wide. As the supply of fossil fuels is finite this trend will only worsen and as an organisation we need to minimise energy use (and costs). Carbon reduction and sustainable developments are corporate responsibilities and is an inherent part in the new CCG's commissioning and corporate performance. The Climate Change Act (2008) gives the legal framework to ensure that a legally binding target of at least an 80% cut in greenhouse gas emissions by 2050 (baseline 1990) is delivered.

We need to contract in such a way that providers take the same approach. We need to promote total cost accounting where this is economically viable (for large projects) and focus on reduced or equal costs and reduced energy use.

Increasingly erratic weather conditions with the main risk of flooding locally.
We need to influence providers to consider the risks associated with flooding and to take measures to minimise service disruption due to flooding. We need to work with NHS England to consider doing the same with primary care premises.

Other issues continue to remain high on the agenda:
Transport (developing, promoting alternatives to individual car ownership and car use), **Food** (locally sourced to reduce transport costs, healthy foods to reduce obesity) and **Waste disposal** (reduce waste, increase recycling).

14.1 What we will do

In order to address these issues systematically as an organisation we will take a number of steps:

- Appointment of a board member and a CCG manager to be responsible for the planning, implementation and reviewing of our plans relating to the above issues.
- Seek volunteers from among its staff to identify and promote possible actions to increase the sustainability of the CCG as an organisation.
- Work with the city council and our providers to create joint approaches that achieve reduced energy use, improved food sourcing, better waste disposal/recycling and reduce risk of flooding.
- Work with NHS England to consider ways that help primary care to move into the same direction.
- Work with the commissioning support unit to integrate our objectives on the road to sustainability into contracts.
- Work with the research community to promote evaluation of the effectiveness our plans.
- Agree with Bristol City Council and specifically their public health department to host an annual event to showcase and review positive developments in sustainability by commissioners and providers.
- The CCG board should receive an annual report (from the board member, manager and staff members involved) to be aware of the actions taken and to contribute to future policy development.

15 Glossary

CCG	Clinical Commissioning Group
ABI	Avon Business Intelligence
AQP	Any Qualified Provider
APCRC	Avon Primary Care Research Collaborative
AMRC	Association of Medical Research Charities
AHSN	Academic Health Science Network
BME	Black & Minority Ethnic
BNSSG	Bristol, North Somerset & South Gloucestershire (refers to these CCGs)
BCMS	Business Continuity Management System
BCP	Business Continuity Plan
CLAHRC	Collaboration for Leadership in Applied Health Research & Care
CPMG	Contract Performance Management Group
CQRM	Clinical Quality Review Meeting
CSU	Commissioning Support Unit
DOH	Department of Health
EPRR	Emergency Preparedness, Resilience & Response
GPs	General Practitioners
HIT	Health Integration Team
IM&T	Information Management & Technology
JSNA	Joint Strategic Needs Analysis
LHRP	Local Health Resilience Partnership
NBT	North Bristol Trust
NIHR	National Institute for Health Research
NHSE	NHS England
NHS	National Health Service
ONS	Office of National Statistics
QIPP	Quality, Innovation, Productivity & Prevention
RCF	Research Capability Funding
R&D	Research & Development
TDA	Trust Development Agency
UH Bristol	University Hospitals Bristol
UoB	University of Bristol

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Item 11 – Appendix B

HSC Commissioning Intentions for 2013/14 for presentation to Health and Wellbeing Board

Title	Service user group	Strategy reference (is there a strategy for this or other mandate)	Summary of the commissioning Intentions	Comments and owner
Accommodation Strategy for MH, LD and Autism	People with MH problems or people with a learning difficulty or people on the Autistic spectrum	Accommodation strategy for MH, LD and Autism Joint with CCG	Develop the market for accommodation and accommodation related support for this service user group Review commissioning arrangements for purchasing the above including the CSS (community support services) contract Commission intensive floating support Jointly commission an assertive engagement service for people with MH needs with Bristol CCG Commission additional support for people to access housing and support using the community supported accommodation approach (floating support)	Consultation underway before being launched officially in October 2013 Catherine Wevill Strategic Commissioning Manager HSC
Autism Strategy	Children, young people and adults with autism	Autism Strategy in response to Autism Act (2009) (see www.bristol.gov.uk/autism)	Jointly develop with Bristol CCG a training strategy covering children and adult's services, aimed at raising awareness and skill levels of frontline staff around autism.	Both will be done in partnership with Bristol CCG.

			Review the need for a specialist early intervention service, aimed at preventing the breakdown of placements and reducing / removing the need for high cost out of area placements.	Owner for both is Catherine Wevill Strategic Commissioning Manager HSC
Integrated Community Equipment Service	All user groups	Core service	To re-commission ICES for a start date of October 2014	Tim Wye Strategic Commissioning Manager HSC
Preventative Services (former supporting people services	Various	Various	Preventative services are classed as discretionary. The council is reviewing its discretionary spend and pending that decision there will be published commissioning strategies over next 6 months for this area of work	Tim Wye Strategic Commissioning Manager HSC
Re-commissioning of Home care provision in Bristol	All user groups that receive or need home care	Home Care Re-commissioning Plan (as agreed by DLT and Exec Member). It will also be agreed by SLT and Cabinet before officially starting.	Re-commission all home care to be provided in Bristol, on behalf of BCC. Following a two stage tender process, contracts will be awarded to home care providers to deliver home care in Bristol on behalf of BCC. This model will focus on how new home care packages are commissioned, but it is expected that existing home care service users will also be affected and may begin receiving care under the 'new model'.	Consultation underway and will end on Oct 29th 2013. Two stage tender process expected to begin late 13 / early 14. Leon Goddard Strategic Commissioning Manager HSC
Care Home Commissioning	All user groups that receive or need a care home placement	Care Home Re-commissioning Plan that will be agreed by DLT, Exec Member and Cabinet.	Introduce a new commissioning process, contract and pricing structure for all care home placements.	Expect to begin consultation towards end of 2013.

				Leon Goddard Strategic Commissioning Manager HSC
Extra Care Housing - Current schemes	All user groups that currently, or may in future, use Extra Care Housing.	Not at present. DLT approval will be sought before process begins.	Process will seek to identify the 'quality' of current care and support providers, with a process to identify which of them will be offered new contracts. Where a new contract is not offered, this will be re-commissioned through a formal tender process.	Expect to make decision on existing providers early 2014.
Extra Care Housing - New Fosseway	All user groups that currently, or may in future, use Extra Care Housing.	The commissioning plan for new Fosseway will need Cabinet approval.	A tender process will be undertaken to identify which provider will i) build the ECH scheme ii) deliver the care and iii) deliver the support.	The Commissioning plan will go to Cabinet in October 2013.
Provision of specialist equipment for Deaf People	People with hearing impairment	Commissioning Plan in development. Mandate is from a) review of voluntary sector in 2011/12 and decision to re-commission. b) Development project commissioned from Voscur by HSC on the needs of deaf people in Bristol.	Re-commission existing service to secure improvements in outcomes.	Plans in development, new service to be in place by June 2014. Owner - Liz Sutton, Strategic Commissioning Manager
Community Support Services	Adults with eligible needs for support at home	Commissioning Plan in development.	Re-commission existing services to simplify contract processes and develop the market for flexible support to improve the lives of individuals with support needs and enable them to be as independent as possible. This includes day opportunities, carer support services,	Strategy in development, for consultation autumn 2013, new services to be in place by June 2014.

			outreach services, accommodation based support and direct payment support.	Owner - Liz Sutton, Strategic Commissioning Manager
Strategic Partnership for Dementia Care Homes	Adults with dementia	Cabinet report Summer 2012	To identify a partner or partners to build two new dementia care homes on two old EPH (elderly persons homes) sites in Bristol one in the south and one in the north. There will involve a block contract with BCC for the partner to provide the care in the homes once they are built.	The procurement launch is imminent (September2013) Owner- Catherine Wevill Strategic Commissioning Manager

Children & Maternity - Overview

1. Joint commissioning in fragmented landscape
2. Joint provision eg disabled children
3. Role of universal services – children's centres, schools, GPs, health visitors
4. Importance of preparing for adulthood
5. Opportunities for whole family work
6. Shifting resources to priority areas/groups

Delivery Theme 4: Children and Maternity

Strategic Ambitions

- Improve the health of vulnerable and excluded children and young people
- Reduce childhood obesity
- Improve access to health services and experience of services for children with complex health needs
- Improve maternal health and reduce infant mortality rates
- Reduce risk taking behaviour which impacts on health
- Improve emotional health and wellbeing
- Improve the physical health of children

Indicators

- Hold ED activity at 12/13 levels (=reduction in real terms)
- Satisfaction with place of birth
- Increase preferred place of death
- Reduce rates of infant mortality

Clinical Lead: Dr Kirsty Alexander (children) and Dr Peter Goyder (maternity)

Lead Officer: Judith Brown

Public Health: Jo Williams

Interventions	2013/14	2014/15	2015/16
• Re-procurement of children's community health services			
• Minor illness pathway: self-care, primary and community services			
• Improve care pathways for children with complex needs			
• Ensure the highest standards of quality and choice for community and hospital maternity services			
• Paediatric clinical network			
• Asthma and respiratory pathway			
• Paediatric GPwSI clinical advice and community clinic			
• Develop integrated disabled, SEN children and young adults service			
• S136 pathway			
• Implement emotional health and wellbeing strategy			
• Implement transition pathways to adult services			
• Implement Avon children's palliative care action plan			
• Improve continuity of ante-natal care			
• Improve access to support for perinatal mental health issues			
• Reduce rates of infant mortality			

KEY

Strategic priority

Other intervention

Improve the health of vulnerable & excluded children and young people

- Safeguarding – all commissioners
- Improve outcomes for specific vulnerable groups (LAC, gypsy/travellers, teenage parents, c&yp with sexually harmful behaviour, young offenders, excluded from school, NEETs)
- Family Nurse Partnership (NHSE)
- FGM – joint work
- First Response & Early Help - all

Reduce childhood obesity

- Maternal obesity – funding gap
- Breast feeding
- Early years and children's centres
- Healthy schools programme
- School meals contract – cost & quality
- Active travel, leisure, play
- Health weight care pathway

Improve access to services and experience for children with complex needs

- Disabled & SEN Children & Young Adults service (DSCYAS) – CCG, CYPS, HSC
- Home to School Transport – CYPS
- Preparing for adulthood – transition pathways
- Short breaks (including specialist & hospice)
- Personalisation & personal (+health) budgets
- Specialist foster placements - gap

Improve access to services and experience for children with complex needs (continued)

- Community children's nursing service – gap
- End of life pathway (CCG)
- Predictive service planning – data sharing!!
- Equipment & communication aids – Opp
- Pooled budgets eg to prevent Out of Authority placements
- Bristol Youth Links

Improve maternal health and reduce infant mortality

- Ante-natal care – continuity and quality
- Perinatal mental health & wellbeing
- Smoking cessation & breastfeeding
- Improved pathways through children's centres, maternity services and health visiting
- Increase uptake of immunisations
- Data and information sharing
- Early Help, safeguarding, parenting support
- Improved housing for families

Reduce risk taking behaviour which impacts on health & wellbeing

- Increase number of health settings that are Young People friendly
- School nursing accessible to young people
- Bristol Youth Links
- Sexual health services for young people
- Drug & alcohol misuse and young offender health
- GP role in promoting young people's health

Improve emotional health & wellbeing

- Commission IAPT Tier 2 for young people
- Improve support for adolescents
- Accessible school nursing service (PH/LA)
- Implement joint strategy NB role of schools
- Section 136 pathway for young people
- Support (and funding) for young carers
- Pooled budgets

Improve the physical health of children

- Reduce inappropriate use of secondary care
- Raise parental awareness of prevention, childhood illness, and access to service
- Improve management of asthma in primary care
- Dental and oral health
- Childhood injury prevention
- Immunisations and vaccinations

Opportunities & challenges

- Role of primary care & GPs in promoting and safeguarding health & well-being
- Reducing dependence on secondary care, both during childhood and as adults eg mental health, obesity all result in burden of ill health in adults.
- Role of universal services in promotion and prevention – schools, children's centres

NHS
Bristol Clinical Commissioning Group

Report for the CCG Board

Title: Funding Transfer from the NHS to Social Care 2013/14

1 Background

The Operating Framework for the NHS in England for 2011/12 set out a process whereby PCT's would receive allocations to transfer to local authorities to support adult social care for 2 years. In Bristol agreements were made between the Council and the PCT on the areas of spend, specified by the Department of Health, and the monies transferred via a Section 256 Agreement under 2006 of the NHS Act. A set of performance measures were agreed and reported on to demonstrate the health benefit of this social care spend. The recent publication of the national Adult Social Care Outcomes Framework data demonstrates that whilst overall delayed hospital discharges in Bristol moved from the 3rd quartile to bottom quartile, the number of delayed discharges attributable to social care moved from second quartile to top quartile. This improved performance is directly attributable to this spend.

For 2013/14 the funding transfer to local authorities will be undertaken by NHS England, again using a Section 256 agreement. The transfer to Bristol City Council, based on the adult social care relative needs formula, is £7.28 million for 13/14.

2 Use of Funding

The funding agreement must be based on meeting the following conditions:

- It must support adult social care services and deliver a health benefit
- The local authority must agree how the funding is best used and the outcomes expected with health partners through the Health & Wellbeing Board.
- Regard must be taken of the JSNA and existing commissioning plans
- A demonstration of the positive difference for services user outcomes
- It can be used to support existing social care services with good outcomes, which would be reduced due to budget pressures in local authorities without this investment.

- Meet the revenue costs of the Caring for Our Future White Paper commitments

3 Governance Pathway

The transfer of these social care monies in Bristol over the last 2 years has been smooth and delivered good outcomes as evidenced above, reflecting the positive joint working between the local authority and health partners. This has not been the case in other parts of the country. Under the new arrangements the proposal is that basis for the transfer should be agreed through the Council and CCG Governing Body before discussion and sign off by the Health and Well Being Board at the September meeting and final agreement with NHS England. This planning process and governance framework will support wider integration and efficiency across health and social care.

4 Context

Like all local authorities, Bristol is facing a significant financial challenge to deliver high quality services within a reducing budget envelope. We are in the final year of the current Comprehensive Spending Review which has seen a £70 million reduction in total council budget with 20 million from Health & Social Care. A further £80 million reduction in the Council's budget is anticipated in the 3 years from 14/15.

We are currently seeing a £800k forecasted cost pressure, in terms of a sharp increase in residential and nursing home placements from our hospitals.

In this context, the funding transfer allows us to mitigate against significant service reductions, whilst also supporting the delivery of a transformation programme that will deliver longer term efficiencies and quality. This activity aligns with health priorities to support the whole of the social care system.

Current transformational activities this year include:

- Re-modelling of intermediate care and re-ablement services - also subject to a DOH Pioneer status bid
- Implementation of a new day opportunities offer through the establishment of 3 Community Hubs
- Reducing our direct provision of residential care for older people and commissioning those services where required
- Commissioning a strategic partner to deliver 3 new residential/nursing units for people with dementia
- Re-commissioning home care contracts to deliver better quality and flexibility to meet demand
- Re-designing our customer pathway and care management structure to support it
- Improving our safeguarding response

5 Proposals for Spend

The proposed areas of spend outlined below have been informed by the strategic planning mechanisms across the health and social care system including:

- Health led Healthy Futures Programme
- Urgent Care Boards
- Summits to address pressures in A&E
- Needs identified in Joint Strategic Needs Assessment
- Emerging priorities from the Health and Wellbeing Strategy

In addition these proposals have been shared with the Chief Operating Officers from our acute trusts. Once proposals have been agreed we will produce a score card of measures that can be monitored by the Health & Social care system through regular reporting to the Health & Wellbeing Board.

5.1 Re-ablement Service £2.5m

Priority from Health & Wellbeing Strategy

This service is a key platform for Health and Social Care to deliver improved independence for individuals and thereby reduce reliance on other services. The service has been reviewed and is now jointly commissioned to deliver a range of improved outcomes and efficiencies, within a single management structure. The service is jointly delivered by the provider directorate within Health and Social Care and Bristol Community Health. The service is a key part of our Pioneer bid and will be essential in our ambition to significantly reduce the length of stay in our hospitals. This will require a significant transformation of the service but the successful delivery of this service will significantly impact on the whole of the social care system, assisting in the reduction of our use of residential and hospital care. The additional social care funding allows us to protect our Health and Social Care 6 million pound investment in this service, to allow this transformation to take place.

Performance will be measured through the targets and milestones set through the joint specification and through the Transformation Reablement Project Board which is also overseeing the delivery of the Pioneer bid outcomes.

5.2 Bed- based Intermediate Care £2m

As part of the system wide consideration of rehabilitation we need to look at the type, quantity and focus of our bed base. We are planning this year to develop Westleigh Resource Centre with additional beds including those for bariatric patients, a current huge gap at the present time. These will be in place by December to support the winter plans.

5.3 Development of Dementia Care Services £1m

Identified as a key priority in Health & Wellbeing Strategy

Demographic changes resulting in people in people living longer will mean that there are more people living with dementia. Following the development of the Dementia Strategy we have commissioned a new service to support people living at home, with the aim of preventing hospital admissions and early admissions to residential care. The service is focussing on short-term work to support individuals and carers in crisis or where there has been a significant change. Taking a re-ablement approach, the service support individuals in an intensive way, including working with current care providers, to stabilise a care package and maintain where possible community living.

Performance will be measured through the targets set within the specification for the service and reported to the joint Dementia Partnership Board.

5.4 Domiciliary Care Capacity £500k

Key contribution to supporting hospital discharge and supporting people in the community.

As part of our re-commissioning of home care contracts we are looking at ways to increase capacity and flex within the market at times of peak demand. This can be measured through the joint Bristol City Council and NHS Bristol CCG specification for the service.

5.5 Adult Safeguarding £250k

Key contribution to improving patient flow from hospital into quality residential and nursing care where required. We can evidence that this work has delivered significant additional nursing home beds into the system this year by ensuring qualitative improvements in care.

Given the continuing high profile nature of the safeguarding agenda, we will invest in a consolidated safeguarding service, with additional senior practitioners alongside additional nursing capacity to be alerters to the safeguarding lead in Bristol Community Health. This will deliver:

- Holistic quality assessments of provider services

- A triage system as part of the remodelled care management service
- Assessment of the effectiveness of care plans within the parameters of a health investigation to determine whether there is health neglect.
- Provide clinical leadership and determine the level of competence /skills of RGN/health professionals
- Determine whether long-term conditions are being managed effectively and properly
- Determine if when someone is at end of life deteriorating, whether the RGN's have recognised this and responded to the changing level of health needs.
- Act as intelligence gatherers
- Liaise with GP's and assist in building relationships between them and care homes
- Provide a prevention and education role as part of their remit to improve competencies, skills and knowledge base of health providers within care homes
- Investigate serious untoward incidents and have a quality assurance function

We will measure the effectiveness of this multi- agency working through our multi-agency Safeguarding Adults Board metrics.

5.6 Deprivation of Liberty Service £50k

Increasing the capacity to meet demand and ensuring that assessments are completed within time scales.

Measured through our multi-agency Safeguarding Adults Board metrics

5.7 Community Equipment & telecare £700k

Key activity to support hospital discharge, maintain independence and prevent hospital admission.

This investment will support the transformation of the Independent Living Service to improve the delivery of timely adaptations. This work is governed through a joint project board with the Neighbourhoods Directorate within the city council

Measures

- Maximise the provision of equipment and home adaptations as a means of independent living
- Increase the number of people meeting their needs through other channels
- Increase the speed of delivery of major adaptations
- Increase the efficiency and cost effectiveness of the service

- Maximise the number of people who benefit from occupational therapy advice
- Improve customer satisfaction / Reduce the number of customer complaints
- Review the current prioritisation assessment model for eligibility for a home adaptation.
- Ensure all adaptation repair requests received in the CSC are handled consistently

In addition we will work with the CCG to develop a joint strategic approach to telehealth/telecare to maximise our joint investment.

5.8 Development of 7 day working £280k

As the health and social care system looks to transform itself and meet the demand for 7 day working, we will develop an approach within our hospital social work teams to ascertain what is required from social care, working as part of the Healthy Futures Programme.

Total spend £7.2m

6 Recommendation

The CCG Governing body is asked to approve these areas of spend, for inclusion in the section 256 agreement and forwarding to the September Health & Wellbeing Board.

Alison Comley, Strategic Director – Health and Social Care Bristol City Council

Richard Lyle, Programme Director, Community, Partnerships & PPI
NHS Bristol Clinical Commissioning Group

Public Health Commissioned Services 2014-15

Sexual Health Programme

Current contracts:-

- Genito Urinary Medicine – UHB
- Contraceptive and Sexual Health Services – UHB
- Sexual Health Services for Young People – Brook
- HIV prevention – Terence Higgins Trust
- Public Health Primary Care Services – GPs and Pharmacies

Plans for 2014-15

Planned review of sexual health services taking place during 2013-14 to inform future commissioning decisions. This will include the following:-

- Right service
- Right provider
- Value for money
- Addressing inequalities in provision
- Targeting those most at risk

Drugs and Alcohol Programme

Current contracts (from November 2013):-

- ROADS – specialist services commissioned from BSDAS, BDP, DHI, St Mungos and ARA
- Public Health Primary Care Services – GPs and Pharmacies
- Specialist drug and alcohol nurses – UHB and NBT

Plans for 2014-15

The specialist drug and alcohol services for Bristol have recently been re-commissioned and will be going live from 1st November 2013

Other services which were not re-commissioned through this process will be reviewed to ensure that care pathways are in place and services "fit" with the new service provision

Weight Management Programme

Current contracts:-

- Adults Tier 1 Weight Management on Referral - Slimming World and Weight Watchers
- Adults Tier 2 Dietetics Service - UHB
- Children and Family Tier 2 programme - Weight Management Centre
- Healthy Weight Nurses – NBT (School nurses contract)

Plans for 2014-15

Adult services will be reviewed this year with a view to re-procurement if appropriate during 2014-15

Children' service is likely to be extended for a further year

School nursing contract is due for renewal next summer

Cancer

Current contracts:

- Public Health Services contract – GP's Pharmacies, Children's Centres, Healthy Living Centres (Stop Smoking Services)

Plans for 2014/15

Review of stop smoking services to inform future commissioning decisions. To include:

- Service provider/s
- Value for money
- Health inequalities

Proposal for introducing 'Make every contact count' and Cancer champions programme

School Nursing

Current contracts:-

- School nursing contract – NBT (CCHP)

Plans for 2014-15

The school nursing provision is being reviewed across Bristol and South Gloucestershire during 2013/14. The results of the review will inform the commissioning process for 2014/15

Breastfeeding Programme

Current contracts:-

- Breastfeeding support service - Barnardos
- Breastfeeding clinics – NBT, VSO
- Breastfeeding counsellors - VSO

Plans for 2014-15

The breastfeeding support service will be reviewed during 2013/14 with a view to re-commissioning in 2014/15

Health Check Programme

Current contracts :-

- Public Health Primary Care Services – GPs

Plans for 2014-15

The health check programme is being extended to cover all GP practices in Bristol. Consideration will also be given to extending the programme to other providers to ensure that we reach those most at risk

Injury Prevention Programme

Current contracts:

- None

Plans for 2014/15:

- A change by DH to PHOF for emergency admissions requires extension of work from 0-18 years to 0-14 years and 15-24 years.
- To extend road safety activities into physical activity agenda

Public Mental Health Programme

Current contracts:-

- **Suicide Prevention** – counselling support for those bereaved by suicide contract with CRUSE , Suicide Prevention Awareness Training contract with Bristol Mind and Men's Health Forum small contract with Care Forum to host the forum
- **Self Harm Prevention** – Self Harm Register and service improvement programme (HIT) UOB/UHB
- **CYP emotional health** – CYPS BCC
- **Race Equality in Mental Health** - policy and strategy development co-funded with AWP plus contracts with community organisations undertaking anti-discrimination and BME mental health engagement with SARI, Off the Record, Nilaari, Re-think.
- **Social Prescribing and targeted prevention for mental health** – Social Prescribing -Positive Minds in Hartcliffe and Withywood; Health Related Welfare Benefits Advice – North Bristol Advice Service, East Bristol Advice Service, Child Poverty Action Group, CAB; Sexual Orientation and mental health – LGBT Mental health
- **Five Ways to Wellbeing** – train the trainer programme and targeted training for commissioned from Happy City, plus little book of Wow and other resources

Plans for 2014-15

To further align with CCG Modernising Mental Health Programme and BCC, to further develop co-design of DRE with MH provider, to maintain strong focus on suicide and self harm prevention, to develop multi –sector approach to No Health Without Mental Health Bristol, to increase focus on CYP emotional wellbeing

Health Exclusion and Vulnerable Groups

Current contracts:-

- Gypsies and Travellers – Specialist Health Visitor (NBT), community development and engagement (BCC Travellers Team)
- People with Learning Disability – the Misfits Theatre Company
- BME and Migrant Health – BME Blood and Transplant Campaign – Faith Forum / BCC, Bristol Young Peoples Leadership Programme, Show Racism the Red Card
- Deaf and Wellness – Parenting Classes (Deaf Parents UK), access to health programme (BCC)
- Offender Health – exercise on release (various fitness centres), Healthy Prison and prison health champions (HMP Bristol), HNA for Bristol Probation Service

Plans for 2014-15

To continue focus on current programmes, aligning and integrating with BCC where possible, to strengthen work on BME and Migrant Health in partnership with CCG and BCC, to develop offender health programme and to undertake an equality audit of public health programmes to identify gaps and clarify leadership responsibility.

Older People

Current contracts:

- Centre for sustainable energy – Fuel Poverty
- Bristol Care and Repair/Kid Rapt –Safety equipment
- Lifeskills – Education
- LiNKage – Activities for older people
- UHB – Improving nutrition for older people

Plans for 2014/15

- Double the reach of the Home Safety Scheme for most vulnerable families
- Create a neighbourhood safety net for falls which builds on social isolation and dementia work.
- Foot care proposal – follow up
- Cooking skills - LiNKage

VAAWG Programme

Current contracts:-

- Safer Bristol Pooled budget

(Joint commissioning of a variety of support services for victims and perpetrators)

- Domestic Abuse Advisors UH Bristol
- Domestic Abuse Advisors NBT - Survive
- BME Outreach Domestic Abuse Crisis Work Next Link
- IRIS Domestic Abuse in Primary Care Next Link
- MARAC support for both Acute Hospital Trusts – NBT, UH Bristol

Plans for 2014-15

Joint Commissioned Contracts being retendered

Health improvement Programme

Current contracts:-

- Knowle West Health Park
- Wellspring Healthy Living Centre
- Knowle West Health Association
- Hartcliffe Health and Environment Action Group (HHEAG)
- Avonmouth Community Centre
- Lawrence Weston Farm
- Forward –(FGM outreach work in Inner City)
- Bristol Community Radio (BCfm) Limited
- Centre for Sustainable Energy (helpline)
- Working in Southmead for Health (WISH

All projects subject to annual review with respect to:

- health improvement outcomes
- value for money
- addressing health inequalities
- targeting those most at risk.

Item 11 – Appendix F

NHS England Commissioning Intentions: 2014 +

- National Strategy process 'A Call to Action' setting out the overall priorities in the late autumn

- Includes Primary Care - local conversations planned during the autumn, asking:
  - How should Primary Care be developed for the next 5 years to meet rising demand?
  - How does it keep people well and provide quick appropriate access when people need it ?
  - Best ways of managing more peoples Long term Conditions
  - How to develop buildings and technology
  - Workforce requirements

- Public Health Commissioning:
  - New Immunisations
  - More Health Visitors
  - Family Nurse Partnerships for vulnerable families

- Specialised Services
  - Managing the impact of standardised requirements for services, which may see some local services change

- Health & Justice - developing work with Police Service on care into custody suites

Community Investment Fund – Commissioning Intentions

Outcome Theme	Funding Stream	Amount set out in strategy 2012-15	From/to	Intention beyond 2012/15
Outcome Theme 1: The VCS is supported to deliver effective services to local communities	VCS Infrastructure Support	£376,000 (plus £78,000 from H&SC, CYPS & CCG)	2011-14 (plus option to extend for two years)	**Extend from 2014-16**
Outcome theme 2: Communities are stronger and more resilient	Centres for Community Action	£350,000	2012-15	Subject to new strategy 2015-18 (commissioning from April 2014)
	Stronger Communities	£300,000	2012-15	Subject to new strategy 2015-18 (commissioning from April 2014)
	Small Annual Grant	£60,000	2012-15	Subject to new strategy 2015-18 (commissioning from April 2014)
	Community Voice & Influence	£82,500	2012-15	Subject to new strategy 2015-18 (commissioning from April 2014)
	Promoting Cohesion	£55,000	2012-15	Subject to new strategy 2015-18 (commissioning from April 2014)
Outcome Theme 3: Inequality for deprived, disadvantaged and excluded communities is reduced	Community Advice Services	£677,000 (plus £76,000 from Public health)	2011-14 (plus option to extend for one year)	**Extend from 2014-16 (subject to cabinet approval for 2015-16)**
	Tackling Discrimination	£90,000	2012-16	Subject to new strategy 2015-18 (commissioning from April 2014)
Supporting victims of hate	Grant to be transferred	£65,000	2012-15	Subject to new strategy

crime & Domestic abuse	to Safer Bristol			2015-18 (commissioning from April 2014)

Item 11 – Appendix H

VAAWG Commissioning Intentions

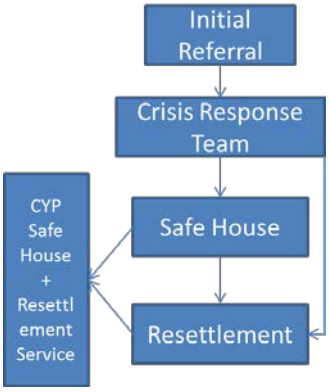
It has been agreed by the VAAWG JCG to undertake VAAWG Commissioning in separate sections as follows:

	Service	Current Provider	Funding Source	Amount £ pa	Contract end date	Commissioning intentions
1	Resettlement Support	Next Link	Safer Bristol	230,387	Mar-14	Commence re-commisisoning during 2013-14
	Safe House provision	Next Link	Safer Bristol	347,786	Mar-14	Commence re-commisisoning during 2013-14
	Crisis Response Team	Next Link	Safer Bristol	60,000	Mar-14	Commence re-commisisoning during 2013-14
	CYPS Safe House + Resettlement Service	Next Link	CYPS + Safer Bristol	123,578	Mar-14	Commence re-commisisoning during 2013-14
2	Survivor Groupwork	St Mungo's	Safer Bristol	45,000	Mar-14	Commence re-commisisoning during 2013-14
3	Stopping Violence	SPLITZ	Safer Bristol	117,000	Mar-14	Commence re-commisisoning during 2013-14
4	Victim Support – IDVA	Victim Support	Safer Bristol	20,000	Mar-14	Commence re-commisisoning during 2014-15
	BME IDVA	Next Link	Safer Bristol	20,000	Mar-14	Commence re-commisisoning during 2014-15
	Community Based Service (Northern/Southern Arc)	Next Link	Safer Bristol	186,500	Mar-15	Commence re-commisisoning during 2014-15

1. Group 1:

Anticipated contract duration (years)	Anticipated possible extention length (years)	Estimated annual contract value	Estimated total contract value (including possible extentions)	Estimated provision start date
3	2	£761,751	£3,808,755	Apr-14

These services provide the considerable majority of Bristol's Domestic Violence and Abuse support. This grouping of contracts is considered to fit well together, with a clear pathway through the services for women and children:



The Crisis Response Team deals with all new referrals to Next Link. This service provides emergency support on a short term basis, and refers into other services for on-going support.

At present, the Safe House service provides 33 bed spaces, comprised of the following:

- 4 communal safe houses with 21 units for women and children (1 safe house/6 units specifically for BME women and children)
- 1 communal safe house with 5 units for single women
- 7 self-contained flats

CAADA guidelines recommend that one refuge bed space should be available per 10,000 population, which equates to 43 bed spaces in Bristol, 10 more than are currently provided.

The Resettlement Service accepts either direct referrals for women and children who have recently moved and require domestic violence and abuse support, or referrals from the Safe House service for women and children who are moving into a new property from a safe house.

The CYP Safe House and Resettlement Service provides support to those children whose parent is receiving support from either the Safe House or Resettlement teams. This support includes individual support plans, out of school and holiday activities, support settling into new schools and areas.

As these services work so closely together, it would not be desirable to separate them or to have separate providers delivering the different aspects.

The commissioning cycle has been discussed and officers / teams identified for input into the Needs Assessment and Business Case. These include Safer Bristol's Performance and Commissioning Support Team (detailed analysis was produced re: refugee and floating support provision when Safer Bristol took over responsibility for these areas and justifications of budgets were required by Cabinet in 2012). VAAWG agencies will be key including BAVA as a reference group. BCC Housing and the Housing Support Team hold important information linked to need and capacity.

2. Group 2 (Survivor Groupwork):

Anticipated contract duration (years)	Anticipated possible extention length (years)	Estimated annual contract value	Estimated total contract value (including possible extentions)	Estimated provision start date
3	2	£45,000	£225,000	Apr-14

This service provides a network of facilitated groupwork sessions across the city for victims of current or historic domestic violence and abuse. The main programmes currently being delivered are the Freedom Programme and the Recovery Toolkit. The main costs of this service are employment of a co-ordinator, venues, clinical supervision and childcare. Facilitators are generally either Children Centre staff providing the sessions as part of their role, or volunteers.

As a smaller stand-alone contract, a competitive grants process could be considered for this service.

3. Group 3 (Stopping Violence Service):

Anticipated contract duration (years)	Anticipated possible extention length (years)	Estimated annual contract value	Estimated total contract value (including possible extentions)	Estimated provision start date
3	2	£117,000	£585,000	Apr-14

This service is a voluntary perpetrator programme and has been in place since 2010. Performance monitoring has revealed that this is an expensive programme with fewer than desired successful completions each year. Safer Bristol has been working with the current provider, Splitz, to ensure improved outcomes (an increase from 11 completions in 2011-12 to 19 in 2012-13) although the JCG still do not consider this to represent good value for money.

Discussions are on-going with Probation who also deliver IDAP, their mandatory perpetrator programme regarding an alternative service delivery model and the accommodation of IRIS non-mandatory offenders on a voluntary perpetrator programme.

When this contract last went to tender; only one bid was submitted (Splitz) and the market has not grown significantly since then.

4. Group 4 (£226,500pa):

These services are also considered to fit well together. It is not intended to begin this process until 2014-15.

5. Resources:

Significant resources will be required to undertake these commissioning processes. The following have been identified:

- Crime Reduction Team
- Performance + Commissioning Team
- Support previously agreed from Supporting People
- Public Health VAAWG officers

The processes will be overseen by the VAAWG JCG, this group will also need to be joined by expertise from procurement and legal.

The core cities will be approached to seek best practice and examples of recent commissions in this field.

6. Timescales:

11th June 2013 – PA + RG meeting with procurement to draw up timescales and scope out project plans. The key process to scope is Group 1. Update to follow.

Item 11 – Appendix I

Preventing Homlessness

Current Commissioning

We are commissioning a range of services to prevent homelessness. These include short-term accommodation-based services, floating support services and complementary "Wraparound" Services. As at Q2 2013-14:

- New contracts are in place for high support services. These are services providing emergency hostel accommodation with support for people recovering from homelessness. These services are working to new specifications which will improve the service user experience, increase % of planned departures & prevent repeat homelessness.
- We have completed the commissioning process for floating support and young parents support services. New services commenced on July 1, 2013. These services ensure effective resettlement, support tenancy sustainment, & provide advice & assistance to prevent eviction.
- Contracts have been awarded for lower support accommodation & are due to start in October 2013. These services provide a pathway for individuals from higher support accommodation to independent move-on. The original process did not yield sufficient accommodation for women, particularly that which could be used flexibly for women with babies. Another tender is taking place to remedy this; the intended contract start date for this accommodation is January 2014.
- The final Commissioning Plan for Wraparound Services was approved on March 28, 2013. Grant agreements have been signed for services that assist homeless households to find work; Contracts have been awarded for mentoring and mediation services that seek to prevent homelessness and tenancy breakdown. Cabinet approval for the tendering of the Compass Centre contract is being sought in November 2013. This contract will provide an outreach and engagement service for all rough sleepers in Bristol, a No Second Night Out service, Extra Support Beds, management of the Compass Centre's ground floor [which includes physical and mental health services, education, training and employment support, including volunteer opportunities], a short lease agreement for utilising 1 New Street in St Judes, and the coordination and management of the Severe Weather Emergency Protocol.
- A commissioning plan has recently been approved for specialist accommodation and support services for younger people with higher support needs. These services are mainly for 16 and 17 year olds as well as vulnerable older teenagers such as Care Leavers.

Outstanding Commissioning Plans/Intentions 2014/15

- Tendering for the Compass Centre contract is likely to take place early in 2014 – with view to a new service in place by October 2014 (when the current contract ends). This is dependent on Cabinet approval in November 2014.

- Gap analysis has identified the need for medium support accommodation for those individuals who are too vulnerable for lower support services. The draft commissioning plan for these services is currently delayed due to budget discussions.

- If consultation on the plan goes ahead in the autumn of 2013 we intend to seek approval for a revised commissioning plan in early 2014; procurement of future services would take place in spring/summer 2014 with new services in place by late summer 2014.

- We are in the process of transferring responsibility for two floating support services for offenders to Safer Bristol. These services are: the WoE service for high-risk offenders which is jointly-commissioned with BaNES & South Gloucs; the Eden House service for women leaving prison. Current contracts end in April 2014 so it is likely that there will be a commissioning process for future provision at some point in early 2014.