*In Partnership with:*

Gloucestershire COUNTY COUNCIL

Gloucestershire NHS
Health Community

# Joining Up Your Care
# (2014-2019)

Produced by Gloucestershire Clinical Commissioning Group
(in partnership with community stakeholders)

**Note: This document, developed by Gloucestershire Clinical Commissioning Group is a second draft, informed by discussions and agreed strategies with partners across the health and social care community. It is explicitly work-in-progress, subject to further engagement with key stakeholders across our county (including the public). The content will be updated to reflect feedback in due course.**

**Further detail regarding implementation within 2014/14 & 2015/16 is contained within a supporting delivery plan.**

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## 1. Executive summary

This document sets out the ambition of the Gloucestershire Clinical Commissioning Group (GCCG) for the continued improvement in the health and wellbeing of the county's people and how we will deliver that ambition.

The Plan begins by assessing the current position and identifying the key quality and resource challenges. While there have been substantial improvements in health and social care over the past 20 years, we now face major challenges to meet people's needs and expectations. Key issues include:

- An ageing population - over the next 20 years, the number of people aged over 85 will more than double.
- Lifestyle – in some of our locality areas within Gloucestershire people are drinking and smoking too much, have a poor diet and don't do enough exercise; if nothing changes, many more of us will be living with multiple long-term health conditions or disability.

An example of the consequences of these drivers is that currently it is estimated that 47,500 people over the age of 65 are living with a long term health condition in the county. This is projected to rise to around 77,000 in 2030.

While there are a range of factors causing rising demand, there is little prospect of funding keeping pace. As a result Gloucestershire is facing a funding gap of circa £85m over the next five years. This Plan aims to close the resources gap while maintaining and, wherever possible, improving the wellbeing and health of the people of Gloucestershire.

The starting point for achieving our ambition is a clear, widely supported, vision:

> ***"To improve health and wellbeing, we believe that by all working better together - in a more joined up way - and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to all local people".***

We believe that delivering this vision means that we need to ensure that:

- People are provided with support to enable them to take more control of their health and wellbeing, recognising that those that are particularly vulnerable will benefit from additional support;
- People are provided with more support in their homes and local communities where safe and appropriate to do so, moving away from the traditional focus on hospital-based care; and
- When people need care that can only be provided in a hospital setting, it is delivered in a timely and effective way.

Applying these principles will enable us to meet national outcomes targets and our local aspirations for the people of Gloucestershire.

Delivering on our vision demands that we are clear about how we will do this. We believe that if we work better together as a community, in a more joined up way, we can transform the quality of people's care. This will require a model that truly delivers integrated care. We believe in a model of integrated care based on a person centric approach where:

*'every individual in Gloucestershire plans their care with people who work together to understand them and their carer(s) needs and brings together services to achieve the outcomes important to them'*

By working together across traditional organisational boundaries, keeping people well, and supporting their recovery after periods of illness, we can improve people's quality of life while also reducing demands on local services. In practice this means:

- Empowering people to improve and maintain their health and wellbeing
- Engaging service users to determine priorities and improve service delivery
- Developing our integrated commissioning function to make a step change in transformation

- Commissioning for outcomes so that we move to align all parts of the system with our vision and goals rather than paying for activity and inputs
- Utilising a Clinical Programme Approach across healthcare to enable us to achieve the best health outcomes possible within available resources.

The starting point must be to focus on prevention. Only by a step change in prevention will it be possible to realise our vision. Before we can improve prevention we must understand and address the root causes which cause people to draw upon health and social services. In many instances we know that issues such as loneliness and poor housing are the real reasons that people seek health and social services. We need to work with the people of Gloucestershire and our partners to identify the demand drivers and put solutions in place.

Some of the demand drivers are a result of lifestyle choices. We need to recognise that changing behaviour is difficult and therefore engaging with the people of Gloucestershire, their carers and the community will be vital. There will be scepticism about the likely impact of investing in behaviour change. This needs to be recognised in a way that encourages innovation but which measures success. This will result in further investment in initiatives that are working but disinvestment from programmes which are not delivering.

Where some degree of care is required, personal empowerment will be encouraged by maximising people's ability to undertake self-care; this will be enabled by high quality care planning. It will also be important to utilise new approaches and technology to enable people to maintain self-care programmes.

To develop better care, we have developed a Clinical Programme Approach (CPA) which brings together a clear clinical pathway approach to delivery, alongside a focus on outcomes and clear programme disciplines. We will use the CPA to deliver three portfolios of programmes, including:

- **Clinical Programmes** - Programmes located around condition specific pathways that are central to our clinical programme approach;

- **Cross Cutting Programmes** – Programmes that ensure a joined up approach at different stages of the patient journey in support of our clinical programmes;

- **Enabling Programmes** – that underpin our work to ensure consistent and robust improvement across all of our commissioned services to support our delivery of the clinical and cross cutting programmes.

This big and important agenda can only be delivered by designing a comprehensive programme which recognises the complexity and overall impacts on the health and social care system. The Plan recognises this and sets out an ambitious but coherent approach over the five years. The overall programme is supported by detailed plans for each major component, recognising initiatives that are already underway and new plans that are essential to the realisation of our vision.

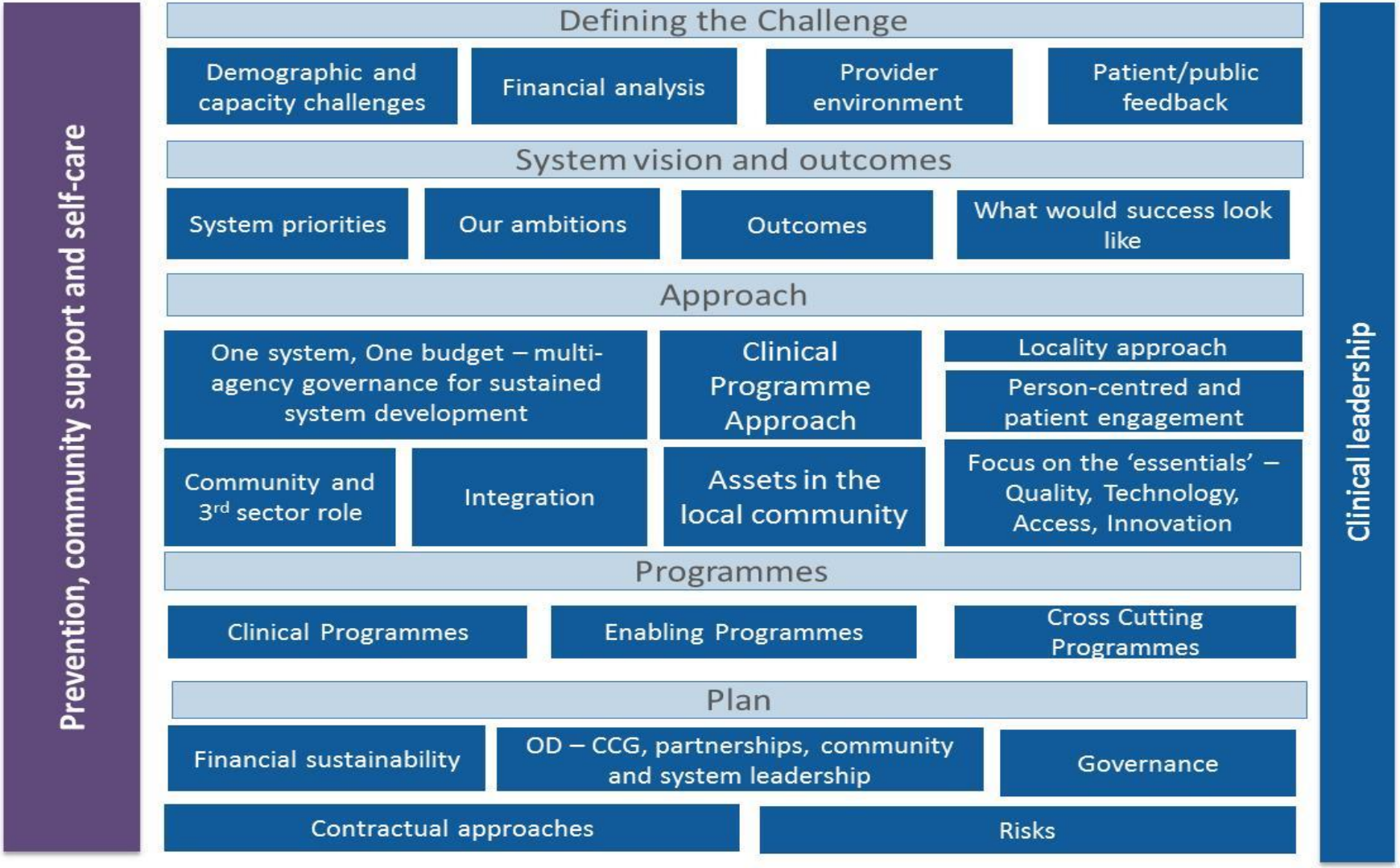
While the Plan recognises the major challenges facing GCCG and the people of Gloucestershire, it also demonstrates how these can be met.

## 2. Introduction

This document (referred to from this point onwards as Joining Up Your Care) describes the five year Strategic Plan for the Gloucestershire Health and Care Community. It covers the period of April 2014 to March 2019 and builds on the existing Gloucestershire strategies for Children and Young People (2012-2015) and Your Health Your Care (2012-2017), remaining under the overall umbrella of the Health and Wellbeing Strategy (2012-2032). 'Joining up Your Care' (JUYC) outlines the proposed changes and developments for our health and care system over the next five years to meet the challenges we face.

The structure of this document has been developed using the framework outlined below.

Joining Up Your Care: Strategy Framework



This framework is designed to provide the reader with a clear structure through which to navigate Gloucestershire CCG's Strategy, including:

- Defining the Challenge – what are the challenges we face and those we need to address through the delivery of our strategy
- System Vision and Outcomes – what are our goals, objectives and ambitions for Gloucestershire
- Approach – how are we going to deliver our strategy, what working practices and tools will we use and who will we work with
- Programmes – what are we going to deliver to address the challenges and achieve our vision
- Plan – when will we deliver our strategy and what structures do we have in place to support its delivery

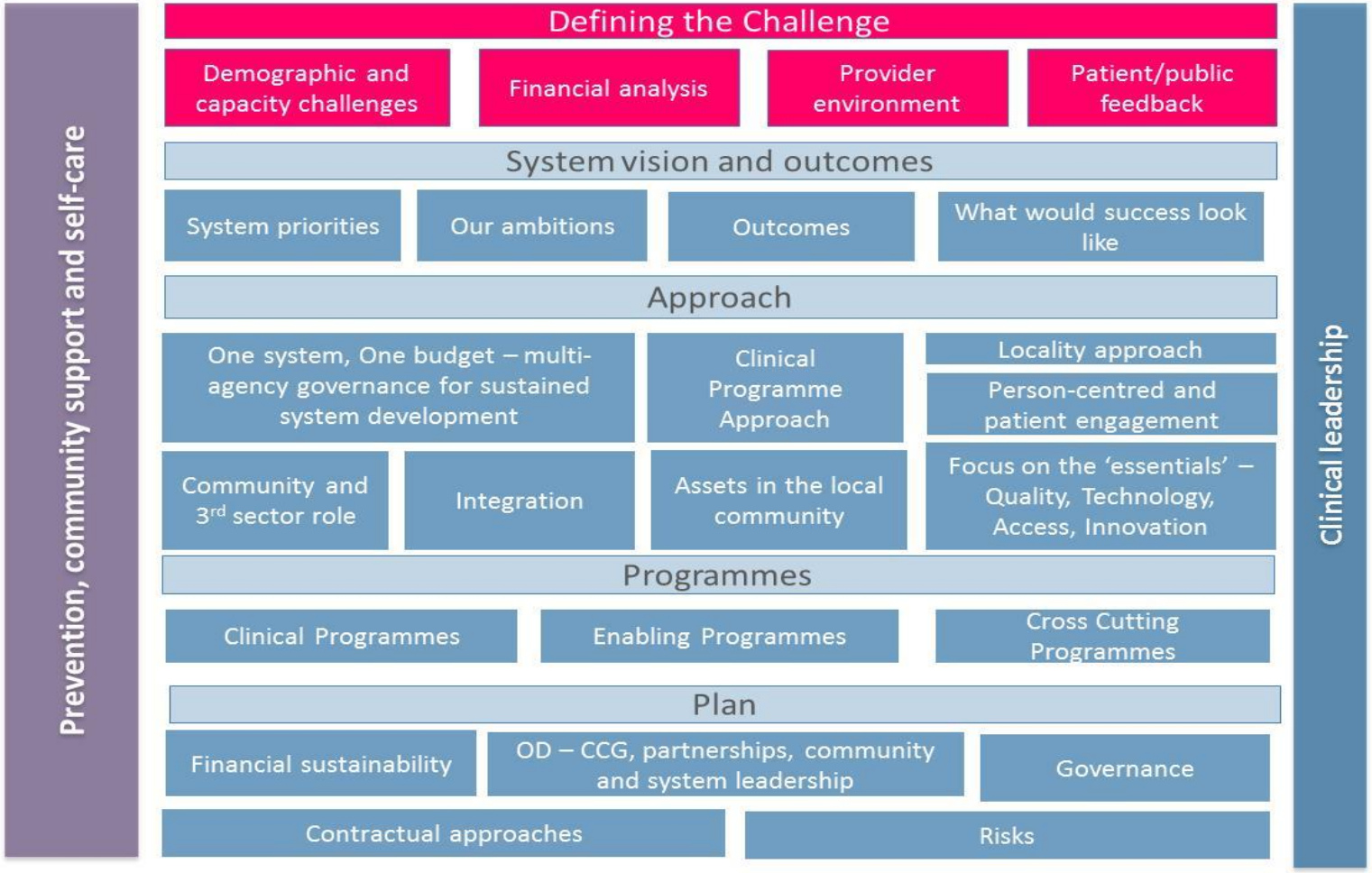
This framework also demonstrates that through the strategy the reader will see two themes that sit at the heart of what we are seeking to achieve:

- Prevention, community support and self-care; and
- Clinical leadership

Each section of the Strategy is signposted using this framework.

## 3. Defining the Challenge

In this section of the Strategy we outline the challenges we face and need to address through the delivery of our strategy.



## 3.1 Motivation for Transformation

Much has improved across the NHS and social care in Gloucestershire over the last 20 years. For example; more care is provided in people's own homes rather than in hospital, other health professionals are now doing tasks previously done by doctors and there have been significant advances in the treatment of illness[1].

However, over the next 20 years, the numbers of people aged over 85 will more than double. We also know that many young people are drinking and smoking too much, have a poor diet and don't do enough exercise. If nothing changes, many more of us will be living with multiple long-term health conditions or disability.

Due to increasing demands, our current health and social care system will struggle to cope. It is already very difficult to meet everyone's care needs and combined with rising costs this means we are running out of money. Also, people's expectations of what the NHS and social care should do are rising. The public is making more demands on health professionals and seeking more engagement in decisions about their care. Dignity and respect and the relational aspects of care are core drivers of patient satisfaction and there is significant room for improvement.

We need to look at how we can care and support people into the future. Care is currently provided by a number of different organisations and it's not always joined up. The JUYC engagement project highlighted a common frustration of repetition in the system, with patients being asked the same questions and undergoing similar assessments. For example, people want access to integrated diagnostics where the NHS is treating the whole person rather than individual symptoms[2]. Only 45 per cent of people agree that NHS and social care services work well together to give people co-ordinated care[3].

[1] Joining Up Your Care, Jack's Story, 2012,GCCG,
[2] Joining Up Your Care Results, GCCG, 2012
[3] Public Perceptions of the NHS and Social Care - An Ongoing Tracking Study Conducted for the Department of Health, December 2011 (Published 2012)

Although things have got better, many people are still staying in large hospitals longer than they need to and sometimes they don't need to be there at all. They could get more of their care and support at home or in the community.

### 3.2 What the public told us before

Over 3,000 people have already shared their views over recent years as part of our 'NHS Offer', Health and Wellbeing ('Fit for the Future') and 'Your Health, Your Care' conversations.

From those engagement exercises with the public we were told to think of the following things to improve health and social care support and services:

- Encourage and support people to adopt healthy lifestyles to help prevent both physical and mental health problems from developing;
- Support people to take more responsibility for their own health and take early action to tackle symptoms and risks;
- Support communities to take an active role in improving health and wellbeing;
- Support people to live independently in their own homes wherever possible, with the right care and community help;
- Provide timely assessment and high quality, safe services when people need care outside the home;
- Join up services through a system of integration in order to improve care, reduce duplication and save money;
- Improve information sharing across health and social care to ensure patient records are available to the right professionals at the right time with appropriate safeguards;
- Ensure we make the most of the limited money available.

When developing the Gloucestershire Children and Young People's Partnership Plan 2012-2015 the key consultation feedback asked us to:

- Ensure that when problems emerge, children and parents are able to access help as early as possible. Families want to make decisions alongside their specialists;

- Ensure that those professionals supporting children, young people and families work together to eliminate duplication – reducing the number of times that individuals have to 'tell their story'.

### 3.3 Public Engagement for Joining Up Your Care

As part of JUYC we have undertaken extensive engagement with the public, staff, and key partners across our health and care community to inform what is described within this Strategic Plan. The engagement was based upon patient illustration, using the fictional character of Jack, to tell people about the scale of the challenge we face in Gloucestershire, and by realising our plans and what we want to achieve. The public engagement exercise for JUYC commenced on 2nd January 2014 for an eight week period, and finished on 28th February.

A broad range of engagement methods were used to promote and facilitate feedback from patients, the public, local stakeholders, including elected representatives, and staff. We have used innovative approaches to help us reach a wider range of people than historically would be involved in such engagement work, both in terms of age and socio-economically. These include:

- Engagement booklets to describe what we are doing and thinking of doing; including feedback forms (print/on line)
- Animated case studies to illustrate our plans
- Countywide media advertising
- Facebook and Twitter
- Invited stakeholder events (sent to over 1200 individual and group contacts including Local Medical Committee, elected representatives, patient and carer representatives, black and minority ethnic groups, disability groups, community and voluntary groups)
- Targeted group awareness raising
- Targeted 'communities of interest' surveying
- Public drop-ins / Information Bus
- Staff briefings

The JUYC engagement gave an opportunity for patients, carers, the public, community partners and staff to comment on our plans, share their views and tell us their ideas; there were 1,370 total face to face contacts and 352 written responses recorded. The full engagement report can be found at http://www.gloucestershireccg.nhs.uk/gloucestershire-ccg-governing-body-papers-13th-march-2014/). The key themes to be noted are:

- Stakeholders identified the importance of having the right information and knowledge to ensure people are supported to manage their conditions and to live healthier lives. Additionally stakeholders requested a raised awareness for patients and staff about all of the services available (both statutory and non-statutory).

- Empowerment was a key message; the importance of self-management, particularly for people with one or more long term condition and the need for patients and their families/carers to be involved in care plans and decision making.

- Stakeholders acknowledged the role of the wider health community and the need for a joined up timely approach across the system, supporting partnership working both with and complementary to health and social care services. This includes making the best use of the voluntary sector and community pharmacists. The feedback identified a need to reduce the repetition in the system, with people asked the same questions or receiving multiple assessments.

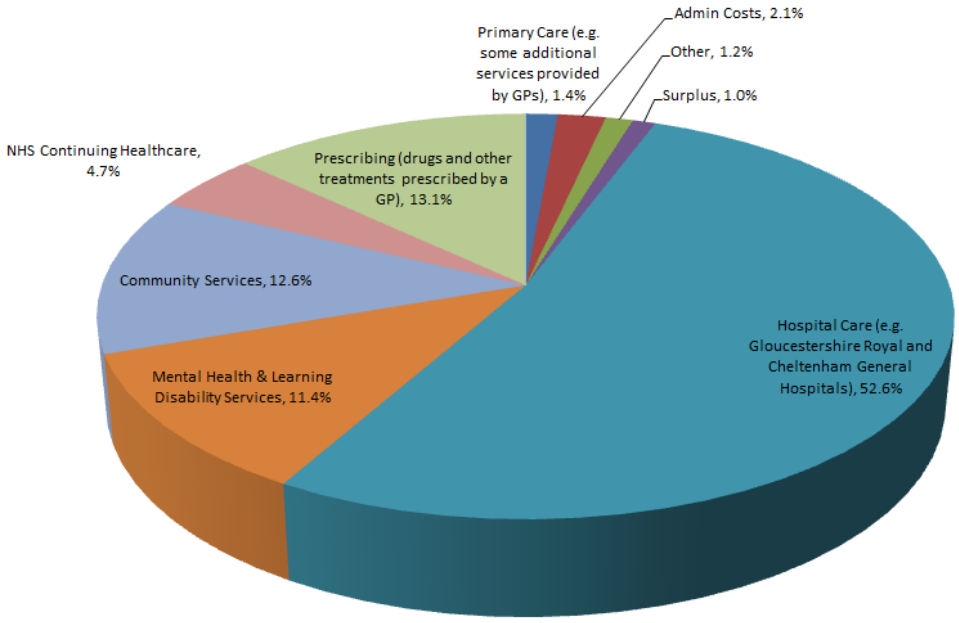
- It was understood that a 'one size fits all' approach was not appropriate, with a consideration of the differing needs our population i.e. urban v rural. The importance of our local population as individuals was clear, this included understating the need for parity of esteem and the importance of the role of carers in providing joined up care that meets the needs of individual patients.

- Stakeholders identified a range of areas that could be a focus of service redesign, this included:

- Recognition that whilst prevention work and community care may reduce the need for acute hospital-based care, there will always be medical conditions that are not preventable and require hospital admissions; it is vital services are implemented to support these people;
- Explore the value offered from one-stop care;
- Improve access to GP out of hours care;
- Ensure further understanding and use of modern technologies within care pathways;
- Strike the right balance between targets and quality of patient experience i.e. waiting times for community therapy services.

### 3.4 Provider landscape

The Gloucestershire Health and Social Care Community is relatively straightforward in comparison to many. The county is served by one Clinical Commissioning Group, one main acute provider, one main community provider, one Mental Health provider and one local authority. Hospital care accounts for 52.6% of the CCG's total budget. Non acute care, which comprises of community care, Mental Health and Learning Disabilities make up the second largest CCG expenditure, comprising of 24% of the total CCG budget.




*GCCG apportionment of total spend (based on 2013/14)*

### 3.4.1 The Current Landscape

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| **Acute Hospital Care** | Currently 80% of our CCG budget for acute hospital care is spent with Gloucestershire Hospitals NHS Foundation Trust. The Trust is based across two main sites; Gloucestershire Royal Hospital and Cheltenham General Hospital. The configuration of clinical services between the two sites has been part of a site and service change review over the past few years to ensure that services are located to ensure best clinical care, service efficiency and to maximise benefits delivered by ensuring appropriate clinical adjacencies between specialties.<br><br>This reconfiguration has seen the successful move of Obstetrics, Neonatology, Paediatric Admissions and Stroke to the Gloucestershire Royal Hospital site and Ophthalmology, Inpatient Urology and Inpatient Vascular patients to Cheltenham General Hospital. More recently in line with |

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| | regional reconfiguration Major Trauma (multiple, very serious injuries) has moved to the Bristol Major Trauma Centre with Gloucestershire Royal Hospital acting as a Trauma Unit. This is an ongoing programme of change which has resulted in the brining together of specialist expertise and improved outcomes for patients.<br><br>In response to ensuring that the sickest patients are seen by specialist staff when they need to be and that they are available to respond to patients and the public, Gloucestershire Hospitals NHS Foundation Trust has reconfigured its Emergency Department. This change saw the Cheltenham General Hospital alter the service ran at night. The Emergency Care Centre within the Emergency Department is run by specially trained nursing staff; doctors are however on site to receive patients previously reviewed by a GP. Patients with critical illness and injury who need treatment from emergency medicine doctors go to Gloucestershire Royal Hospital at night.<br><br>Although at a CCG level acute hospital care activity is concentrated at Gloucestershire Hospitals NHS Foundation Trust the geography of our county results in locality activity also having significant acute hospital care flows to other acute trusts across our borders i.e. Wiltshire, Oxfordshire, Bristol. Gloucestershire CCG has established contractual monitoring arrangements in place to understand activity flows and access of these services at a locality level. |
| **Community Services** | Gloucestershire Care Services are the provider of community services in our county. This includes the provision of our seven Community Hospitals, District Nursing, Specialist Nursing (Diabetes, Respiratory) Therapy Services (Occupational Therapy, Physiotherapy, Speech and Language Services and Podiatry), Children's services, Sexual Health and Dental services. As part of the Transforming Community Services transition Gloucestershire Care Services became separated from NHS Gloucestershire |

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| | (predecessor PCT) in 2013. The organisation is currently progressing through the Trust Development Agency pipeline to achieve NHS Foundation Trust status. |
| **Mental Health** | 2gether NHS Foundation Trust is the main provider of Mental Health inpatient and community services for Gloucestershire's population. Mental Health commissioning is undertaken through a joint commissioning arrangement with Gloucestershire County Council, this includes the joint development of policies and strategies, oversight of funding arrangements for approval and assurance and joint commissioning management posts across organisations. Mental Health Services in Gloucestershire has seen significant service redesign over the last three years with focus on out of county placements and the reduction of our inpatient facilities to increase community provision. 2gether NHS Foundation Trust are now working with the local health and care community to focus on providing integrated care pathways for mental and physical health conditions which will aim to improve the quality of care delivery and support holistic care planning as part of the implementation of Integrated Community Teams.<br><br>As a provider 2gether NHS Foundation Trust are exploring different but related markets to develop different service models to support organisational sustainability. |
| **Local Authorities** | Gloucestershire County Council is the local provider for Social Services and provides a joint commissioning role with the CCG for some services. Gloucestershire CCG and Gloucestershire County Council have established joint commissioning arrangements in place, supported by a Partnership Agreement. This includes the oversight of joint funding arrangements and the allocation of resources to jointly commission services for the local population. Commissioning funding is allocated and managed in different ways for different services. In support of joint commissioning, NHSG and GCC jointly fund a small number |

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| | of Joint (or Lead) Commissioner posts:<br><br>• Mental Health<br>• Children and Young People<br>• Older People / Long Term Conditions<br>• Learning Disabilities<br>• Physical Disabilities<br><br>There are a number of benefits to this composition through our ability to focus on our shared vision and ambitions for our local community and the joint planning and delivery of our service improvement initiatives.<br><br>Our local authorities, Gloucestershire County Council and District Councils offer a full range of public services with established links to health care, such as Public Health, Housing, Communities and Neighbourhoods and Transport. Understanding the impact of housing changes on health and social services will be a fundamental part of our work. Public Health are key stakeholders in the prevention and self-care agenda supporting local health and wellbeing. |
| **General Practice** | There are currently 84 GP practices in Gloucestershire who provide PMS/GMS services for the population. Performance of these practices is managed by NHS England Bath, Gloucestershire, and Swindon & Wiltshire Area Team. |
| **Other Providers** | Gloucestershire has a number of established private health care providers both within and outside the county that provide a range of care services from diagnostics to elective care. Together, Private and 3rd Sector (volunteer, charitable) organisations provide a comprehensive range of treatments and therapies that support NHS services, such as hospice services, that increase choice and offer opportunities to reduce waiting times. |

Provider development in Gloucestershire is crucial to delivering the outcomes within this plan. The key issues can be summarised as:

- Procurement must be systematic and robust to ensure that all contracts awarded deliver high standards of clinical outcomes whilst also delivering best value.
- Robust contract management will be critical to ensuring the benefits are realised from all NHS providers
- There is scope to increase the extent to which quality drives the CCG's interface with providers, and the CCG intends to increase the extent to which the public and patient voice informs commissioning models and contract monitoring.
- Providers are, in the main, focused on treatment and cure delivery models. Through definitions in contracts, providers will be supported to maximise the opportunities to deliver the public health improvements required within all settings.

### 3.4.2 The Future Landscape

Over the five year period described in this plan, our analysis of the impacts of demographic growth demonstrate that if the pattern of health and care provision stays the same within Gloucestershire the demand on existing health and care services for our population will significantly increase. To live within our means our approach to the delivery of healthcare in Gloucestershire will need to change, and may include opportunities to realise the benefits of increased provider integration. Close collaborative working with our provider community to develop and implement new service models and pathways will be central to ensuring success. Section 6.2 describes some of the planned clinical interventions to improve outcomes for our patients and to ensure that the delivery of healthcare is reshaped to ensure future sustainability. Our clinical programmes approach is the main vehicle for engagement with our providers across all sectors, to ensure that our change programmes have strong stakeholder buy in and are truly clinically led.

### 3.5 Summary of Challenges

The challenges facing Gloucestershire include:

- Rising life expectancy means that the population aged over 65 is increasing rapidly, more rapidly in Gloucestershire than England as a whole.
- This growth is increasing fastest in the oldest age sub-group; those aged 85 and over, with a predicted growth of 60.5% by 2021.
- As life expectancy increases, so will the number of people who will live with one or multiple long term health conditions that limits their lifestyle. In Gloucestershire it is estimated that 47,500 people over the age of 65 are living with a long term health condition. This is projected to rise to 77,000 in 2030.
- Current unmet need of long term conditions such as Coronary Heart Disease, diabetes and dementia make the real prevalence rates likely to be significantly higher. Nationally, care of people with long term conditions accounts for 70% of the money spent on health and social care in England.
- Compounding the issue of an ageing population, disparities in deprivation across the county are mirrored in health outcomes - rates of premature mortality from Cardio Vascular Disease, respiratory disease and some cancers are correlated with deprivation across districts.
- There is some variation between the localities across Gloucestershire, resulting in health inequalities; for example smoking, alcohol related admissions and obesity are higher than average for England in areas such as Cheltenham, Gloucester and Forest of Dean.
- The number of unpaid carers is likely to need to rise by over 10% by 2017 in order to meet increased care needs.
- The increased demand on health services that all these factors place on the systems, occur alongside a reduction in funding for the provision of health and social care. The average cost of treatment for an over 85 year old, the

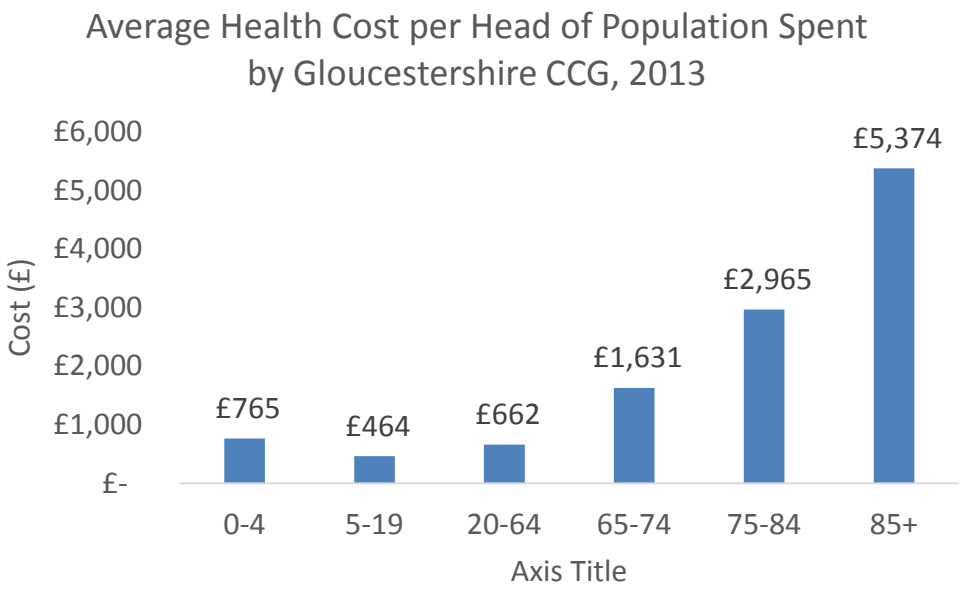
fastest growing population group, patient is £5375, compared to £661 for a 20-64 year old.

- As the increased demand is not matched by the same increase in funding, Gloucestershire is facing a financial gap of circa £85million over the next five years if we don't make considerable changes to the way we deliver services for our population.
- A key part of our approach will be moving away from episodic models of care delivery to integrated care pathways focussed on patient centred care delivery across providers that make the best use of technology and skills to reduce waste and inefficiency in our health systems.
- The significant change across health and social care will require organisational and cultural development across the system.

Further information is contained within Annex 1.

### 3.6 Financial Challenge

The overall average cost per patient in Gloucestershire is £1,011. However, this masks a correlation of increasing cost with patient age, due to the prevalence of Long Term Conditions as outlined above. As the most expensive group of patients is increasing the fastest within Gloucestershire, there are additional pressures on the financial resources of the CCG.



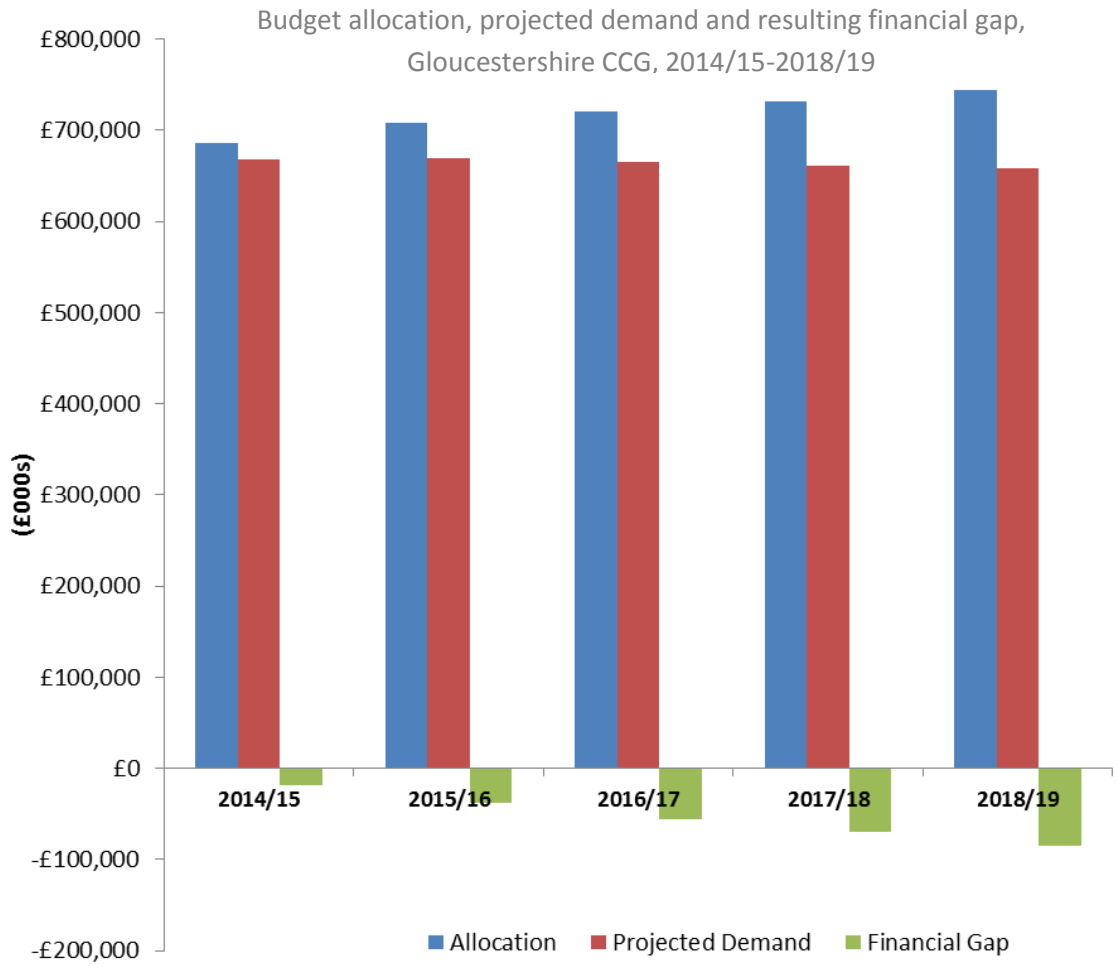

*Source: GCCG Analysis of 2013 spend data*

The increase in funding over the next five years is not expected to keep pace with this predicted increase in demand. The CCG's allocation currently falls within a range whereby it is deemed to be at its target allocation. In order to remain within its financial allocation and deliver the surplus requirement the CCG will need to review the way that resources are invested, to ensure that we are making the best use of them. The CCG will need to make QIPP savings of circa £85million over the next five years.

The anticipated savings required has been based on best estimates of a number of variables and changes to these will alter the level of savings the CCG will need to make going forward. Key sources of estimation are:

- Population change and demand these estimates are based on Office for National Statistics population projections and demand projections based on the last three years. If the shift to an older population differs to the forecast then it is likely that the demand shift will also alter;
- Better Care Fund – the financial model includes the investment required for the Better Care Fund as currently estimated. However, there a number of risks to this which include the impact of The Care Bill revised estimates which are being developed by the Local Authority
- The model includes a 4% efficiency requirement from all providers over the period; this is a high risk assumption as it assumes that providers

can deliver a 4% year on year efficiency in services regardless of their current position in terms of effectiveness. The total within the model for the 4% provider efficiency saving is £99m;

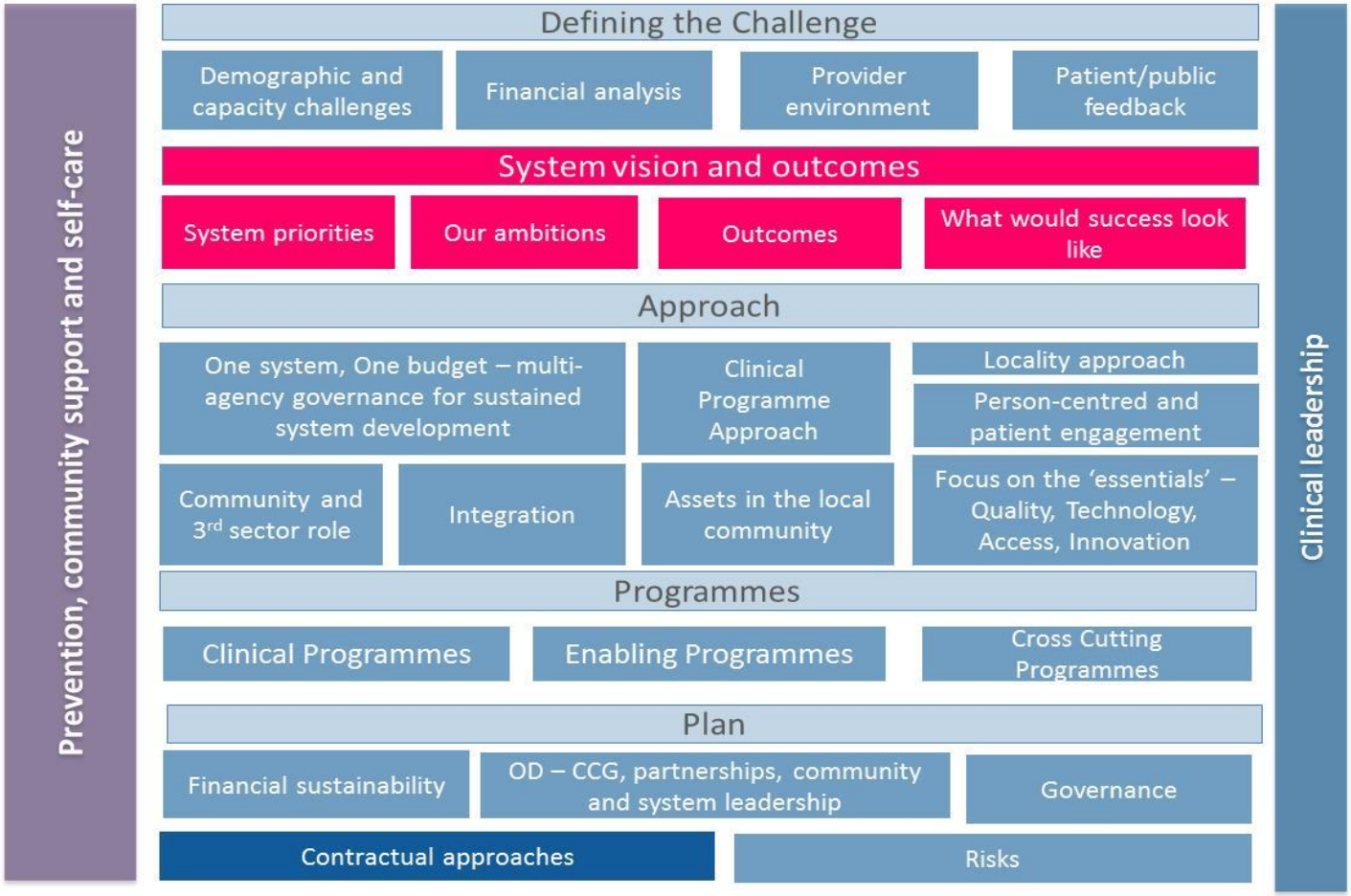



*Source: GCCG analysis of 2013 spend data*

This represents a significant financial challenge to the health community. In addition to this there are significant financial pressures within the Local Authority estimated at £25m per year for three years. The CCG and the Local Authority are working together to join up programmes so that their plans are complementary.

## 4. System Vision and Outcomes

In this section of the Strategy we outline our goals, objectives and ambitions for Gloucestershire.



A vital starting point for achieving transformational change in Gloucestershire is to agree a shared vision across NHS, Local Authority and voluntary sector partners. As part of our work to develop JUYC, we have been seeking to develop and agree a (concise) shared vision across the health and care community. The latest draft of this vision is below and has been endorsed collectively and also individually by each relevant organisation. Our shared vision for the next five years is:

***"To improve health and wellbeing, we believe that by all* working better together - in a more joined up way - and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to all local people".***

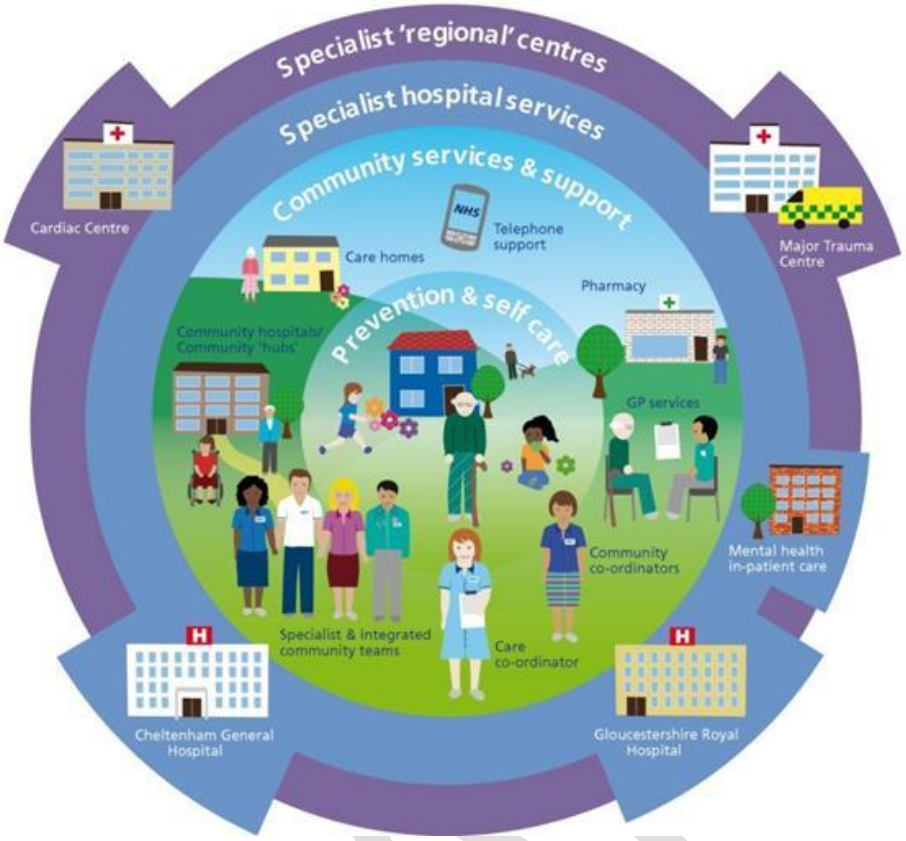
** The health and care community in Gloucestershire consists of the Clinical Commissioning Group and main NHS service providers in the county, the County Council and District Councils, and colleagues representing the public and those representing the voluntary sector.*

### 4.1 Our Ambitions

Underpinning our vision are the following ambitions:

- People are provided with support to enable them to take more control of their own health and wellbeing. Those that are particularly vulnerable will benefit from additional support;
- People are provided with more support in their homes and local communities where safe and appropriate to do so, thus moving away from the traditional focus on hospital-based care; and
- When people need care that can only be provided in a hospital setting, it is delivered in a timely and effective way.

This vision and ambitions are illustrated in the following diagram:




## 4.2 How are we going to work together to make all this happen?

We have agreed a set of principles as the foundation of our collaborative working:

- A **person-centred approach,** where organisational boundaries are less important than the outcome and experience for each individual;

- To build stronger, more sustainable communities and in turn improve the health and wellbeing of local people, we will draw upon, and stimulate the provision of, the diverse range of **assets within each local community;**

- We will adopt a "**one system, one budget**" approach. This means the money we have available can only be spent once to achieve the best possible outcomes for all local people, regardless of organisational boundaries. This will be implemented through:

- Utilising a clinical programme approach, where we identify the budget for a specific condition and review the whole clinical and care pathway from prevention to end of life. The aims include achieving the best possible outcomes within available resources, whilst also reducing waste, harm and variation;

- Exploring and testing the use of innovative forms of contracting, enabling individual providers to work together collaboratively to deliver elements of a care pathway or service, working to shared objectives;

- Maximising the opportunities to commission services jointly across health and care organisations.

- We will design the most efficient and effective services possible:

  - Agreeing the best route people take through their care. Care pathways - will be a key mechanism for change and be developed based on evidence of best practice, maximising the use of available technology. The pathways must then be implemented to ensure people access the right care, in the right place, at the right time; services, where appropriate, will be available seven days a week;

  - We will create a systematic approach to delivering transformational change, training a wide range of staff across our health and care community on an ongoing basis. When designing services, we believe a relentless focus on reducing the time patients spend waiting will deliver the most efficient care.

It is vital that our shared vision for the future of health and care services in Gloucestershire is based on sound evidence of impact. There have been numerous studies across the world, over many years, considering the benefits of integrated care. Most recently, a Kings Fund report (October 2013) analysed a health and care community with many similarities to Gloucestershire; Canterbury, New Zealand. The report included a focus on seeking an evidence

base for the effect of the package of measures implemented by the Canterbury system leaders. Whilst the report could not identify significant positive impacts of individual measures in isolation, it did conclude significant impacts when considered as a whole, particularly on the use of acute hospital care services. This work emphasised the importance of a system-wide approach for transformational change to occur.

Whilst a number of the building blocks of success are already in place or being developed in Gloucestershire (for example Integrated Community Teams), a number of other areas are now included within this Five Year Strategic Plan, for example exploring innovative forms of contracting, and a systematic approach to care pathways and delivering transformational change. It is vital to note that these building blocks of success are not unique to only Canterbury; there have been many other examples across the UK and worldwide, thus creating an even stronger evidence base.

Finally, there are two additional areas of focus that the health and care community in Gloucestershire consider to be crucial to transformational change in the county: utilising the assets in our communities and from the voluntary and community sector, as well as supporting people to take greater responsibility for their own health and wellbeing. It is clear from the numerous studies covering both these areas that, done well, they can have multiple benefits for preventing ill health, in the short, medium and long term.

### 4.3 What Does Success Look Like?

Through our strategic approach we will be looking to:

- Improve the health of people in Gloucestershire, not just managing them when they are ill and promoting the best possible health outcomes - prioritising those of best value within the resources available. We will also maintain emphasis on reducing health inequalities, including tackling variation between our commissioning localities and ensure equitable and accessible services seven days a week (as appropriate); promoting right care, in right place at right time
- Develop strong, high quality, clinically effective and innovative services

- Ensure the voice of our patients, carers, families and public is heard to inform our priorities and ensuring we deliver in line with our aspirations and that the individual is at the centre of care, and involved in decisions about their care.

- Ensure appropriate care is provided as close to home as possible, reducing avoidable urgent care admissions supported by alternative planned care pathways that reduce unnecessary steps, improve efficiency and reduce waste and duplication. We will also ensure parity of esteem with equality between mental health and physical health.

- Work together to ensure a transformative approach to delivering change; enabled through innovative approaches to contracting models and a clear partnership with the community and voluntary and charitable sector to support the provision of preventative, self-care and social prescribing solutions before and alongside clinical interventions.

- Ensure quality and cost effective services across our health & social care community; ensuring best use of our resources and assets and that people have a positive experience of care.

- Build a sustainable and effective organisation, with robust governance arrangements throughout the organisation and localities and strong leadership as commissioners at all levels of the organisation.

### 4.4 Our Outcomes

The national performance standards set by NHS England are designed for a more outcome focussed service delivered by NHS organisations. The national framework categorises the better outcomes we want to achieve into five core domains:

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring people have a positive experience of care

5. Ensuring that patients in our care are kept safe and protected from avoidable harm

To assess delivery of the domains there are seven national measurable ambitions; which we utilise to assess our delivery of these outcomes:

| | |
|---|---|
| 1. Securing additional years of life for the people of England with treatable mental and physical health conditions | *In Gloucestershire we currently benchmark well on this indicator and over the next five years intend to build on this to further improve life expectancy for our population. In addition we will focus on the inequalities between localities, in order to reduce avoidable variation.* |
| 2. Improving the health related quality of life of the 15 million+ people living with one or more long term condition, including mental health conditions | *In Gloucestershire we currently benchmark well on this indicator and over the next five years aim to continue to build on this to further improve health related quality of life for our population* |
| 3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital: | *In Gloucestershire we are currently within in the 2nd quartile compared to national rates, we aim to improve on this position over the next 5 years taking into account underlying growth in emergency care* |
| 4. Increasing the proportion of older people living independently at home following discharge from hospital: | *Gloucestershire is in the mid quartile nationally and we aim to improve on this over the next 5 years to support more people to live in their own homes* |
| 5. Increasing the number of people having a positive experience of hospital care: | *Gloucestershire is in the upper quartile based on national data, we intend to sustain and improve this where possible* |
| 6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community. | *GCCG are supporting 2gether trust and local GPs by building on the national CQUIN to optimise the physical health of patients with Mental Health conditions.* |

| | |
|---|---|
| 7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care | *GCCG are actively working with our providers to share the learning from serious incidents, near misses, never events and monitoring implementation of action plans. We analyse infection control trends and the safety thermometer data. These all contribute to eliminating avoidable harm in our provider organisations.* |

In addition to the seven outcomes priority will also be placed on:

- Ensuring better outcomes for people across health and social care including:
    - The prevention of some hospital and care home admissions;
    - Less time spent in hospital;
    - Increased identification of people who are at risk of requiring services in the future;
    - Increased provision of preventative services;
    - Increased provision of services to extend the ability to live independently and develop resilient local communities.
- Greater clarity on who is involved in a person's care, what the expectations are for the person and more focus on the goals and quality outcomes defined with the patient themselves;
- Improved communication between professionals and organisations to ensure that services are better coordinated, service responses are timely and there is improved connection to wider community based assets so that people feel valued and supported to live in the community.
- Increasing our Dementia diagnosis rate. The Dementia Strategy in Gloucestershire has seen increases in the rate of dementia diagnosis, which

we will look to build on over the next five years (with step change increases within the first two years).

- Infection Control: We will continue to focus on delivering improvements within infection control (covering MRSA and C-Diff), sharing good practice to continuously improve performance.

- Our local Quality Premium will focus on reducing emergency admissions for children with lower respiratory tract infections (a subset to ambition three presented above): Based on our outlier performance to date we will focus on reducing acute admissions for children with respiratory conditions, through the re-design of urgent care pathways across our system.

Our focus on outcomes will not stop at the nationally mandated outcomes; we will also be using our clinical programme approach (see Approach) to drive an increasingly outcome focussed approach to the commissioning and delivery of services.

### 4.5 Reduce Health Inequalities

Reducing health inequalities is a key priority within the Health and Wellbeing Strategy and remains a fundamental aspect of JUYC. Alongside the countywide inequalities we are looking to address as part our outcome measures, at a locality level there remains some stark variation.

Working in partnership across the community we use a range of data and information when we develop policies, set strategies, design and deliver our services. We believe that it is important to understand the composition of our population at a local level as this enables us to:

- Engage effectively with different communities to understand their varying health and self-care support needs;

- Commission services to meet their health and self-care needs in an appropriate manner;

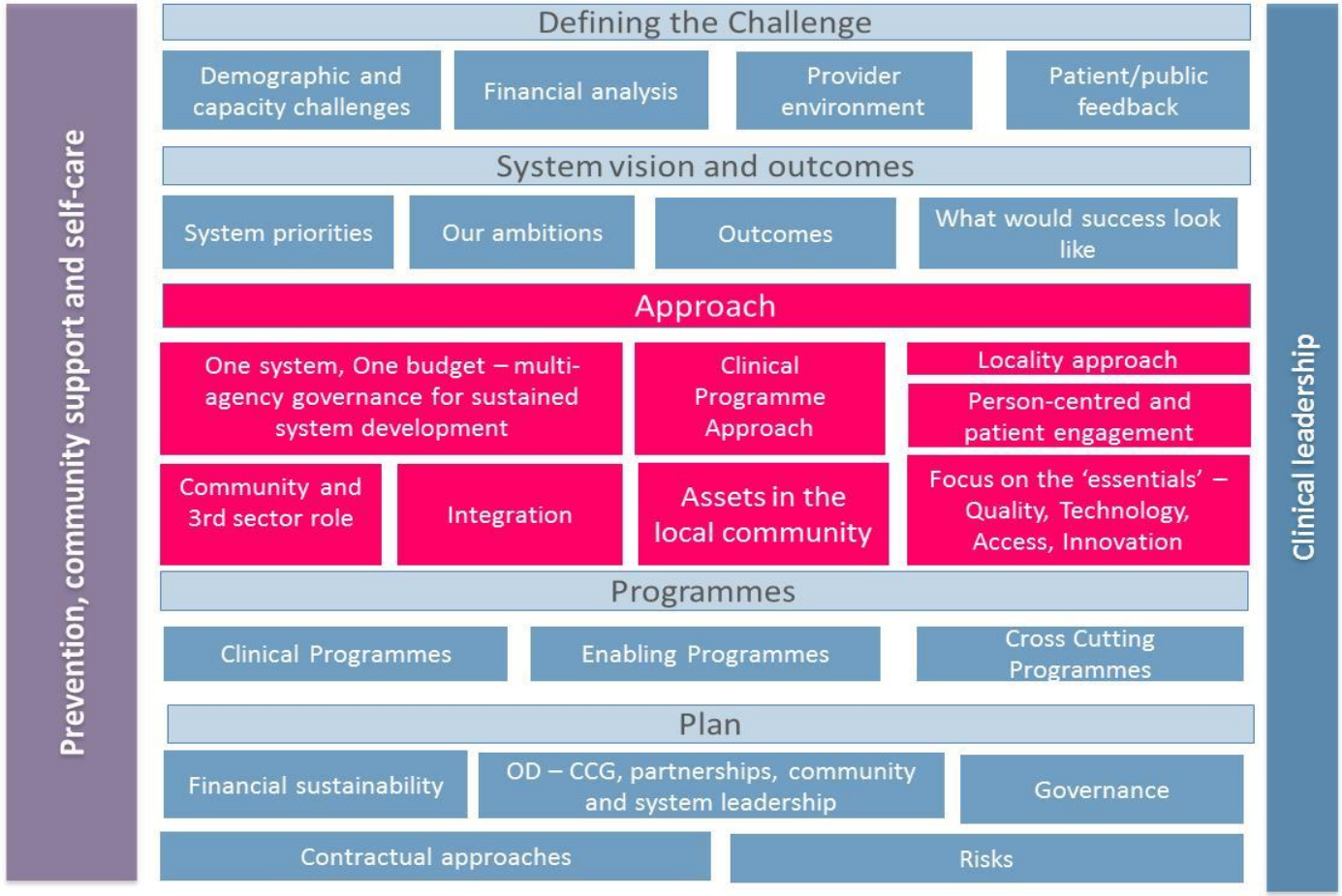
- Assess the likely impact of our decisions on the diverse communities; and

- Work with these communities to minimise any adverse impact and maximise any positive impact.

We believe that through ensuring the promotion of equality and reduction of health inequalities, which remains central to our commissioning approach, we will deliver tangible improvements to both outcomes and experience for our population. We are also committed to developing an inclusive workplace and support staff to develop their competence in focusing on equity for the population they serve.

## 5. Approach

In this section of the Strategy we outline our approach – who we will work with, the tools and working practices we will use and our focus.



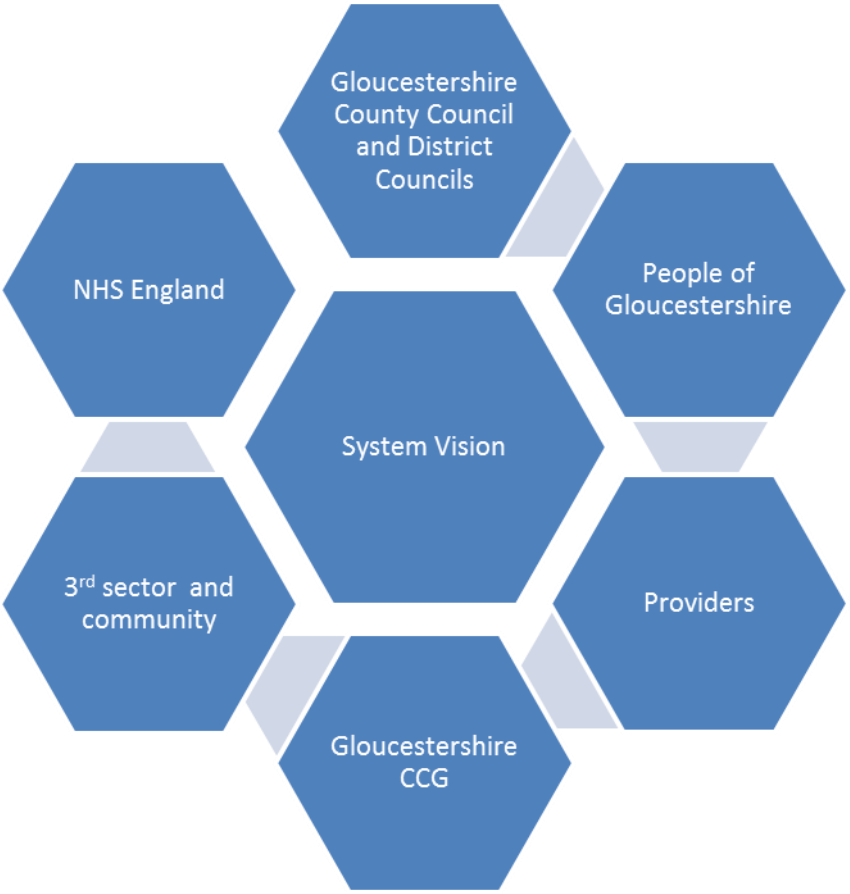
In this section of the Strategy we describe our approach to 'How' we will deliver our vision, ambitions and objectives. This includes:

- One system, One Budget – who we will work with to deliver our strategy
- Clinical Programme Approach – how we will organise ourselves to deliver
- Maintaining Focus on Essentials – our focus

## 5.1 One System, One Budget

As outlined in our vision and ambitions, we will be working with our partners across Gloucestershire to deliver person-centred care. This will focus on working across primary, community, hospital and social care boundaries to support the future of health and social care and emphasise preventative and self-care programmes, alongside the more traditional clinical interventions.

Our partners in the delivery of our vision include:



We believe that if we work better together as a community, in a more joined up way, we can transform the quality of people's care. This will require a model that truly delivers integrated care. Whilst there are numerous definitions of integrated care within published literature, our vision for a modern model of integrated care based solely on a person centric approach where:

> *'every individual in Gloucestershire plans their care with people who work together to understand them and their carer(s) needs and brings together services to achieve the outcomes important to them'*

By working together across traditional public sector organisational boundaries, keeping people well, and supporting their recovery after periods of illness, we know we can improve people's quality of life whilst also reducing demands on local services.

Furthermore, as defined within the Better Care Fund proposal and national and international best practice, a key element in delivering our vision will be to adopt the principle of 'one system, one budget'; where providers of more integrated services 'work together and respond together'.

Key priorities within this work include:

- To develop a shared vision of the service and to change the staff mind-set and approach to care, ensuring it is focused on each individual person working across organisational and professional structures (as in previous section of this strategy);
- To explore and agree new contract forms to reward and incentivise integrated working;
- To ensure pathways underpin integrated working and ease the path for people accessing services;
- To move towards a single service model that breaks down silos and barriers to teams and services working together for the best outcomes for local

people and communities, without the need to spend time on creating formal new organisations.

We recognise that there are a number of enablers to the delivery of our intention to work in an integrated way – including:

- Service-user engagement
- Integrated commissioning
- System leadership
- Locality approach
- Community and voluntary and charitable sector role

### 5.1.1 Service-user Engagement

At the heart of our shared system vision is the person – around which care will be designed, developed and delivered. Joining up care can only be a reality when we and our partners actively seek constructive connections with local people; whether as individuals or as part of the wider population. Engagement will be structured through a programme that includes:

- **Empowerment of individuals to determine their own care and wellbeing** - we and our partners can demonstrate that individuals are fully engaged[4], co-providing their own health and wellbeing through well informed, shared decision making between themselves, their carers, their clinicians and other health and social care staff.
- **Engagement in service design** – that the experiences and expertise of our local population are used to inform our strategic commissioning priorities.

Patient and public experience and engagement data is gathered in many ways, such as:

[4] Wanless: fully engaged scenario http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publichealth/Healthinequalities/Healthinequalitiesguidancepublications/DH_066213

- from Health Watch Gloucestershire (HWG) via quarterly HWG Master Comments;
- via contacts with our in house Patient Advice and Liaison Service (PALS), which handles, records and collates information from individuals making compliments, comments or raising concerns or complaints (a.k.a. 4Cs);
- via visitors to our Information Bus, our mobile engagement resource;
- targeted engagement with groups frequently referred to as 'seldom heard' or 'communities of interest', representing the nine protected characteristics[5], using credible networks in the local community;
- reports prepared by our individual providers in relation to quality elements within contracts, such as CQUINs, through regular Clinical Quality Review Groups and information published in provider Quality Accounts e.g. Friends and Family Test (FFT) response rates, results and actions taken and outcomes achieved in relation to qualitative data collected via FFT, Patient Stories and other real time patient feedback; and
- responses from individual citizens and representatives of communities of interest to planned public engagement and consultation activities, which are presented and published in Outcome Reports.

Before engaging or consulting on any significant[6] service changes, we test the rationale, as well as our plans for engagement or consultation, for all potential service change proposals with our unique NHS Reference Group, made up of representatives from Health and Care Overview and Scrutiny Committee (HCOSC) and HWG. Plans are also discussed during HCOSC meetings in public, and outcomes presented.

Our principle will be to challenge the effectiveness of the engagement and communication with patients and citizens, adapting our approaches in response to feedback, ensuring we pay particular attention to groups

[5] Protected characteristics as set out in Equality Act 2010
http://www.legislation.gov.uk/ukpga/2010/15/section/4

[6] Health and Social Care Act 2012, which updated the 2006 NHS Act, describes statutory duties for CCGs with regards to engagement and consultation with the public about 'significant' service changes.

frequently referred to as ‘seldom heard’ such as children and young people, or those with communication difficulties.

As leaders of the local health economy, we have embedded lay representation within our Clinical Programme Approach, which is the mechanism by which, with our partners, we will decide which services we should develop or buy to deliver the best outcomes for the population within the resource available. Lay representation is embedded within all CPGs in two ways: through our contracted ‘Lay Champions’, whose role is to ensure that patient experience data is fully taken into account and is informing CPG discussions, and via Health Watch Gloucestershire, whose representation brings a patient perspective to CPG discussions and working groups.

### 5.1.2 Integrated Commissioning

As commissioners, Gloucestershire CCG and Gloucestershire County Council already work together and undertake significant joint commissioning responsibilities, in line with agreed principles that local people, our communities and our providers can expect us to work to. In light of the shared challenges we face, it is recognised that not only do we need to build on these existing arrangements to make a step change in transformation; but that this has to be done at scale and pace. Commissioning in an even more joined up way is crucial to improving life for residents in treating health, public health, social care, and other local authority functions such as housing, education and leisure, as a whole system rather than lots of individual services. It is anticipated that greater integrated commissioning will support improved health and wellbeing, make it easier for people to understand and access services and make better use of our resources. In many instances, the needs of patients and service users are indivisible to agency boundaries but the responses to meet that need are often diverse and sometimes disjointed across organisations.

Alongside this, the Commissioning process is resource intensive and there are efficiencies in doing this jointly, alongside ensuring incentives to make changes that benefit the wellbeing system as a whole, as investment by one organisation can result in savings by another.

We know that transformation will not happen overnight, but by further integrating our commissioning functions together the benefits to be delivered include:

- Improved outcomes for our population;
- Alignment of commissioning intentions across Health and Social Care ;
- Facilitating the development of new market opportunities in the county;
- Improvements in core services;
- Reduced duplication of effort and spend;
- Increased focus on quality standards;
- The alignment and improvement of business processes for commissioning.

### 5.1.3 Locality Approach

Gloucestershire's seven locality groupings are generally based on the geographical areas of:

- Gloucester City
- Cheltenham
- Forest of Dean
- Tewkesbury
- North Cotswolds
- South Cotswolds
- Stroud and Berkeley Vale

Each locality is represented within the CCG Governing Body; and holds a Locality Executive Group with a focus on locality and countywide commissioning, as well as wide membership engagement.

Our locality commissioning structure:

- Supports two-way engagement between GP practices and the work of the CCG
- Provides vital intelligence on local health needs and the reality of services 'on the ground'
- Allows local leadership for service developments
- Ensures strong links with local communities, as well as borough and district councils

Locality groups have developed their own locality plans that have been informed, and supported by, Public Health and Local Authorities that take into consideration local variation, while aligning to the CCG strategic priorities. Their focus is predominantly on responding to both local variances and countywide priorities, supporting delivery of an integrated out of hospital health and social care model.

Localities are fundamental to delivering our ambitions, both as commissioners but also recognising their vital role as main providers of healthcare. Continued closer working with local authorities will be important in developing shared priorities and developing joint plans to deliver better outcomes, and forms one of the key priorities for locality development. As our locality commissioning model matures, we will explore localities being supported to undertake additional responsibility for the delivery of our challenges.

### 5.1.4 Assets in the Local Community (Working with the Community and Voluntary Sector)

We will work across the Gloucestershire Health and Care Community to develop a sustainable model to drive innovation, service redesign and development that uses our community assets to support a healthy community. We will review our physical premises to ensure effective utilisation; exploring the use of community hubs to enable closer working between services (both statutory and non-statutory) and providing a patient based focus.

Over the next two years we will:

- Develop a joint approach (including the composite training programmes) to transformational change across the Health and Care Community;
- Build capacity around systems leadership, change management and service improvement tools and techniques;
- We intend to take advantage of innovation opportunities within our developments, establishing a robust framework to enable and support clinical research and development in line with our Quality Strategy.
- Work in partnership with adult social care and a range of housing colleagues from different districts to plan how to utilise the Better Care Fund to best effect to support those people who wish to and who are able to remain within their own homes, with appropriate support. Local Delivery Plans will be extended to encompass this work.
- Work with some of our existing community providers to ensure staff work within a culture which is designed to routinely connect or re-connect individual patients to the resources and assets within their community as part of a person centred approach to care. We will do this through a range of training programmes, together with coaching and mentoring support.
- Develop a test and learn approach in Stroud and Berkeley Vale with a focus on patient centred care, self-care, greater integration with mental health services and better connection to existing community resources. Following a test and learn phase across four Integrated Care Teams, this integrated model of service delivery will be rolled out to each Locality.
- Work in partnership with the Voluntary and Community Sector (VCS) Alliance, which is an independent charitable organisation, to ensure that we capture the knowledge of and listen to the opinions of the vast range of voluntary sector providers in the county, prior to embarking on schemes of work. This will be done via a health forum to be established by the VCS Alliance.
- Work specifically in Gloucester City with colleagues from partner organisations to deepen relationships between a variety of service providers to help improve the overall provision of services within the City.

The aim is to collectively increase understanding and awareness of the services and wider community assets available across the city and ensure that, wherever possible, there is a greater joining up of the provision of these services and wider community assets through specific work based projects. This may require pan organisational development and or training, which recognises that in order to progress the vision, cultural and mind-set shift needs to take place.

### 5.1.5 Systems Leadership

As part of the development of one system, one budget a systems approach to the development of leadership will be applied to address the challenges we face across Gloucestershire. The systems approach recognises the complexity of the challenges we face and programmes of work to address them; developing approaches, skills and culture above and beyond those of the traditional models for management and change.

## 5.2 Clinical Programme Approach

Over the last two years we have developed the Clinical Programme Approach methodology as a fundamental approach to commissioning (see Annex 3). The aim is to provide a transparent framework for defining the best health outcomes possible for the population, for a given clinical area, within the resource available and then commissioning services to deliver these outcomes. The approach involves engaging colleagues from across the health and care community, as well as clear methods for understanding what matters to the population and patients. The approach will support end to end pathway redesign, focusing on preventative care, integrated person centred pathways and independent living.

Patient and Lay representatives are embedded within each of our Clinical Programme Groups providing a voice to directly influence the work of the programmes.

The principles we work to are below, each of which is described in more detail thereafter:

- Building an evidence base to deliver impact
- Commissioning for outcomes
- Patient centred

### 5.2.1 Building an Evidence Base to Deliver Impact

It is vital that our shared vision for the future of health and care services in Gloucestershire is patient centred, based on sound evidence of impact. There have been numerous studies across the world, over many years, considering the benefits of integrated care. Most recently, a Kings Fund report (October 2013) analysed a health and care community with many similarities to Gloucestershire; Canterbury, New Zealand. The report included a focus on seeking an evidence base for the effect of the package of measures implemented by the Canterbury system leaders. Whilst the report could not identify significant positive impacts of individual measures in isolation, it did conclude significant impacts when considered as whole, particularly on the use of acute hospital care services. This work emphasised the importance of a system-wide approach for transformational change to occur; which is fundamental within the Gloucestershire community moving forwards.

### 5.2.2 Commissioning for Outcomes

The clinical programme approach embeds a focus on outcomes, providing a transparent framework for defining the best health outcomes possible for the population within the resource available and commissioning services to deliver these outcomes.

The principles for developing an outcomes approach are summarised as:

- Outcomes should be meaningful and measurable;
- Measures are for the whole population impacted within a given clinical programme area and not based on provider performance indicators;

- The measures should be applied to conditions that can demonstrate amenability and sensitivity to intervention;
- The scope of outcomes measured should include patient reported and service level outcome measures;
- Process measures can be used as proxies if useful where no suitable outcome measure exists (particularly in order to capture intermediate measures where outcomes are longer term);
- Measures should take account of the whole pathway, ideally across all interventions including where a patient has declined or not been accepted for an intervention (e.g. where shared decision-making has been part of the process).

It is also important to note that:

- The CPGs have utilised the Spend Outcome factsheets and Tool (SPOT) to identify benchmarked outcomes; which has informed our priority programmes for 2014 to 2016 alongside our benchmarked financial outcomes
- We are aware, however, that the outcome set is limited within this tool and we are working locally to expand the outcome information available to the CPGs, starting with Ophthalmology and Musculoskeletal (NB Cancer already has a substantial national outcome set and other CPGs require review for which additional support has been employed by the Quality Team)
- The outcomes already available and those required for the future have been mapped, based on the relevant evidence and recommendations from professional bodies. We will be working towards developing and embedding this through 2014 – 2016;
- The outcomes will form part of a dashboard available to CPGs, accounting for the fact that delivery of improved outcomes in some areas will be incremental.

Alongside our local developments the national performance standards set by NHS England are designed for a more outcome focussed approach. The

national framework categorises the outcomes we aim to achieve through three main requirements:

- ‘Everyone Counts’: Ambitions for GCCG for seven key outcome measures;
- Quality Premium ambitions (including one locally defined);
- Better Care Fund national and local ambitions.

### 5.2.3 Maintaining Focus on the Essentials

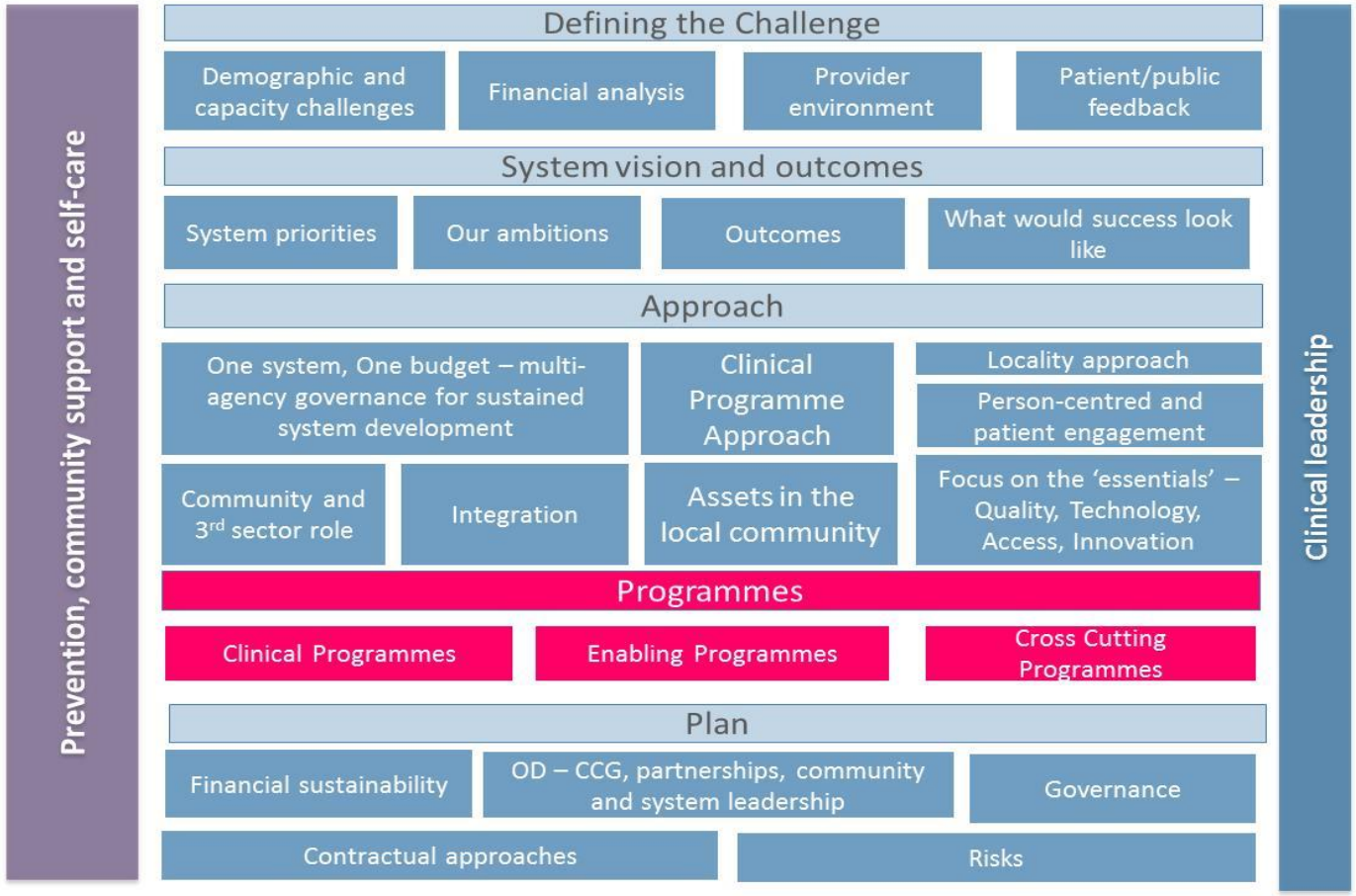
There are a number of essential elements that will apply to all of the characteristics of every successful and sustainable health economy, such as:

- Quality: The Fundamentals;
- Ensuring Access;
- Developing Innovation; and
- Improving the Use of Technology to Support Delivery

More details on our approaches to these areas are set out in Annex 2 – Maintaining the focus on essentials and section 6.3.5 – enabling programmes, use of technology.

## 6. Programmes

In this section of the Strategy we outline what we will deliver through our programmes of work to address the challenges and achieve our vision.



The programmes are divided as follows:

- Clinical Programmes - Programmes located around condition specific pathways that are central to our clinical programme approach
- Cross Cutting Programmes – Programmes that ensure a joined up approach at different stages of the patient journey in support of our clinical programmes
- Enabling Programmes – that underpin our work to ensure consistent and robust improvement across all of our commissioned services to support our delivery of the clinical and cross cutting programmes.

A summary diagram of our programmes is set out below:

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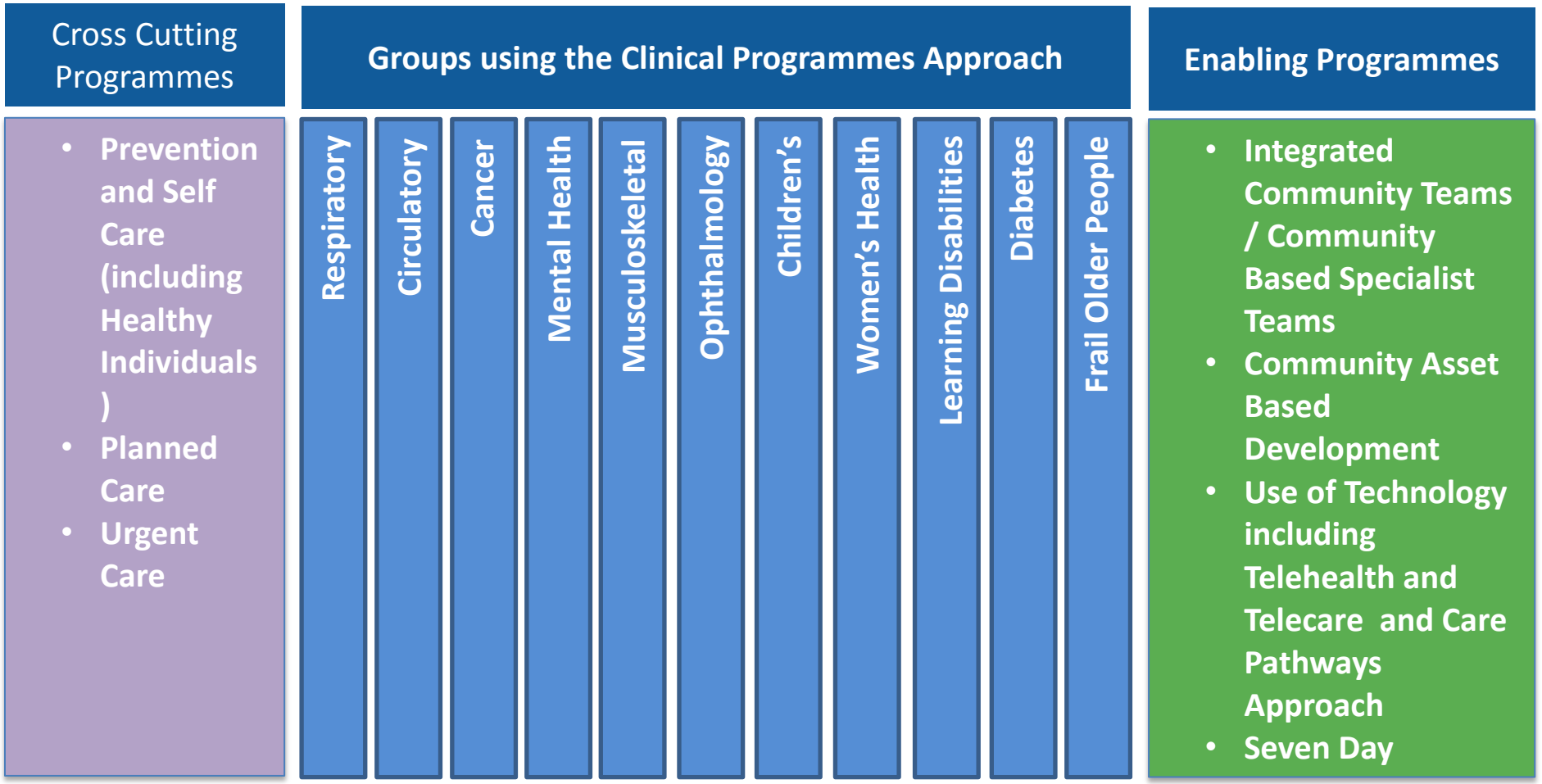


## 6.1 Clinical Programmes

The clinical programme approach described in detail in section 5.2 of this document is primarily expressed through the clinical programme groups established in Gloucestershire. These fora are where clinical leaders and managers across all sectors meet and work together to improve the patient journey, from prevention and self-care to end of life, within their specialty clinical areas. A core principle of the way that the programme groups work is to focus on how to deliver best value within the budgets available for the given clinical area under consideration. A short summary for each of the clinical programme areas is set out below:

### 6.1.1 Cancer

Some cancers are preventable and we will support our population to make the healthy life choices that reduce their risk factors. However for everyone that does develop the disease we are committed to ensuring the best possible health outcomes and compassionate care.

Our priority work programmes will include:

- Supporting the NHS England national screening programme, we will aim to improve earlier diagnosis. The work programme will include an education programme, practice and locality support and advice and guidance; alongside alignment to the primary care offer;
- Launching a programme to develop our approach for Cancer Survivorship during 2014/15; working with partners across the health, social care and voluntary community services. Our plan is to adopt and develop the recommendations of the National Cancer Survivorship Initiative for our local population;
- A focus on patient experience, we will develop a systematic approach to understanding and improving patient experience across the entire pathway;
- A programme of best practice and affordable care audits against peer group health communities will be undertaken on selected pathways to ensure we

are identifying areas where we can improve the financial sustainability and quality of cancer services.

The CCG will be working closely with our providers to improve performance with Gloucestershire CCG and Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) both reviewing the referral management process and increase GP engagement within this specialty through the Cancer CPG.

### 6.1.2 Diabetes and Endocrinology

The future planned delivery of diabetes services will see bold, innovative and exciting changes over the next five years.

The vision and ambition for the development and delivery of diabetes services going forward supports the wider Gloucestershire health and social care community strategy and approach as set out in JUYC; namely that it responds in full measure to both local and national challenges and imperatives (incl. ageing population living with more complex illnesses, no additional investment, increasing demands etc.) and is the thread that runs through the design, development and commissioning of diabetes care for our population.

Our ambition therefore is to:

- Develop a person-centred approach providing patients with the support to take greater responsibility for their own health and well-being
- Develop integrated care pathways ensuring that artificial boundaries between primary, community and acute hospital care are removed, eliminating duplication and increasing efficiency and positively impacting on the patient experience of care
- Deliver transformative change by collaborating with patients and our health & social care partners

If successful, then we would envisage a Gloucestershire-wide diabetes service that provides:

- A suite of self-care/self-management tools to support those people with diabetes-related illnesses who are able and motivated to do so
- Comprehensive primary and acute hospital care prevention services
- All non-complex (or 'non-specialist') diabetes care to be provided closer to home by primary and/or community-based healthcare teams
- Early specialist access and/or opinion to diabetes services
- Joined up care between health and social care services

All diabetes developments and associated project and work programmes come under the auspices and governance of the Diabetes & Endocrinology Clinical Programme Group. The group has a direct mandate from the CCG Governing Body for the oversight and delivery of the diabetes work programme; membership includes all relevant providers and the presence of a Lay Champion ensures that meaningful links are made to patient groups e.g. Diabetes UK Support Groups.

The programme of work is designed to improve the patient experience and quality of care and in addition, release cash-efficiency savings as a result of:

- Repatriation of long-term follow-ups (mainly Type 2) from acute to primary and/or community care
- Reduction of all generalist, diabetes outpatient appointments
- Reduction of non-elective diabetes-related admissions
- Improved efficiency through integration with community-based teams and services

The above developments will also contribute to:

- a reduction in acute capacity (fewer outpatient clinics, potential reduction in short-stay admissions)
- a potential transfer of workforce from the acute to community diabetes teams (e.g. consultant diabetologist sessions)

- a more primary-care focussed and supporting community diabetes specialist team
- greater integration with countywide GCS Integrated Community Teams
- a greater number of diabetes patients motivated and able to self-care/manage

The next five year period will also provide the opportunity to consider and test different models of contracting (i.e. Alliance) along with the development of Personal Health Budgets which together or independently, will potentially support and drive a more robust approach to the integration of health and social care.

The successful implementation of the above developments will make a marginal recurring financial contribution across the wider system.

### 6.1.3 Ophthalmology

Ophthalmology has become an increasing priority within our clinical programmes in response to the pressures of demographic changes, disease prevalence i.e. Diabetes and the rising cost of drugs. The Clinical Programme Group has developed a programme of key workstream that will ensure patients receive the right care, at the right time and within the most appropriate setting, whilst ensuring the implementation and adherence to national clinical policy. Over the next five years the programme aims to achieve:

- Maximal patient benefit for every pound spent on eye care for patients in Gloucestershire
- Deliver a more patient centred approach
- Making the pathway and services suitable for frail older people with multiple comorbidities

This will be delivered through:

- Protocols for decision making and thresholds for treatment

- Maximum use of non-medical staff
    - Optometrists
    - Nurse Practitioners
    - Community Optometrists
- Maximise use of technology / imaging to manage referrals

### 6.1.4 Cardiovascular

Cardiovascular Disease (CVD) is an overarching term that describes a family of diseases sharing a set of common risk factors. This strategy largely focusses on conditions causing or resulting from atherosclerosis, in particular coronary heart disease and stroke. It also links with other clinical areas such as chronic kidney disease, peripheral arterial disease, diabetes and vascular dementia. Many people who have one condition commonly suffer from another.

The Circulatory CPG vision and objective for the next five years is to improve the outcomes and quality of care for people with or at risk of cardiovascular disease by focussing on:

- Improving the assessment and coordination of care for people with CVD
- Improving prevention and risk management
- Enhancing case finding in primary care
- Better early management and secondary prevention in the community
- Improving acute care
- Improve care of patients living with CVD
- Improving information gathering in order to inform future commissioning

Our vision for success is a health community that identifies those with or at risk of CVD and ensures prompt investigation and treatment in the most clinically appropriate place. Those who experience an acute episode and are admitted to hospital will receive care and treatment to national standards with timely return to the community with specialist or generic support as appropriate. Providers of care will be sharing information and plans of care effectively

reducing the likelihood of delays or repeated assessment/information gathering. Those who require specialist rehabilitation will be able to access this in order to reach their full potential and reduce the likelihood of further related events. Services will demonstrate a level of quality that is reflected by the patient experience.

Our strategy aims to ensure that cardiovascular services and pathways of care reflect best practice guidance on quality and outcomes. By ensuring services meet both national and local standards the number of people having a positive experience of hospital care, care outside hospital, in general practice and in the community will increase.

Prompt assessment, intervention and rehabilitation will prevent people from dying prematurely, increase life expectancy and ensure people recover quickly and successfully from episodes of ill-health. Ensuring robust community based cardiovascular services will reduce the amount of time people spend avoidably in hospital and increase the proportion of older people living independently at home following discharge from hospital.

The timely provision of information and support, including support with self - management will ensure the best possible quality of life is maintained.

By reviewing current activity and levels of service provision across the pathways of care together with predicted disease patterns and trends, capacity measures will be used to inform service developments going forward. The development of alternative pathways and robust integrated service provision is key to meeting future demand and ensuring people receive their care in the most appropriate place (not simply defaulting to acute hospital care). Financial investment may be required (cost to be determined) in order to redesign services and offer alternative pathways however by improving the management of patient flows the potential for reducing acute hospital care referrals and related costs together with shorter lengths of stay exist.

Our commissioning priorities for the first two years of this strategy are:

- Brain Natriuretic Peptide (BnP) - introduction of new pathway for improved detection and referral of patients with Heart Failure

- Palpitations/ Electrocardiogram (ECG) – review of existing pathways with potential redesign
- Frail Older People CVD Reviews
- Stroke pathway (acute/community) review of current pathway and identification of opportunities for service improvement
- Cardiac pathway (Chest pain, Echo, Angioplasty) review of current pathway and identification of opportunities for service improvement
- Atrial Fibrillation – promotion of best practice
- Familial Hypertension

### 6.1.5 Respiratory

The future planned delivery of respiratory services will see bold, innovative and exciting changes over the next five years.

The vision and ambition for the development and delivery of respiratory services going forward supports the wider Gloucestershire health & social care community strategy and approach as set out in JUYC; namely that it responds in full measure to both local and national challenges and imperatives (incl. ageing population living with more complex illnesses, no additional investment, increasing demands etc.) and is the thread that runs through the design, development and commissioning of respiratory care for our population.

Our ambition therefore is to:

- Develop a person-centred approach providing patients with the support to take greater responsibility for their own health and well-being
- Develop fully integrated care pathways ensuring that artificial boundaries between primary, community and acute hospital care are removed; eliminating duplication, increasing efficiency and positively impacting on the patient experience of care

- Deliver transformative change by collaborating with patients and our health and social care partners

If successful, then we would envisage a Gloucestershire-wide respiratory service that provides:

- Comprehensive primary and acute hospital care prevention services
- A suite of self-care/self-management tools to support those people with respiratory illnesses who are able and motivated to do so
- Non-complex (or 'non-specialist') respiratory disease care closer to home by primary and/or community-based healthcare teams
- Early specialist access and/or opinion to respiratory services
- Joined up care between health and social care services

All respiratory developments and associated project and work programmes will come under the auspices and governance of the Respiratory Clinical Programme Group. The group has a direct mandate from the CCG Governing Body for the oversight and delivery of the respiratory work programme; membership includes all relevant providers and the presence of a Lay Champion ensures that the relevant links are made to patient groups e.g. British Lung Foundation Breathe Easy Groups.

The programme of work is designed to improve the quality of care and in addition, release cash-efficiency savings as a result of:

- Moving non-elective and elective (outpatient) activity levels towards peer average/top quartile performance
- Reviewing and re-designing specific service areas e.g. sleep apnoea
- Repatriation of non-specialist respiratory care to community-based services
- Improved integration with community-based teams and services

The above developments will also contribute to:

- A potential reduction in acute capacity (fewer respiratory beds, reduced short-stay episodes of care)

- a potential transfer of workforce from the acute to community respiratory teams
- additional training and support for primary care healthcare teams
- a greater number of respiratory patients motivated and able to self-care/manage
- greater integration with countywide GCS ICTs

The next five year period will also provide the opportunity to consider and test different models of contracting (i.e. Alliance) along with the development of Personal Health Budgets which together or independently, will potentially support and drive a more robust approach to the integration of health and social care.

The successful implementation of the above developments will make a significant (recurring) financial contribution across the wider system.

### 6.1.6 Musculoskeletal (MSK) and Trauma Services

MSK includes rheumatology and pain management and is a priority because:

- Increasing older population with bone health problems
- Evidence that we benchmark high for our population in terms of some surgical and outpatient activity
- We need to improve our outcomes for fractured neck of femur (NOF)
- We need a new model for rheumatology that supports patients better in the community and with reduced reliance on expensive drugs
- Pain is a significant long term condition that affects growing numbers

Our vision as a programme is to achieve:

- Reduction in fractures for the population

- Reduction in occurrence of self-reported MSK pain
- Good patient reported outcomes for key pathways
- Maximise long bone fracture outcomes linked to original functional status
- Maximise good patient experience including waiting times across MSK pathways

We will do this by:

- Protocols for shared decision making and thresholds for treatment across all pathways
- Maximum use of conservative management options as appropriate
- Review and redesign with patients of the management of rheumatology conditions
- Design of best practice long bone fracture (including fractured NOF) pathway with a focus on time to surgery and tailored, patient focussed rehabilitation
- Review and redesign of the community based and self-management elements of the pain management pathways.

### 6.1.7 Mental Health

The No Health without Mental Strategy sets out a clear and compelling vision centred on six overarching objectives, as follows;

- More people will have good mental health;
- More people with mental health problems will recover;
- More people with mental health problems will have good physical health;
- More people will have a positive experience of care and support;
- Fewer people will suffer avoidable harm;

- Fewer people will experience stigma and discrimination.

The Mental Health and Wellbeing Strategy for Gloucestershire reflects the national strategy "No Health without Mental Health", seeking to achieve parity of esteem for mental and physical healthcare alongside improving mental health related outcomes for the people of Gloucestershire. As such the strategy is ambitious and comprehensive; recognising sustained effort and strong partnership working will be required to deliver the proposed outcomes. We aim to ensure there is a joined up system between physical and mental healthcare across primary, acute hospital and social care services in the county. The key elements of the commissioning strategy are as follows;

- Increase access to psychological therapies;
- Improve access and pathways to mental health crisis services;
- Implement integrated clinical care pathway across mental and physical health care;
- Improve access to psychiatric liaison services in acute and community hospital settings;
- Increase focus on recovery for people with serious mental health conditions.

### 6.1.8 Learning Disability

Within GCCG the focus of learning disability commissioning is to improve the health and wellbeing of all people with a learning disability within Gloucestershire. This will mean the continued improvement of health inequalities amongst people with a learning disability responding to recommendations made in both the Mansell Report (2007) and Winterbourne View Report (2012). Providing a clear outcome focus based on robust clinical evidence, working with GPs across localities, GCCG will ensure a joined up approach between health and social care and other services providing for a community based network of support.

The schemes involve a remodelling of existing assessment and treatment services for people with learning disabilities who present with challenging behaviours to ensure they are delivered in line with the recommendations of the Mansell Report (2007) and Department of Health Winterbourne View Final Report (2012).

### 6.1.9 Frail Older People

The Frail Older People Clinical Programme Group has a strategic overview of the challenges around ensuring that services meet the needs of older people in Gloucestershire, and has a membership that includes health and social care commissioners and providers, as well as Healthwatch and Lay Champions.

The impact of the growing ageing population has significant health, economic and social consequences for limited and already stretched resources, and will have a similar impact on carers and families. The older person is more likely to have complex long term conditions, with a growing recognition that both dementia and frailty are not necessarily a consequence of age and should be considered in the same way as other long term conditions – with clear pathways and responsive services that aim for wellbeing with people supported to live in their community.

Recognition that a partnership approach is essential to develop sustainable integrated services with stakeholders fully engaged and committed to improve the physical and mental wellbeing of older people and their carers.

*Dementia*

- Redesign the Managing Memory 2gether Service to provide greater support to primary care, whilst freeing capacity to manage complex diagnosis of dementia
- Achieve NHS England's target of dementia diagnosis of 67% of the dementia prevalence by March 2015 (currently at 55%)
- Shift emphasis for non-complex diagnosis from acute hospital to primary care, describing the range of support for primary care including community networks

- Work with Lay Champions to collate the experience of the person with memory loss and diagnosis of dementia in primary care and acute hospital care

*Integrated Frailty Pathway*

- Small core planning team using the NHS England frailty pathway guidance to develop an integrated frailty pathway http://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf . A productive workshop is moving towards three process mapping sessions with stakeholders
- Agree a frailty assessment tool and an approach that suggests frailty is everybody's business
- Identify priority areas
- Progress Older People's Advice & Liaison project

### 6.1.10 Children

As the name implies this population focussed programme will look at the needs of children and young people (up to age 18) across our health and care system. We know that outcomes late in life and adulthood for many are heavily influence by what happens in their childhood. Locally the health and wellbeing of children is better than the England average, but there are noted demands within our unscheduled care system, particularly for under four year olds, and variation in provision across our communities. Additionally there is room for improvement in mental health provision and prevention of self-harm and a growing concern with regard to obesity. This is a key clinical programme that has significant system wide implications:

Over the next five years the CCGs' children and young people's CPG vision and objectives is to improve the quality and outcomes for children and young people by:

- Improving urgent care pathways for children to reduce emergency admissions and readmission to hospital

- Work collaboratively with partners to increase health visitor numbers to improve outcomes for vulnerable families
- Contribute to the delivery of the Gloucestershire Early Years Strategic Framework
- Work with partners to implement the Children and Families Bill to improve services for children with Special Educational Needs and Disabilities (SEND).
- Continue to develop multi-agency pathways i.e. autism spectrum
- Review and monitor delivery of statutory functions i.e. looked after children, adoption.
- Sustain a focus on safeguarding
- Ensure effectiveness of mental health service for children and young people

We will ensure partnership working is promoted to safeguard children, young people and vulnerable adults within Gloucestershire. We will outline a series of principles and ways of working that are equally applicable to the safeguarding of children, young people and adults in vulnerable situations, recognising that safeguarding is everyone's responsibility. As part of the GCCG Quality strategy the importance of clear roles and responsibilities, up to date policies and procedures, the role education and training provides and how we will be held to account locally and nationally are all emphasised to ensure safeguarding is promoted within all of our work.

### 6.2 Cross Cutting Programmes

The primary focus of our approach to delivery of change is through our clinical programmes as described above. However, our clinical programmes do not cover every aspect of care delivered for our populations and the work in the individual groups will identify areas of improvement along particular aspects of pathways that have the potential to improve services across the range of clinical services. To support this, we have established a number of 'cross-cutting' working groups that will focus on ensuring we have a joined up approach to stages along the patient pathway. A summary of our cross-cutting programmes is as follows:

- Prevention and Self Care Programme (Healthy Individuals)
- Planned Care Programme
- Unplanned (Urgent) Care Programme

### 6.2.1 Prevention and Self Care

As outlined in the 'Vision & Outcomes' section of this document, a key element of our strategy will be to ensure that our population are supported in prevention and self-care – ultimately to improve health. We have a number of initiatives underway to support this strategy and are working with our partners across the health and social care economy to provide this support – especially through our important links and relationships with our community and the voluntary and charitable sector.

Prevention and self-care are at the heart of a sustainable future for Gloucestershire; within which we are looking at innovative approaches to address the health inequalities across our county whilst responding to the projected prevalence increase in long term conditions; to improve outcomes for our population. The health and social care community is currently developing its strategic approach to prevention, self-care, and self-management. This aims to join together existing programmes and projects and to ensure both evidence-based approaches and high impact interventions are applied. The 'healthy individual's' clinical programme that will be established to oversee this priority will be co-designed with our partners incorporating the principles of the clinical programme approach.

Patients who are empowered to make decisions about their health often experience more favourable health outcomes. Shared Decision Making will be developed across the prevention and self-care programme as a recognised approach for patients and clinicians to collaboratively make decisions about an individual's healthcare. Our initial work will explore Shared Decision Making through the Musculoskeletal (MSK) programme to ensure a consistent, formalised approach across the care. Once tested as an approach we would expect that this will be developed for all relevant areas of our commissioned services.

An integral part of the self-care and prevention programme will be the key role carers play in supporting the care we provide and understanding the needs of the person they care for. The critical role of carers as main care-providers must be recognised and we acknowledge being a carer can also bring its own health costs. Locally we are progressing with the carers' agenda and will continue to implement our local 'Joint Carers Commissioning Strategy 2013-2016'. Our strategy recognises the national priority to support carers to remain healthy, mentally and physically well; to be treated with dignity and employs the use of Joint Strategic Needs Assessment to identify care needs.

#### 6.2.1.1 Healthy Individuals

Our overall vision is to enable a cultural shift from a reactive, disease-focused fragmented model of care towards one that is more proactive, holistic and preventative

The drivers for the change include:

- The number of older people in Gloucestershire predicted to increase by 70% (an increase of 78,000) by 2035, the number of people living with diabetes and stroke is projected to increase by approximately 34%, and Coronary Heart Disease (CHD) 50%.
- People with long-term conditions are the most frequent users of health care services accounting for 50% of all GP appointments and 70% of all bed days. Minor ailment account for 20% of GP's workload.
- Evidence shows that supporting self-care, increasing shared decision making and personalisation can all have benefits on people's attitudes and behaviours, quality of life, clinical symptoms and use of healthcare resources.

We will deliver our vision by working towards the house of care framework for long term conditions and adopting an approach that places a significant emphasis on prevention and early identification working in collaboration with partners. This will be achieved by undertaking programmes of work around the following themes:

- Prevention of long term illness, earlier identification and taking early steps with those at risk
- Commission programmes and supporting communities to help people to self-care
- Develop workforce expertise to become co-producers in health
- Creating the right conditions to inform and empower individuals and carers

#### 6.2.1.2 Prevention

We will work with a broader range of providers, including healthy living pharmacies and the voluntary and charitable sector, to make support more accessible and more joined up. As a consequence we would expect GPs and other health care professionals to increase the referrals made to different types of support promoting health and wellbeing, such as walking clubs, books on prescription or weight management programmes in the community. This builds on the whole system approach already used in Gloucestershire for obesity, using very local community involvement and co-production approaches.

The work programme will also continue to develop existing asset based approaches across Gloucestershire; delivering through the locality infrastructure. In future we would expect people to have access within their communities to local support for healthy lifestyles, co-designed and provided by local communities themselves with some support from our health and care community where needed; with a particular focus on areas of need.

***Gaye's Story***

*"Last year, my GP referred me to Slimming World for 12 weeks. I'm absolutely delighted with the results. After 11 weeks, I had lost 1st 10lbs, and started feeling so much better. I now have excellent control over my diabetes and have managed to stop having insulin injections during the day. I've also reduced the amount I need at night.*

*Initially, I really didn't want to join a slimming club. However, the Slimming World consultant Kathy is really supportive and encouraging, and the other people in the group are very friendly and inspirational. I've decided that I will carry on attending Slimming World to lose even more weight as the health benefits are truly amazing!"*

*Gaye from Tewkesbury*

#### 6.2.1.3 Self-care

As stated in 'Transforming Participation in Health and Social Care' (NHS England 2013) "People's lives can be transformed when they have the knowledge, skills and confidence to manage their own health and when they can shape their treatment to fit with what is important to them. When health outcomes and goals are agreed, needs are better met and people are supported to manage their own care." Therefore in line with this we will look to improve outcomes, provide value for money and improve quality of life for the people of Gloucestershire. We will work more closely with key patient groups, to better understand how people would like to manage their care, supporting this with high quality care planning, the use of technologies and access to consistent approaches to secondary prevention such as medicines optimisation and primary prevention.

We will ensure that those with existing long term conditions are provided with programmes that help them take control of their conditions, for example Self-Management Programmes. This would include much greater use of technology to enable people to take control of their own health (building on our existing Telehealth programme), providing information and support, but also remote monitoring and feedback to support independent living.

The development of our strategic approach to self-care will also include personal care planning. As outlined in the NHS Mandate (March 2012 to April 2015) and 'Transforming Participation in Health Care' the requirement "that every person with a long-term condition or disability has a personalised care plan supporting them to develop the knowledge, skills and confidence to manage their own health," should be in place by April 2015. In response we will ensure:

- A review of existing documentation and plans is carried out, including electronic care plans, to ensure this key deliverable is achieved within Gloucestershire;

- Consistent approach to long term condition care planning and published availability of plans;
- There are consistent approaches to personalised, outcome focused goal setting within care plans, evidencing and embedding good practice;
- Shared decision making including patient decision aids is included within our approach
- Training for health & social care professionals, including review of potential for incentives and support for professionals e.g. motivational interviewing, is considered as part of embedding an approach across Gloucestershire.

The NHS Mandate also includes an objective that everyone "who could benefit will have the option to hold their own personal health budget, as a way to have even more control over their care". We acknowledge that personal health budgets offer a new tool to support self-management and care planning with patients as partners in the management of long-term conditions. We are aware of the challenges this will bring in terms of the way services are currently commissioned, funded, contracted for and provided and will ensure that in line with national guidance our local population is supported in their right to request a personal health budget.

In Gloucestershire we have already started to consider how personal health budgets can be implemented at a continuing healthcare level for both adults and children and are participating in the 'Markers of Good Practice' programme led by NHS England. This continues to be developed locally and we will continue to work towards the implementation of personal health budgets to ensure that a collaborative multi-organisational approach is developed.

***Wendy's Story***

*"When I got home from hospital, Hayley from the Gloucestershire Respiratory Team visited me about my chest problems. She was great and taught me how to use my inhaler more effectively – it has really helped my breathing. She also gave me a self-management plan to help me recognise when my condition flares up and what to do when this happens. Now I keep prescribed medications at home so that I can take them as soon as I need to. The first time that happened I was frightened and didn't feel very confident, so I phoned the respiratory team. They reassured me and I did my self-management plan. Since then I feel much more confident and in control. I also went to an exercise and education group for people with COPD like me. The specialist who had visited me at home was there on my first day which made me less nervous – and I didn't have to repeat everything either. The exercises I did there showed that my oxygen levels had dropped, so I went to see the oxygen nurse in a clinic and now use oxygen on a daily basis. I've learned so much thanks to the GRT. I am less breathless and much more confident about managing my condition."*

*Wendy from Gloucester*

#### 6.2.1.4 Social Prescribing

There are many community-based and preventative organisations and services operating within Gloucestershire which successfully support the wellbeing of the population. For example there are approximately 400 groups and/or projects in Stroud District alone. These can be poorly understood, underutilised and can appear disjointed to users and referrers. In addition, locality GPs have identified problems in their understanding of the availability of such services and access and the willingness of some patients referred, to take up the service offered can be problematic. The impact of this can be:

- Increased repeat visits to GPs (and potentially other services) and increased prescribing
- On some occasions unnecessary emergency admissions
- Poor health and wellbeing outcomes that could be avoided
- Inefficient utilisation of existing resources and so instability for small scale providers

Social prescribing is a structured way of linking patients with non-medical sources of support within a community. These opportunities may include opportunities for arts, creativity, physical activity, learning new skills, volunteering, mutual aid, befriending and self-help, as well as support with, for example, employment, benefits, housing, debt, legal advice, or parenting problems.

We are undertaking and evaluating a number of Social Prescription pilots which are operating on a locality basis. The pilots involve a range of statutory and voluntary and charitable sector partners working together to better connect patients with non-medical needs to the range of opportunities which exist in their communities. Examples include services which support carers, services providing housing and debt advice, signposting to services which assist those who are lonely or and/or isolated and support for those with drug and

alcohol issues. If successful, the CCG aims to expand the pilot projects out roll them out across each locality.

### 6.2.2 Planned Care

Our aim for planned care continues to be ensuring that people access timely and high quality diagnostics, assessment and treatment. As we plan for the future, it is essential that all organisations work together in a joined-up way to ensure that services are of high quality and that access criteria and equality of access for patients are consistent. Through the CCG's clinical programme groups we will work to understand the patient pathway, using a commissioning approach based on understanding clinical need and defining expected patient outcomes.

We will also build on innovation across the system to ensure that further productivity and improved patient experience are delivered. This will include:

- Reviewing the effectiveness of new services, such as advice and guidance and new local services that offer opinion/ assessment only services, to aid more efficient and timely clinical decision making;
- Working towards increasing provision of outpatients and ambulatory services in a community setting where clinically and cost effective to do so;
- Further development where appropriate, of specialist multidisciplinary assessment and treatment interface services.

We will develop strategies across the county to ensure that patients receive specialist care when appropriate, in line with agreed clinical pathways, and when any stay in hospital is for the shortest possible time. This will be supported by initiatives to ensure patients are admitted on the day of their surgery not the night before, and enhanced recovery programmes to ensure that patients recover from surgery as quickly as possible.

Consistency of services is fundamental within our approach; aiming to ensure equity of service (including referrals) for our population through the joint development of clear health and care pathways to reduce variation. These pathways will be developed by clinical staff and give both them and patients clarity about services that are available, as well as when they should be used.

It will also have an important feedback and education tools for clinical staff, and ensure that patients are treated in the right place at the right time, and will be underpinned by increased involvement of patients in making key decisions about their planned care treatment. We expect patient choice to be at the heart of planning, so that patients are able to be empowered to choose not only where they are treated, but also what their treatment is. Key elements to deliver this are the continued development of self-care and shared decision making across all areas of healthcare, as well as the development of consistent care pathways developed by clinical collaboration and underpinned by clinical evidence and patient outcome data.

We recognise the significant challenge in elective care, and are committed to ensuring the resources can be utilised to meet the rising demand for services alongside improving outcomes for patients. Our work will deliver more streamlined elective care pathways, with delivery of clinical outcomes that meet good practice standards and in doing so significantly improve productivity and cost efficiency across all care settings from both a provider and commissioner perspective. As part of this challenge will we also address the appropriateness and effectiveness of the interventions we offer such as Individual Funding Requests, this will include alignment to the Effective Clinical Commissioning Policies lists and that mechanisms are in place to provide clarity across organisations.

***Paul's Story***

*"I found this to be a friendly, local service, and the appointment was made very quickly. I was taken to my appointment promptly, and was immediately put at ease by the staff in the ultrasound clinic. They explained the procedure clearly and carried it out with no sense of rushing me, and I had an overall feeling of real care and understanding.*
*My dignity was a priority, and I knew exactly what was happening, so felt happy throughout the whole procedure."*
*Paul from Stow-on-the-Wold*

### 6.2.3 Unplanned (Urgent) Care

Urgent Care will be a critical priority for us over the next five years in terms of delivering national performance targets, alongside ensuring patient experience and outcomes are sustained and improved. The priorities moving forward will reflect the National Urgent Care Strategy that has been defined within the

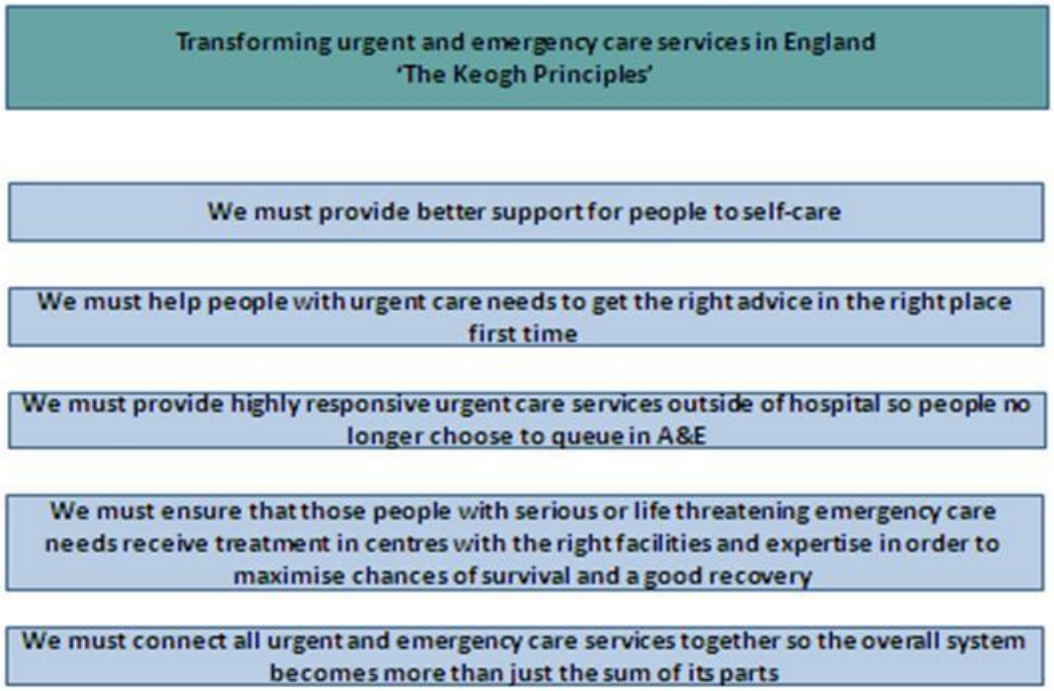
recent Bruce Keogh report “Transforming urgent and emergency care services in England”. This defines a clear vision for urgent care which is fully endorsed by us as we move forward and design services that reflect the needs of our local population. The vision is simple and states:

- For patients with urgent but not life threatening needs we must provide highly responsive, effective and personalised services outside the hospital. These services should deliver care in or as close to people’s homes as possible, minimising disruption and inconvenience for patients and their families.

- For those people with more serious or life threatening emergency needs we should ensure that they are treated in centres with the very best expertise and facilities in order to reduce risk and maximise their chances of survival and good recovery.

- If we can get the first part right then we can relieve pressure on our hospital based services, which will allow us to focus on delivering the second part of the vision.

The challenges facing our urgent care system in Gloucestershire are clear, which provides us with a foundation for identifying the opportunities for improvement. The five key elements described below have been defined nationally, but will be the bedrock upon which we continually develop our urgent care services within Gloucestershire.




**Bruce Keogh Report – 'Transforming Urgent and Emergency Care Services in England 'The Keogh Principles'**

These principles have been applied to identify local priorities:

- ***"We must provide better support for people with self- care"***

Prevention and self-care is pivotal across this whole five year strategic plan, aiming to build independence, knowledge, skills and confidence for people to manage their own care.

- ***"We must help people with urgent care needs to get the right advice in the right place first time"***

We believe it is essential that when people feel they need clinical advice or treatment for an urgent care need they must be rapidly supported in accessing the right advice or service first time round, and as close to home as possible. In order to achieve this we will work closely with the national team to influence the enhancement of our NHS 111 service. This will ensure the public regard this as the "smart call to make" and that the people of Gloucestershire are provided with a 24 hour, personalised priority contact service. This work will be informed by trials of models of care, such as clinical triage. Through these trials where we can evidence that enhancing of skill mix and adapted internal

pathways have a positive impact on patient experience and can be delivered in a cost effective manner, these will be rolled out.

- ***"We must provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E"***

To avoid people choosing to queue in A&E, or being taken to hospital unnecessarily to receive treatment they need, the services outside Gloucestershire Royal Hospital and Cheltenham General Hospital must be enhanced. To achieve this we will:

- Provide high quality, same day, everyday services within the community (including within primary care);
- Harness the skills and expertise of a range of professionals, including community pharmacists and Emergency Care Practitioners;
- Further develop ambulance services so they are better equipped to treat patients at the point of contact;
- Look to develop a strategy linked to the development of urgent care centres;
- Roll out of Integrated Community Teams, including a Rapid Response Service.

This will be further supported by the development of the Community Services Commissioning Plan, which will incorporate recommendations from the Keogh Report and our approach to the development of Urgent Care Centres.

- ***"We must ensure that people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and good recovery.***

There is a national steer to introduce two levels of hospital emergency departments with the aim of introducing two defined titles:

- Emergency Centres
- Major Emergency Centres

Once further guidance is received during 2014 we will work closely together in order to ensure that a model which is fit for purpose within Gloucestershire is developed. This model will need to ensure that highly performing and high quality services are provided that acknowledge the national direction and ensures that, where appropriate, specialist equipment and expertise is made available to the people of Gloucestershire.

- ***"We must connect the whole urgent and emergency care system together through networks"***

We aim to make the whole urgent care system operate as effectively and efficiently as possible, becoming much more than the sum of its parts. A well-established Urgent Care Network Board with a wide ranging membership from across the Health and Care Community is already in place, including representation from Health Watch (thus ensuring the views of the local community are understood and influence strategic review and planning). The Network Board is supported by a Countywide Urgent Care Governance Group, which has the membership of clinicians from our major local providers.

We are eager to work collaboratively in ensuring that when people require hospital care their discharge from hospital is undertaken in a timely and high quality way. With this in mind we will continue to build upon the work that has started within Gloucestershire with our major local NHS providers, which has identified key aspects of work that will ensure any delays within the system are minimised. Schemes will be developed to provide support to internal length of stay plans, to drive on-going improvements in the community, address interim placements and take forward audit outcomes; in turn contributing to the Better Care Fund.

Only by building the right system and better supporting the people of Gloucestershire to use it effectively will we be able to achieve improved outcomes for urgent care services and truly deliver high quality care. We know we have significant work to do in response to the Bruce Keogh Report, as well as responding to local intelligence (including patient feedback) in relation to our urgent care services.

## 6.3 Enabling Programmes

In this section of the Strategy we describe the enabling programmes we propose to implement to deliver the CCG's vision and a number of other initiatives we are implementing to support the provision of seamless, efficient and high-quality clinical services to our population. The content of this section of the strategy is outlined below and described in more detail thereafter:

- Communities Strategy:
    - Integrated Community Teams
    - Community based Specialist Teams
- Use of Technology
    - Telehealth and Telecare
    - Care Pathways Approach
- Seven-day Services
- Consistent Primary Care Offer
    - Developing new ways of working in primary care
    - Develop improved integrated out of hospital care 7 days a week
    - Primary care offer enhanced services
- Medicines Optimisation
- Workforce Strategy

The enabling strategies are further supported by the planning and governance approach, in particular the effective management of our resources and the utilisation of different contractual approaches to achieve outcome based commissioning (as further described in section seven).

### 6.3.1 Communities Strategy

Alongside an emphasis on integrated services for our population and a focus on prevention and self-care, JUYC is about seeing people at the centre of the health and care system, with services wrapped around them in or near to their home. We see community services as the vital bridge that spans across from people in their home, through to specialist hospital-based care. We will therefore focus a considerable amount of our time to ensuring these services are developed to meet the needs of our population. This will be led through the establishment of a new multi-agency Community Services Programme Board, drawing together planning issues through the short, medium and long term.

The first main task of this Programme Board, through 2014, will be the development of a detailed five year Community Services Commissioning Plan, building on what is described within this strategic plan. This plan will be developed through a series of 'How we care for people when they…?' work streams:

- Need a diagnostic test;
- Have a minor injury;
- Have one or more long term condition(s) and may or may not require reablement;
- Require intensive specialist support in their own home;
- Require rehabilitation and/or reablement following an acute clinical event;
- Need surgery.

As part of the development of the plan, we will consider how we can have an effective and affordable network of community facilities, including community hospitals, that can each specialise in a range of services, but also act as 'community hubs'. We think this will make best use of staff skills, equipment, technology and the limited money available. As part of the development of our community services we have an identified programme of service redesign that will inherently link our strategic approach to integration with delivering services that meet the needs of our population. These include:

### 6.3.2 Integrated Community Teams (ICTs)

Our ICTs bring together occupational therapists, physiotherapists, social workers, reablement workers, community nurses, administrative and other support staff to work as one team providing support typically to four GP practices with a combined population of around 30,000 patients. As identified in the primary care priorities, the role of GPs is pivotal in this work alongside close working with community hospitals, community specialist services, voluntary services and other care providers to provide assessments, treatment and support for people within the community.

In order to develop the ICTs substantial investment has been committed to increase the capacity of the existing teams. This has involved providing a training programme for team and professional core competencies development. This will increase the capability within the community (particularly around advanced assessment, first line diagnosis, multi-disciplinary goal setting and nurse prescribing) and ensure increased functionality (covering both a rapid response and high intensity service) provide a comprehensive 24/7 service. This additional functionality will be in place across the county by the end of 2014/15, following a locality by locality roll out.

The service will focus initially on those people who currently need to be admitted to hospital or require expensive packages of social care, providing a rapid response service, alongside care and case management to support specific people in their homes as far as possible. As outlined within the primary care section, increasingly teams will also be working closely with primary care to identify those people with a long term condition, not at the point of exacerbation, but who will benefit from more proactive, 'upstream' and personalised case managements.

Further development of the ICT programme (deemed phase two) will extend the scope of integration to wider services; including greater connection with mental health services, incorporating prevention and self-care priorities such as Asset Based Community Development; and the adoption of the principles of

our current 'Living Well' programme being piloted in two local areas of the County.

### 6.3.3 Community Based Specialist Teams

Our focus to date for the integration of specialist teams has commenced within respiratory services. The future planned delivery of respiratory services will see bold, innovative and exciting changes over the next five years.

Our ambition within respiratory services is to:

- Develop a person-centred approach providing patients with the support to take greater responsibility for their own health and well-being;
- Develop fully integrated care pathways ensuring that artificial boundaries between primary, community and acute hospital care are removed; eliminating duplication, increasing efficiency and positively impacting on the patient experience of care;
- Deliver transformative change by collaborating with patients and our health and social care partners.

If successful, then we would envisage a Gloucestershire-wide respiratory service that provides:

- Comprehensive primary and acute hospital care prevention services;
- A suite of self-care/self-management tools to support those people with respiratory illnesses who are able and motivated to do so;
- Non-complex (or 'non-specialist') respiratory disease care closer to home by primary and/or community-based healthcare teams;
- Early specialist access and/or opinion to respiratory services;
- Joined up care between health and social care services.

As part of our approach we are keen to learn from the model of integration within our specialist respiratory teams, and expand to further specialists as appropriate. This will provide a link to the ICTs across our community.

***Mr Keene's Story***

*"I remember how efficient they were. Within seconds they were doing blood pressure checks and talking to me. They were so kind. They really made me feel better instantaneously. If you get somebody who knows the job, and who can talk to you properly, they make everything so easy. They certainly didn't push me to go to hospital. In hospital I've always been treated well, but I was treated just as well, if not better, here at home. The first day they came three times and we both knew jolly well that if we did have to ring, they would come. We had different members of the team, and everyone was the same. They were so good, so polite and so helpful."*

*Mr Keene from Longford*

### 6.3.4 Use of Technology

Developing our approach to using technology is essential to many aspects of our work. There are currently three main elements to our approach to the use of technology.

- Supporting patients directly through the use of technology – Telehealth and Telecare
- Using technology to improve the way patients are supported through our services – shared care records
- Using technology to support clinicians to work effectively – Care pathways approach

#### 6.3.4.1 Technology

Everyone Counts: Planning for Patients 2014/15 to 2018/19 describes how NHS organisations should utilise the array of technology available to the healthcare organisations

The Commissioner has a dual role in terms of informatics. Firstly, to secure effective and efficient systems to manage its core business and secondly to encourage its health and care providers to identify what is required from a patient or service user perspective.

Our Information Management and Technology (IM&T) strategic direction has been signed up to by our health community:

- Clinical Decision Support
    - Continued roll out and development of risk stratification
    - Appraisal of tools for clinicians to support clinical pathways
- Integrated Care – Clinical Record Sharing – effective sharing of records between the professionals involved in the care of an individual, including social care.
    - Continued roll out of summary care record
    - Continued roll out of electronic prescription services
    - County wide development of shared records across pathways including social care, primary care community and acute clinical records
- Patient Facing Services – using technology to provide individuals with more information about their health and services to enable them to make better decisions about their health.
    - Development of Telehealth within Gloucestershire
    - Review of text messaging services and on-line appointment booking for patients and clinicians
    - Improve information available on-line to patients
- Commissioning Enablement – improving data quality to ensure that the right information (the evidence-base) is available to inform decision-making and support commissioners in their role to plan, monitor and review services;
- Enabling Infrastructure – this will include the development of information governance and data standards, CCG IT infrastructure and programme governance
    - appropriate information governance arrangements. Existing information sharing agreements will be reviewed and updated using best practice, including the Caldicott reviews. These will then be

developed on an ongoing basis to support the implementation of each element of specific IM&T plans.

- a county wide IM&T steering group has been established to oversee the county wide elements of the IM&T strategy. This group reports into the Gloucestershire Strategic Forum.

The strategy benefits are:

- Shared information to support integrated joined up care
- Better information to support clinical decisions
- Faster communication and turn-round times across the health community
- Greater patient access to information about their care
- Improvements to staff working lives
- Improved resource utilisation and cost savings
- Better information for management and governance

#### 6.3.4.2 Telehealth and Telecare

Telehealth and Telecare are embedded within the models of care we currently provide in Gloucestershire. However, it is noted that both of these assistive technologies play a key role in the modernisation of the service we provide, as a fundamental tool in responding to demographic demand and pivotal to delivering our self-care agenda. Personalisation provides choice to our patients, requires us to work with them to feel supported, and empowered to manage their own health. Telehealth provides patients with the confidence and control of their care and wellbeing, enabling safer and effective care to deliver better outcomes, whilst also generating efficiencies and added value through a more flexible use of our workforce. Locally we will re-commission our Telehealth service to provide a service that is fit for the future and that supports patient care based on an agreed pathway and aids clinicians to better manage patients. Our model will embed Telehealth further within primary and

community care through integration with Integrated Community Teams and Specialist Nursing Teams whilst exploring the role within discharge from acute hospital care.

Telecare in Gloucestershire is an established mainstream technology within our health and social care model. Over the next five years we will further integrate Telecare across our health and social care community as a tool to enable patients to live independently in their own homes, avoiding unnecessary hospital admissions and facilitating timely discharge from hospital. The local health and care community will take a holistic approach to the provision of assistive technologies embedding them within our Integrated Community Teams, in order to respond to individual care needs and promote technology in more households to increase self-care and support people to live independent lives.

#### 6.3.4.3 Care Pathways

Clinical Pathways are ***designed to support the implementation of clinical guidelines and protocols,*** providing structured, multidisciplinary plans of care including progress and outcome details. They provide detailed guidance for each stage in the management of a patient's specific condition over a given period of time. Care pathways provide support covering clinical management, clinical and non-clinical resource management, clinical audit and also financial management.

The Kings Fund defines pathways simply as follows:

> *"Pathways should spell out precisely what should be done and where the resources to do it are available."*

Where existing pathways appear to have failed it appears that they have focussed too much on the underlying clinical guidelines (which is often a reinvention of existing national guidelines which are already widely available), on clinical protocols (which are operational specifications developed by individual providers in order to implement care within their teams), and have not focussed on usability.

In effect they have not been “operationalised” (not designed to be operational tools). As we develop new pathways of care based on evidence and improving patient experience, we want to ensure that information is available to patients and to professionals to ensure these pathways are followed. Our vision is for an accessible system which can be easily kept up to date that ensures that pathway information is used routinely to ensure the right care in the right place at the right time.

Our objectives, therefore, are:

- To develop a county-wide consensus on the management of and support for specific conditions, which can act as a template for consistent care across the county and be referenced by all interested parties. This requires a standardised methodology to direct the development process so that in each case the same types of information is collated, with the relevant stakeholders involved in development;
- To publish the consensus view for all stakeholders and providers to see, ensuring in-house operational systems and the countywide pathway are aligned and agree a suitable online publishing medium;
- To develop a consistent approach to making information available to patients about their care, including Shared Decision Making;
- To help those at the point of care to deliver care in the agreed way, including referral criteria and supporting information. Although most providers will have their own in-house operational systems, our member practices do not have one and so we will have to provide this element.
- To monitor compliance with pathways and develop this as an educational tool to engage clinicians in delivering better quality care and understanding the reasons for and dealing with unwarranted variation

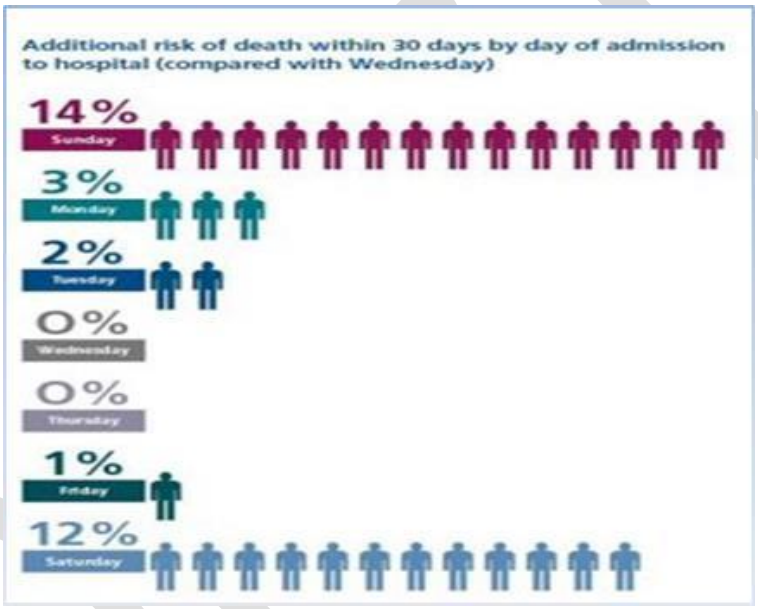
Adoption of a Gloucestershire approach to care pathways will ensure we realise the benefits from redesigning care. We will have a system which enables us to understand whether or not pathways are being followed and the outcomes we expected from the redesign are being achieved, these will include delivery of improved patient outcomes and expected financial benefits.

We will prioritise delivery of pathways dependent on their expected impact and likelihood of gaining consensus. Without this development, we will

struggle to realise the benefits of the clinical engagement being undertaken as part of the clinical programme approach.

### 6.3.5 Seven Day Services

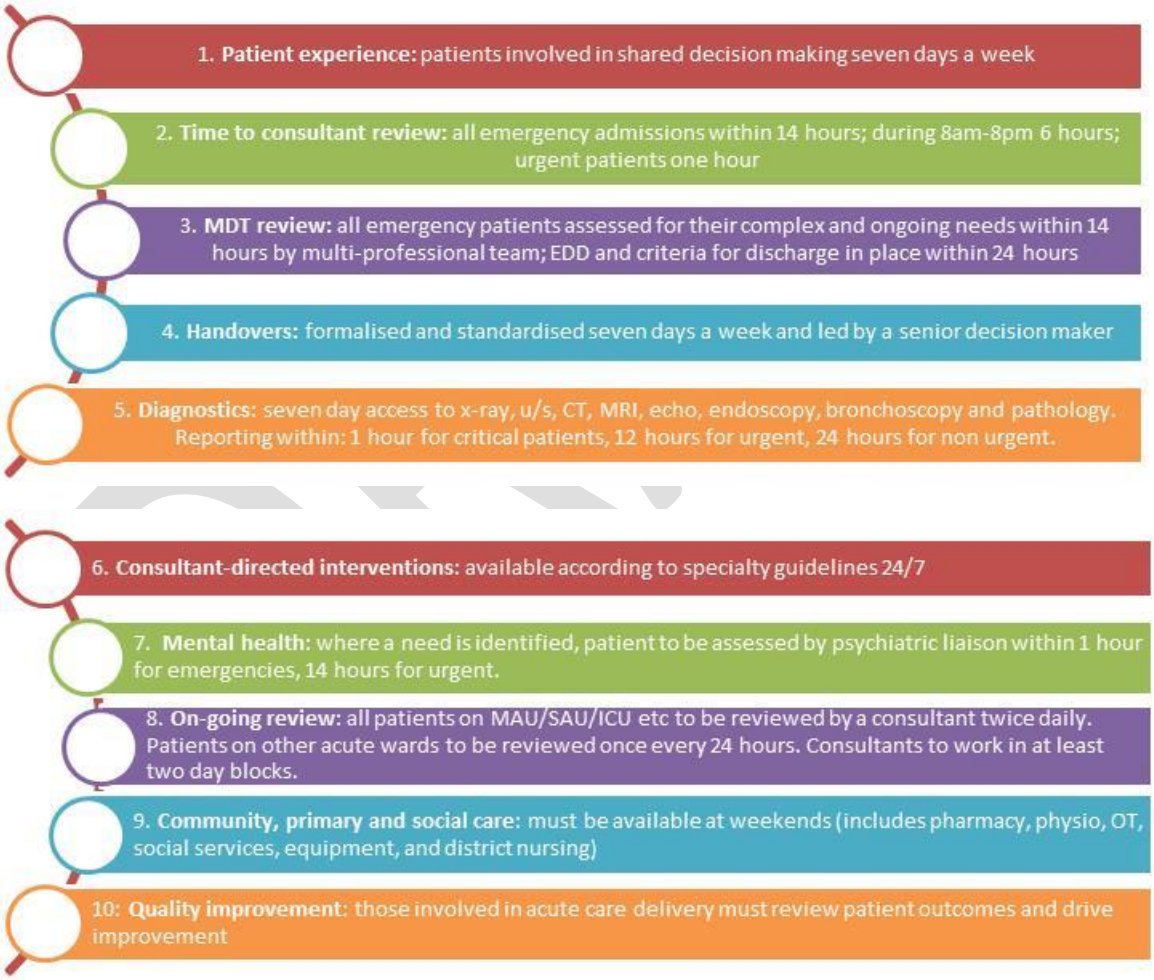
Considerable emerging evidence is showing significant variation in outcomes for patients dependent upon the day of the week they are admitted. Currently, at a national level, it is suggested that patients admitted on a Sunday are 14% more likely to die than those admitted during the week (as shown below), additionally these people have longer lengths of stay and a higher chance of readmission.




*Source: Royal Journal of Medicine Study on additional risk of death by date of admission*

Whilst it is difficult to replicate this data locally, we know in Gloucestershire patients admitted on Sunday stay in hospital on average a day longer than those admitted during the week. Based on the work of the 'NHS Services, Seven Days a Week Forum', we expect that the cause of weekend variation is multifactorial, such as staffing levels, fewer senior decision makers, consistency of support services (e.g. diagnostics) and the availability of community and primary care services (including social care). In order to address the variation and improve our patient outcomes we will work to ensure that appropriate routine services are available seven days a week,

acknowledging that this is not only focused within our hospitals, but across the whole system. We will initially focus on urgent care, reviewing our services alongside the ten Clinical Standards produced by the NHS Services, Seven Days a Week Forum to generate recommendations for priority action across our health and care community. The ten clinical standards to be implemented progressively during 14/15 up to 16/17 are outlined below. These standards cover acute, social, community and mental health care and so will require a community-wide implementation approach through this five year strategic plan with a clear link to each organisations service development plans and the Better Care Fund.




Building on this work, we will introduce measurable clinical standards bridging the entire health and care system that ensures equitable access to treatment for people regardless of the day of the week. This work will be led by the Deputy Chair of Gloucestershire CCG who will lead a multi-organisational group

looking at priority areas, evidence, and self-assessment information against these standards. This group will be responsible for piloting seven day services in key priority areas to understand the cost-effectiveness and challenges involved in this redesign. The group will also lead work understanding the cultural, logistical and operational challenges in moving to a seven day system including how different organisations will need to have a coherent approach across the county.

Seven day services will be a key focus across our local health system addressing not only in hospital care, but functionality within primary and community care to ensure a whole system approach to transformation.

***Susan's Story***

*"A short while after kidney surgery, I visited my GP with chest and back pain. My GP referred me to the Ambulatory Emergency Care (AEC) Unit for a chest X-ray and blood tests and I got the results within two hours. Because the tests were inconclusive, I was then given an appointment for a CT scan via the AEC. On both occasions, my experiences within the AEC were outstanding. I would rate the quality of care and timeliness of care as 10/10 and would recommend the service to my family and friends. For me, the AEC service 'stops people worrying' as assessment, diagnostic tests and care is carried out in a timely way."*

*Susan from Gloucester*

### 6.3.6 Consistent Primary Care Offer

As outlined in 'A Call to Action', the demand for primary medical care has increased over a number of years with patient consultation rates more than doubling and the length of consultations increasing. The increasing older population and prevalence of long term conditions means that primary care will need to adapt to new ways of working in order to remain sustainable into the future. We also recognise that the current system of in hours primary care, the out of hours service and the role of NHS 111 can result in services becoming fragmented and lacking co-ordination, sometimes resulting in patients being inappropriately directed to services that are not the most appropriate for meeting their health needs.

Our plan is to ensure:

- All Gloucestershire patients have easy access to high quality primary care;

- Access to urgent primary care will be simplified to avoid unnecessary use of emergency hospital care;
- Services should be jointly commissioned across health, social care and the voluntary and charitable sector with patients receiving the right service to meet their needs.

Covering a large population, primary care in Gloucestershire is delivered by 84 practices; varying in the size of practice and population they serve. We will ensure a consistent 'Primary Care Offer', whereby all patients living in Gloucestershire will have access to the full range of primary care services, including all of the enhanced services, from either their existing practice or another local practice.

A key part of our plan for primary care will be the development of a Gloucestershire Primary Care Strategy. The strategy will present the case for change and clearly outline the priorities for investment, including:

#### *6.3.6.1 Developing new ways of working in Primary Care*

We need to support GP practices to adapt and change to meet the increasing challenges, both in terms of patient demand, but also to remain sustainable as independent providers of primary health care. Innovative approaches to the provision of care will be fundamental to meeting the demand for primary care in the future, with a focus on empowering patients. Patients will understand more about their health and take more responsibility; this will require greater use of technology within primary care, for example email, text, and Skype. GP practices will be supported so that they can easily refer/signpost their patients to the very extensive range of voluntary services available and will be able to refer their patients with confidence that their wider social needs will be met.

Financial constraints and increasing patient demand will be fundamental drivers of change for GP practices. GP practices will be encouraged to maximise opportunities to collaborate with their neighbouring practices and local health providers to provide the full range of health services across a larger geographical area. GP practices will no longer have to provide all services at individual surgery sites; instead collaborative working will create

efficiencies. Technology will play a pivotal role for different ways of delivering and supporting joined up working across the community.

The strategy also includes a focus on primary care workforce; the CCG will work with GP practices, the Deanery and NHS England to develop this. High quality training and skill mix development is vital for a sustainable primary care service and this will only be achieved through joint working.

### *6.3.6.2 Develop improved integrated out of hospital care, 7 days a week*

We need to develop an out of hospital care model around the seven localities within Gloucestershire. The localities are natural communities and provide opportunities to deliver integrated out of hospital services close to people's homes. Primary care will be regarded as central to the wider out of hospital system of care with person-centred care delivered close to people's homes. It will provide clearly recognisable out of hospital services, not only to the patients but also the whole health and care community; this will require joint commissioning to ensure an integrated approach across all organisations. This will bring more care closer to people's homes, shifting activity from acute hospital care to primary care where it is evidenced, safe and appropriate to do so.

As outlined within the Better Care Fund flexible provision over seven days will be accompanied by greater integration across our services; our GP practices will collaborate in networks focused on populations within given geographies, with community, social care services and specialist provision organised to work effectively with these networks which are known as Locality Executives. A core focus will be on providing joined-up support for those individuals with long-term conditions and complex health needs and will inherently link across our priorities in primary care.

The interface between GP in-hours and GP out of hour's services needs to be managed more effectively with clear accountabilities for patient care clearly defined and understood. GPs have a key role in ensuring the out-of-hours service and other community services are co-ordinated to ensure more integrated care for people. Fundamental to the delivery of the strategy is to ensure the resources are utilised across the system. Within primary care this

means a focus on the delivery of integrated seven day working and a further focus on supporting the urgent care priorities, particularly with the elderly. In line with the demographic challenges presented earlier in the document we will ensure better joined up care for high risk vulnerable patients; with primary care continuing to provide the crucial co-ordinating role, identifying high risk patient groups (supported by the use of a risk profiling tool) which would benefit from an enhanced primary/community care response to avoid unnecessary admissions to hospital.

Relationships between GP practices, community teams, local voluntary organisations, and GP out-of-hours providers will need to be developed at a locality level to ensure continuity of care for people, with them all actively striving towards improving communication and co-ordination. The effective sharing of records between the professionals involved in the care of an individual, including social care across pathways will help enable the continuity of care.

#### *6.3.6.3 Primary Care Offer Enhanced Service*

Additionally the importance of Enhanced Services within primary care remain our focus, with the ongoing review of Enhanced Services to ensure services commissioned are effective allowing funding to be released to those with the best evidence of efficacy; as a result we have developed a new Primary Care Offer Enhanced Service. This has been co-produced by local GPs and Practice Managers with a clear focus on quality improvement as well as supporting innovation within primary care. The development of the new Enhanced Service has been undertaken in conjunction with local GPs and Practice Managers. This co-production approach has been well received and the final specification has been supported by Area Team (NHS England), Local Medical Committee and CCG Locality Executive Groups. The enhanced service will be available to all GP practices within Gloucestershire and comprises of four building blocks; this approach was taken to help identify clearly the added value of each element to our strategic objectives:

- Building Block One: Improving Quality in Primary Care
- Building Block Two: Enhanced Primary Care

- Building Block Three: Supporting the Urgent Care Agenda
- Building Block Four: Influencing Clinical Commissioning

As a result of our priorities we expect:

- Improved quality in primary care by reducing unexplained variation – using primary care benchmarking data to highlight outlier GP practices and seeking explanation on the variation. Developing actions plans to reduce variation where appropriate;
- People have access to the full range of core and enhanced primary care provision, wherever they live in Gloucestershire. This could be delivered by individual GP practices or an intra-practice working model where GP practices join together to provide the wide range of services for patients;
- New Care Pathways – This means making it clear where and when and by whom a person should be seen depending on their condition. It will improve continuity of care and reduce duplication with professionals working closer together to coordinate the persons care;
- Patient Experience – listen to, understand and respond to patient experience to help inform commissioning decisions;
- Developing a Patient Charter within primary care that explains the Primary Care Offer and how patients should access NHS services to meet their needs. This will also be used as an educational tool to explain the wide range of NHS services and when and how they can be accessed;
- Development of a local Carers Charter to be implemented across all GP practices – recognising the vital role of carers in supporting the vulnerable and high risk patients;
- Joint planning between localities and Local Authorities/Public Health, identifying the joint priorities and working together to best effect – refreshed Locality Development Plans in place across all seven localities;
- Working collaboratively with local GPs and County/Borough Councils to develop new ways of maximising the use of wider Voluntary and Community services (social prescribing).

### 6.3.7 Medicines Optimisation

Effective medicines use is a cross cutting theme relevant to all five of the key domains of the NHS Outcomes Framework alongside the five most cost effective interventions recommended by the National Audit Office on health inequalities, reflecting the central importance of medicines in delivering healthcare benefits to patients.

The aim of the medicines optimisation approach is to ensure that the right medicine is prescribed to the right person at the right time in the right formulation, whilst ensuring that prescribing is as safe, clinically effective and cost effective as possible. Medicines account for a significant proportion of community spend, representing approximately 12% of Gloucestershire CCG's total budget, with further spend in partner organisations.

Increases in prescribing will continue to be driven by proactive identification and management of long term conditions, together with our aging population. As per NHS England forecasts, associated prescribing costs are expected to increase by approximately 5% per annum.

There is an increasing recognition within the NHS that an effective medicines management strategy needs to extend beyond simple prescribing savings measures, to also include a focus on more patient centred medication management issues, as well as the need for supporting further improvements in medicines safety. The term 'medicines optimisation' is increasingly being used to represent a more holistic approach to achieving the maximum benefits and value for money from medicines use within the NHS, whilst minimising the associate risks.

We will maintain the focus for medicines optimisation through five areas:

1. Utilise national current best practice principles to maximise clinical effectiveness and cost effectiveness.

2. Medicines optimisation will be a central element in the development of integrated care pathways and the review of care pathways, ensuring that appropriate clinically evidenced medicines are recommended for use.

Increases in prescribing costs can sometimes be required to reduce total pathway costs, for example use of oral anticoagulants for people suffering from Deep Vein Thrombosis.

3. Work collaboratively across the health and care community to maximise clinical and cost effective medicine use, for the benefit and convenience of the patient i.e. through the joint formulary.

4. Maximise safe medicines use by the development of primary care initiatives to identify areas where safer medicines use could be achieved and support the local implementation of associated actions. Medicines safety improvement is specifically referred to in the NHS Outcomes Framework and can result in avoidance of medicated related admissions.

5. Reduce the amount of wasted medicines in Gloucestershire. Working with colleagues in the Gloucestershire health and care community, and local Community Pharmacists, to ensure that people receive the maximum benefit from the medicines they have been prescribed.

### 6.3.8 Workforce Strategy

Our strategic plan sets out the scale of the challenges facing the NHS in Gloucestershire and our ambitious programme to deliver sustainable change. Central to delivery will be ensuring that we have the right numbers of staff with the right skills, located in the right places to provide high standards of care to all of our patients. Our overarching workforce strategy is still under development under the leadership of the Gloucestershire Strategic Forum, a group where leaders from the commissioning group, council and provider organisations meet to share ideas and lead work on key strategic issues.

### 6.3.9 Specialist Regional Services

Our vision for patients with complex or rare health needs is that they should always receive the highest quality specialised care which should be seamlessly joined-up with all other aspects of their care, regardless of whether they are accessing local, regional or national specialised care.

Our approach is to work collaboratively, with co-commissioners in NHS England and other health and social care partners, to:

- Ensure all patients receive high quality care in line with the new National Service specifications for specialised care;
- Build well integrated pathways of care;
- Improve sustainable use of resource, including encouraging a shift of focus towards prevention to reduced specialised service demand;
- Uphold local accessibility as an important criterion, especially for patients with long-term conditions or extended periods of treatment;
- Ensure that any review or reconfiguration of service provision is based on clear clinical evidence and with full involvement of patients, public and stakeholders;
- Contribute to promoting innovation and research to improve patient care.

We are also committed to the principles of strong clinical involvement and maintaining a wider-system view. We have established a clinical programme approach with active groups formed to give a 'whole pathways' view for key health priorities. Our clinical programme groups provide a strong framework for supporting good integration of pathways, which may be supported by a number of different commissioning organisations. Our approach to collaborating on specialised commissioning will have significant benefits to improving quality and outcomes. For example in order to prevent people dying early the work of our Cancer Clinical Programme Group (CPG) is a supporting a three-year primary care Early Diagnosis programme. Our goal is to improve health outcomes for patients, but also to reduce some of the requirement for complex and invasive treatments. We will therefore be working with specialised services commissioning colleagues to understand how this transformative shift can be sustained.

We welcome NHS England's consultation on the development of a five-year strategy for specialised care and are preparing to actively contribute to Area Team and national events. We recognise the objective of concentrating care in 15-30 specialised centres, however there is a need for significant additional

work on the service-level planning to understand what this means and how this will be implemented in areas outside large conurbations, recognising the tension between improving the quality of care and the distances that patients will need to travel.

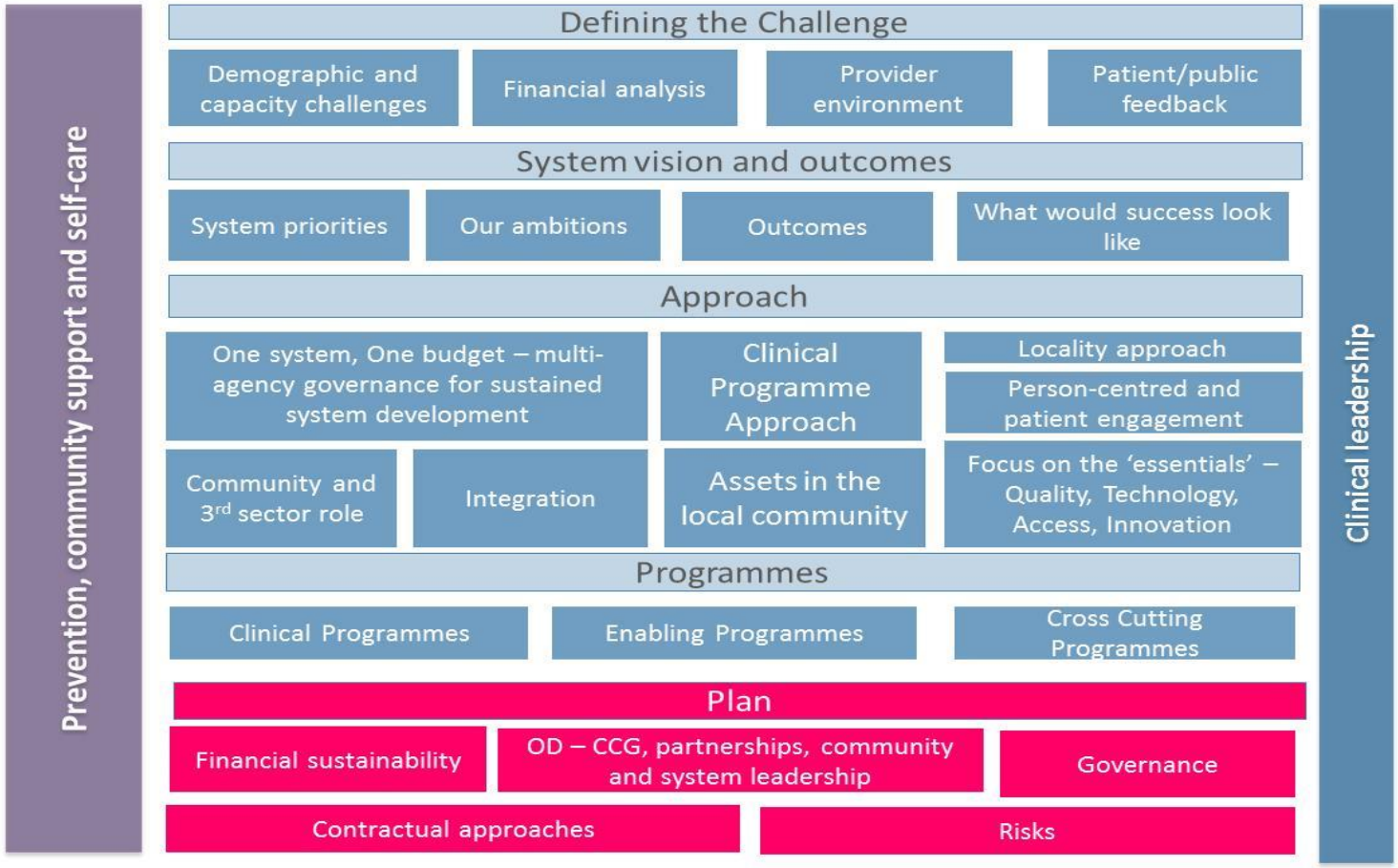
Our strategic approach to collaborating on specialised commissioning will also maintain the sustainability of the clinical teams that serve our local population. Many clinical teams provide a mix of general, complex and specialised care. Our CPGs will therefore pay attention to any specialised reconfiguration proposals that could destabilise the local provision of general services.

We support the value of active programmes of research and teaching in supporting clinical excellence. Our CPGs have an important role in cohering horizon scanning and facilitating innovation for our local health community and building wider engagement with Strategic Clinical Networks and Academic Health Science Networks.

Gloucestershire has a geographical position on the border of two specialised commissioning regions with significant patient flows in both directions. In the interests of our population we will take an active role in facilitating broader development dialogues when required over the next five years.

## 7. Delivery Plan

In this section of the Strategy we outline when will we deliver our strategy and what structures we have in place to support its delivery.



In this section of the Strategy we describe:

- A high-level plan for the delivery of our strategy
- Financial sustainability
- Governance
- Contractual approaches
- Our Organisational Development Plan and intentions
- Risks

## 7.1 High-level Plan

We have a detailed plan for the delivery of our strategy in years one and two (Operational Plan) and the plans for our later years will be developed as we evolve and the information available to make meaningful plans becomes available. We have, however, provided an outline of how our programmes progress over the life of this strategy below.

## 7.2 Financial sustainability

The Gloucestershire Health Community has a stable financial position and this has put the health community in a good position in terms of planning for the next five years. The position of the health community to be able to continue in a financially sustainable way over the planning period will be dependent on the ability to work jointly together and alongside other partners, such as the Local Authority, to deliver the transformational change that is needed to deliver the savings required. The savings, including provider savings, total just under £200m.

The five year financial framework sets out financial plans to enable delivery of all national and local targets and underpins the five year strategy. The impact of the Better Care Fund has been included within the financial plans.

### 7.2.1 Five Year Financial Plan: Investments

The planned investments are driven by the programmes within the overall strategy and focus on the key themes within the strategic plan around care closer to home, changes to the urgent care system, self-management and social prescribing. To support this strategy, the CCG will progress investments in community care, primary care, ambulance services, 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 five years. Investments also cover anticipated costs of new drugs, including NICE technology appraisals, technology, quality initiatives across providers and funding for seven day services across all sectors

Within its financial plan the CCG has set aside a proportion of its recurrent allocation to be used non-recurrently to support service transformation within Gloucestershire. In 2014/15 this represents 2.5% of the allocation which reflects the magnitude of the change required in the first two years of the five year plan to deliver the savings required including the requirements of the Better Care Fund. The monies will be used to fund:

- double running costs during a transition phase;
- the cost of fixed term pilots ;
- non recurrent costs required to enable service models to change;
- exit costs for services.

### 7.2.2 Financial Planning Assumptions

#### 7.2.2.1 Allocations

The CCG receives two financial allocations from NHS England, a programme allocation and a running cost allocation. The programme allocation funds all expenditure on health care services, the running cost allocation funds the cost of the CCG. The table below sets out the baseline allocations anticipated for

the next five years (excluding the return of prior year's surplus and the Better Care Fund).

| | 2013/14 £m | 2014/15 £m | 2015/16 £m | 2016/17 * £m | 2017/18 * £m | 2018/19 * £m |
|---|---|---|---|---|---|---|
| **Programme Cost Allocation** | 653.538 | 667.524 | 678.872 | 691.092 | 702.840 | 714.789 |
| **Programme Allocation Growth** | | 2.14% | 1.7% | 1.8% | 1.7% | 1.7% |
| | | | | | | |
| **Running Cost Allocation** | 15.090 | 15.053 | 13.535 | 13.523 | 13.513 | 13.504 |
| **Change in running cost allocation** | | -0.25% | -10.08% | -0.09% * | -0.07% * | -0.07% * |

** Allocations for these years are not yet known, allocations for these years are based on planning guidance from NHS England*

Running cost allocations were set at £25 per head of population for 2013/14. For 2014/15 and 2015/16 these amounts will be £24.73 and £22.07 respectively. It has been assumed in the plan that the running cost allocation will be in line with the indicative figures published by NHS England on 31st January 2014.

#### 7.2.2.2 Other Planning Assumptions

The CCG's five year plan includes the following planning assumptions which include those detailed in the NHS England guidance.

| | 2014/15 | 2015/16 | 2016/17 * | 2017/18 * | 2018/19 * |
|---|---|---|---|---|---|
| Headroom fund for non-recurrent costs including cost of change | 2.5% | 1% | 1% | 1% | 1% |
| Surplus requirement | 1% | 1% | 1% | 1% | 1% |
| Operational/Contingency Reserve | 1% | 1% | 1% | 1% | 1% |
| **Provider Contracts:** | | | | | |
| Acute Inflation | 2.6% | 2.9% | 4.4% | 3.4% | 3.4% |
| Non Acute Inflation | 2.2% | 2.9% | 4.4% | 3.4% | 3.4% |
| Provider Efficiency | -4% | -4% | -4% | -4% | -4% |

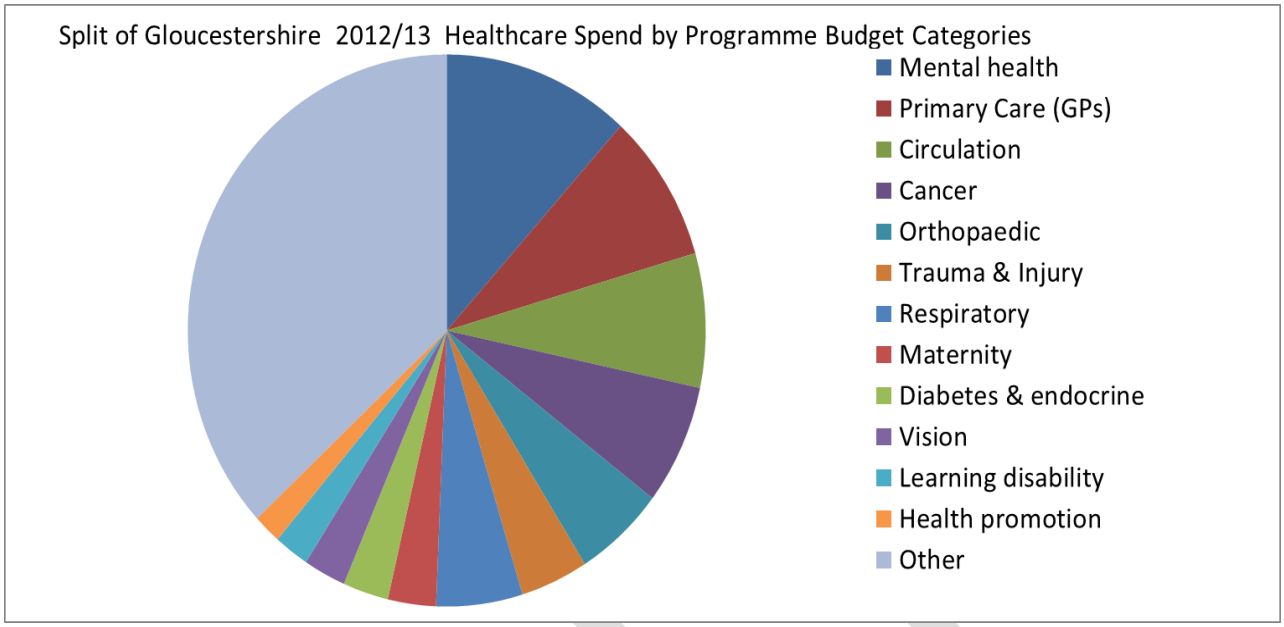
*-percentages for these years are based on planning guidance from NHS England

| | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|---|---|
| Demographic & demand growth | 2.2% | 2.1% | 2.4% | 2.5% | 1.4% |

The CCG has excluded the quality premium from its strategic plan because the annual value that the CCG will receive is not known. Funding received from the quality premium will be applied to initiatives improving quality across the whole system.

### 7.2.3 Where Do We Spend Our Money

The split of expenditure between our priority clinical programme groups is shown in the pie chart below.




*Source: GCCG analysis of programme budgeting data*

During the last year the CCG has benchmarked its expenditure, starting with programme budgeting analysis and outcomes against other CCGs with a similar population. This has identified areas where we spend more money for the same, better or worse outcomes; these are the key areas of focus for a part of the CCG's strategic plan.

### 7.2.4 Better Care Fund

The Better Care Fund (BCF) was announced in the summer of 2013 as a mechanism to transform local services so that people are provided with better integrated care and support. The 2015/16 fund for Gloucestershire is made up as follows:

| Gloucestershire Position | 2014/15 £000s | 2015/16 £000s |
|---|---|---|
| Social Care Capital Grant | | 1,409 |
| Disabled Facilities Grant | | 2,550 |
| Existing Funding Transfer | 11,596 | 11,596 |
| New Funding Transfer | | 24,393 |
| **Total Fund** | **11,596** | **39,948** |

These monies are not new monies and in order to release monies for investment into the Better Care Fund the savings schemes within the strategic plan must deliver the transformational changes. Within Gloucestershire, there is a transfer of funds of £35,989k from the CCG into the BCF in 2015/16. The Better Care Fund will continue the commitment to integrated care within Gloucestershire. In addition to this, the CCG and the Local Authority have a number of Section 75 and Section 256 agreements. Over time, we will review the fund, alongside existing partnership agreements, and look to see whether to create a larger Better Care Fund. The key priority is to deliver the initial aims within the Better Care Fund across the health and social care pathways to reduce the overall pressure in both these systems.

### 7.2.5 QIPP and CRES

In order to remain within its financial allocation and deliver the surplus requirement the CCG has to make QIPP savings of circa £85m over the next five years. Inherent within the commissioner financial plan is an annual 4% tariff deflator on all provider contracts.

| | 2014/15 £m | 2015/16 £m | 2016/17 * £m | 2017/18 * £m | 2018/19 * £m |
|---|---|---|---|---|---|
| **Commissioner QIPP** *(lower range)* | 18 | 21 | 17 | 15 | 15 |
| | | | | | |
| **Provider Efficiency (estimated)** | 19 | 20 | 20 | 20 | 20 |

This represents a significant financial challenge to the health community.

The five year strategy identifies our priorities to ensure we can deliver the commissioner QIPP gap, with further detail on 2014/15 and 2015/16 held within our implementation plan.

### 7.2.6 Management of Financial Risk

The key risks identified within the financial plan are:

- Demographic growth exceeds planning assumptions;
- Demand for services (additional to demographic growth) exceeds planning assumptions for both elective and non-elective care;
- Changes to the CCGs allocation with specialist commissioning are cost neutral;
- QIPP plans do not deliver the planned changes within the timescales;
- New drugs come onto the market, including NICE Technology Appraisals, in excess of the amounts set aside within planning assumptions.

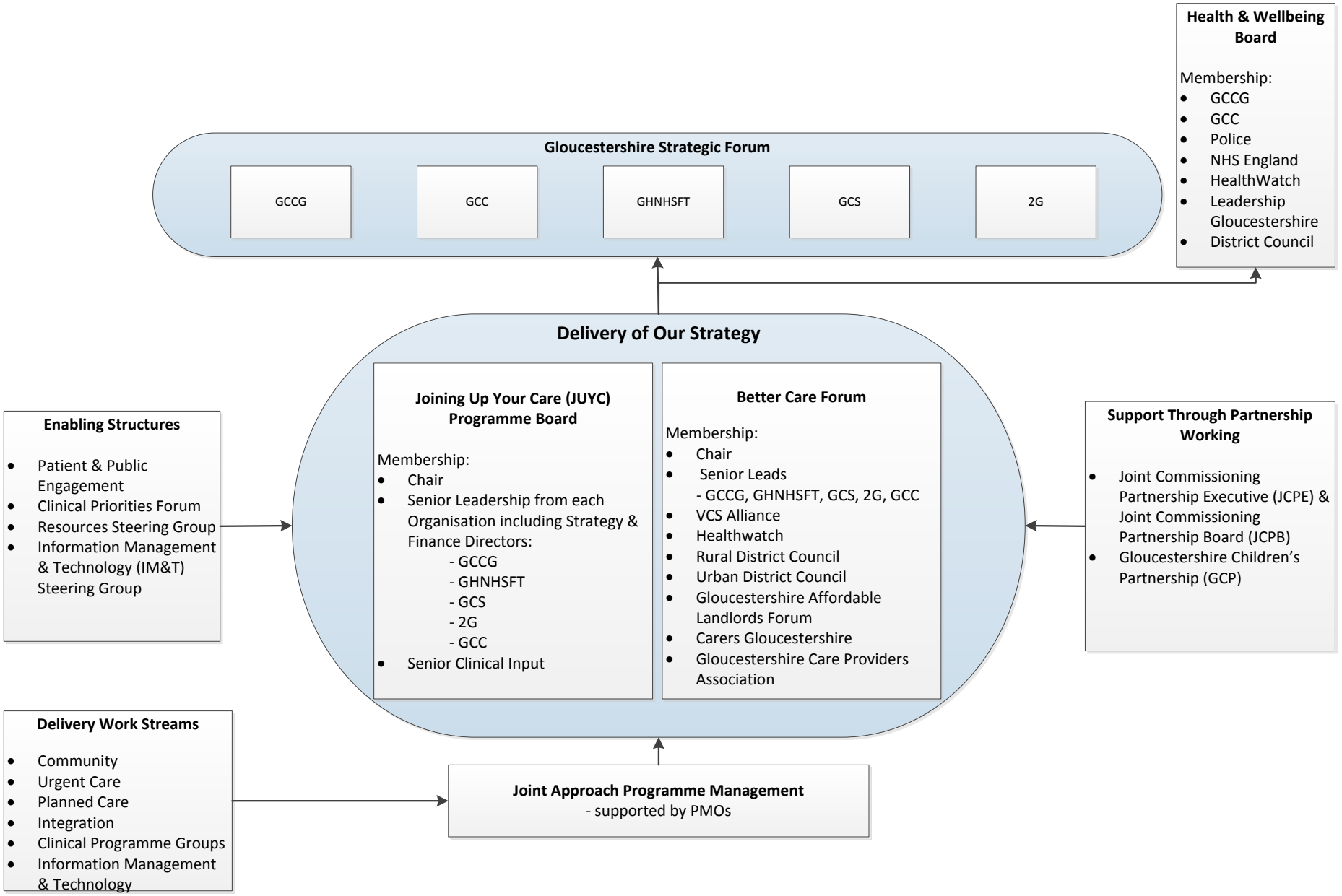
Key mechanisms to manage financial risk are:

- The CCG will hold a minimum of a 1% activity and contingency reserve each financial year;
- Collaborative working with other commissioners to ensure that plans are coterminous minimising overall risk and taking advantage of joint opportunities;
- Robust contract management will include the application of national incentives and penalties to help deliver the performance targets and also the changes in year;
- Adherence to the CCG's financial management framework;
- Regular reviews of best practice elsewhere to inform an ongoing programme of change.

### 7.3 System Governance

In order to deliver the wide scale system change as outlined in the strategy, the governance builds on the existing health and social care community framework. As agreed as part of the development of YHYC, much of the integrated infrastructure is in place to support delivery of the work programme with some minimal amendments to take account of the Better Care Fund and expanding scope from YHYC to include Children's services.

The proposed structure is shown in the diagram below (fig. 6), providing a summary of the main groups, the responsible chair and representation of groups which are new to the governance framework.




## Figure 1 Gloucestershire Governance Roadmap

The governance is well established, and has been utilised for the delivery of system wide changes including the YHYC strategy for adults and older people.

Key points to note regarding the governance arrangements are:

- The entire structure represents integrated forums for the health and social care organisations to work together.
- The Terms of Reference for all the groups will be assessed to ensure clarity of decision making and advisory authority in relation to the key strategic components of the plan.
- Integrated delivery groups will be in place to support the various programmes of work; and will be accountable for designing, implementing, programme and performance managing the individual programmes and projects. The proposed delivery group will maintain oversight at a community level.

In evaluation of the current work programmes the following amendments to the governance are proposed:

- The introduction of a Better Care Forum to include the voluntary sector and Health Watch to lead on discussions regarding the Better Care Fund;
- The introduction of a joint approach to programme management (therefore dividing the responsibilities of the current YHYC programme board into a JUYC strategic discussion and delivery of the implementation plans). This encapsulates a change of scope, expanding the role to have oversight of all community strategies including JUYC;
- Underpinning the governance structure is the assumption that internal organisational decision making and governance exists beneath the integrated layer, for example commissioner initiated schemes will be sponsored by CCG members prior to forming part of an integrated work plan.

## 7.4 Contractual Approaches

The types of contracts available to us are a key enabler of the delivery of this strategy and whilst the contractual discussions between commissioner(s) and provider(s) remains within a formal structure outside of the strategy governance, the strategic plan supports the development of contractual approaches to support delivery of the large scale system change presented. Of the transformational approaches that can be taken to care pathway commissioning, the main two for consideration in Gloucestershire are summarised in the table below:

| Approach | Benefits | Considerations | Pricing approach |
|---|---|---|---|
| **Lead Contractor** Contract with provider who is responsible for management and delivery of whole care pathway. This provider may not be largest provider in pathways but focuses on delivery | - Reduced inefficiency<br>- Improved pathway coordination<br>- Commissioner has one contract to manage | - How will patient choice be supported<br>- Commission retains accountability for services commissioned, but is reliant on prime contractor holding subcontractors to account | - Risk share<br>- Gain Share<br>- Exploration of different funding models, applying nationally developed principles for different contracting models |
| **Alliance Contracting** Separate contracts with individual providers but with shared objectives | - Reduced inefficiency<br>- Improved pathway coordination | - Relies on strong working relationships between providers<br>- Need to be clear about where responsibility for delivery lies. | - Risk share<br>- Gain Share |

It will be clear that no one size fits all model could be deployed, and each programme area considered for an alternative approach to contractual models

will be assessed in its own right. Alongside innovative approaches to contractual models, the community will continue to ensure the NHS Standard contract is utilised to support commissioning of the changes with specifications clearly moving the community to a more outcome approach to patient care.

Innovative approaches to contractual solutions is core to our Better Care Fund plan, within which a key element in delivering our vision will be to develop specific service plans for the organisation of integrated care across primary, community, hospital and social care that adopts the principle of 'one system-one budget' and where providers of more integrated services 'work together and respond together'

- To develop a shared vision of the service and to change staff's mind-set and approach to care to ensure it is focused on each individual person and works across organisational and professional structures
- To explore and agree new contract forms to reward and incentivise integrated working
- To ensure pathways underpin integrated working and eases the path for people accessing services
- To move towards a single service model that breaks down silos and barriers to teams and services working together for the best outcomes for local people and communities, without the need to spend time on creating formal new organisations

We recognise that we need to ensure there is sufficient leadership and support available to facilitate and drive forward the change and transition challenges involved.

### 7.5 Organisational Development

We have a strong culture of organisational development at Gloucestershire CCG and have a robust plan in place to build our capability to deliver our ambitious vision. Our plan focuses on:

- Building strong clinical and multi-professional focus to add real value

- Developing meaningful engagement with patients, carers and their communities
- Development of a joint approach to service redesign and the delivery of change
- Establishing clear and credible plans which continue to deliver the QIPP challenge
- Forming proper constitutional and governance arrangements and capacity and capability to deliver
- Working collaboratively with our health and social care partners to co-commission
- Developing great leaders who individually and collectively can make a real difference

We are also focusing on undertaking the following tasks to build our capability to deliver:

- Raising awareness of the Clinical Programme Approach, with a focus on enabling patients to take control of their own care.
- Appointing clinical/managerial leads for each programme area
- Engaging with member practices to ensure that our programmes have a deep clinical perspective

Our Organisational Development Plan will be refreshed on a regular basis to make sure we stay abreast of our development challenges, the environment we need to work in and respond to and the strengths of our staff and stakeholder teams.

### 7.6 Risk Management

There is an existing governance structure in place across the Gloucestershire health community, building on an integrated infrastructure embedded as part of the development of YHYC. The responsibility of monitoring risk with regard

to our 5 year strategy will sit with the Strategy Group who will report by exception to the Gloucestershire Strategic Forum. A risk register is in place which collates strategic, organisational and programme risks (as appropriate); with routine updates in place.

In relation to the five year strategy the following risks and mitigating actions should be noted:

| Key Risk | Level of Risk | Mitigating Action |
|---|---|---|
| The organisation is not able to deliver the transformational programme required to achieve financial balance in each year. | **M/H** | Transformation programme to be agreed across the health economy to enable buy in and delivery. Robust financial planning to include scenarios which take into account risks to delivery and mitigating actions to deliver financial balance. Programme Management Office will need to keep tight control on the various programmes of work and their sequencing to ensure delivery of benefits to enable further change to take place |
| The economic outlook for commissioning partners is very tight and decisions made by these organisations could have a negative impact on the CCG's plans. | **M/H** | Joint working between the CCG and commissioning partners to be further strengthened and joint work across systems to enable benefits to be realised by all partners |
| The impact of the Care Bill is not yet known but estimates are higher than originally anticipated which will impact on the Local Authority and the BCF and, thus, the CCG's own financial position | **M/H** | Financial modelling is being undertaken by the Local Authority to be shared across partners in order that the impact can be assessed and planned. |

| Key Risk | Level of Risk | Mitigating Action |
|---|---|---|
| The workforce required to deliver changed services is not available either through numbers of specific staff groups or in terms of changed skill sets | M/H | Workforce planning to model the impact on specific staff groups will be undertaken within the health economy to ensure a realistic assessment in relation to workforce is in place. Links to Health Education England will also be developed to influence the overall workforce training and development programme. |
| Specialist commissioning's five year plan impacts on services within Gloucestershire and destabilises local services moving care further | M | Work jointly with specialist commissioners to assess impact of specialist services strategy on non-specialist services and to then work jointly to ensure that key services remain within Gloucestershire |
| NHS Constitution targets are not delivered sustainably with increased pressure on provider financial positions | M | Commissioning of services will continue to include careful monitoring of performance and identification of early warning signals of any deterioration in performance to enable action to be taken promptly |
| Benefits and risks are not equally shared across partner organisations or stakeholders leading to a focus on individual organisational priorities. | M | Gloucestershire have developed a health community led strategy and will ensure that the strategy delivers positive benefits and outcomes for each organisation; we will ensure that they dovetail with organisational priorities and existing work plans. |
| Ability to balance resource for individual organisational priorities and collaborative working priorities compromised, especially through periods of significant transition. | M | Regular engagement with key groups to ensure that they understand the changes that will happen as a result of the strategy will be supported by the system leadership across the health community. |

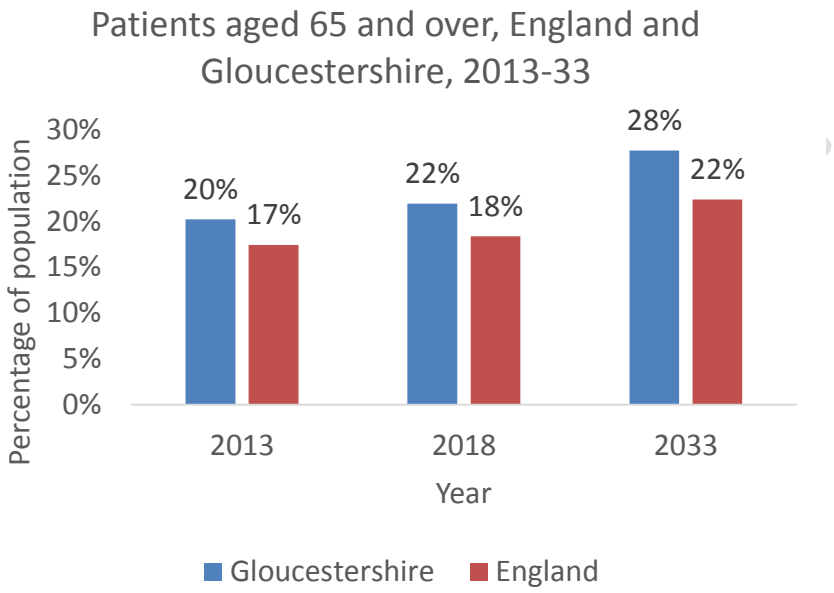
| Key Risk | Level of Risk | Mitigating Action |
|---|---|---|
| Different business and contractual models are not agreed. | **M** | Early discussions taking place regarding options for change. Models linked to ensuring delivery across all partners. Ensuring stakeholder sign up to key deliverables and outcomes. |
| The significant shifts in the shape of service provision fail to gain sufficient public and political support, leading to a failure to achieve the objectives set out in the strategy. | **L** | Extensive patient and public engagement exercise JUYC launched to outline areas for consideration that form our strategy. System leadership identified across health community and with key stakeholders. |
| Individual and organisational learned behaviour does not adapt to new to ways of working, leading to a negative reaction to the change and a breakdown of programme delivery. | **L** | Health & Social Care leaders to ensure engagement and transparency with staff groups across their organisations. |

## Annex 1: Public Health Information

### Ageing population leading to increased demand for health services:

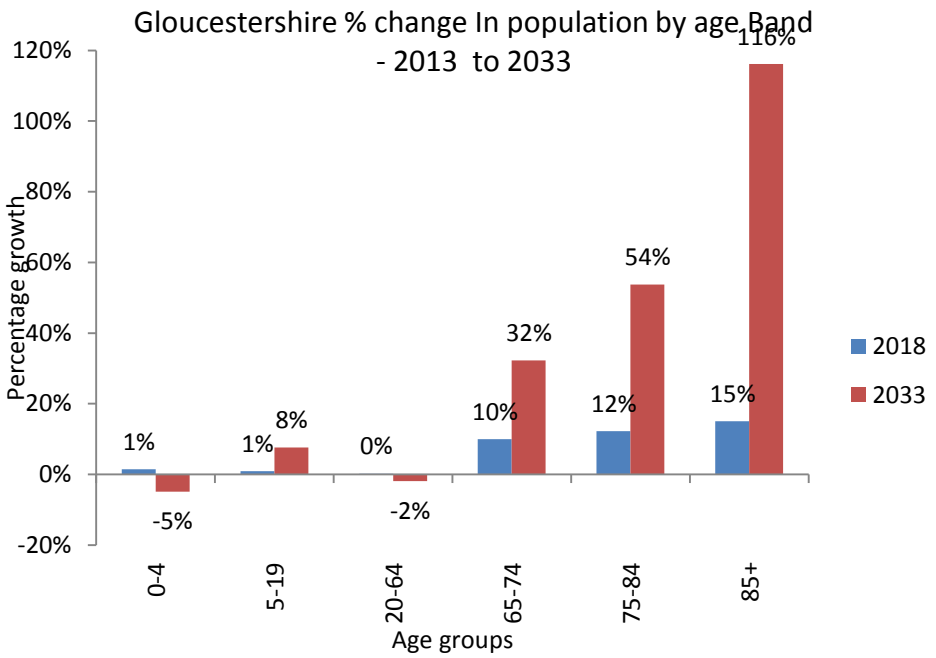
Rising life expectancy means that the already significant proportion of the population in Gloucestershire over 65 years old is increasing rapidly.

Between 2001 and 2011, the growth in those aged over 65 outpaced that of younger age groups and grew at a faster rate than for England as a whole. In the future, the population in Gloucestershire aged 65 and over is predicted to continue to grow at a faster rate than the rest of the country - over 65s will represent a quarter of the population by 2018 and almost a third by 2033.



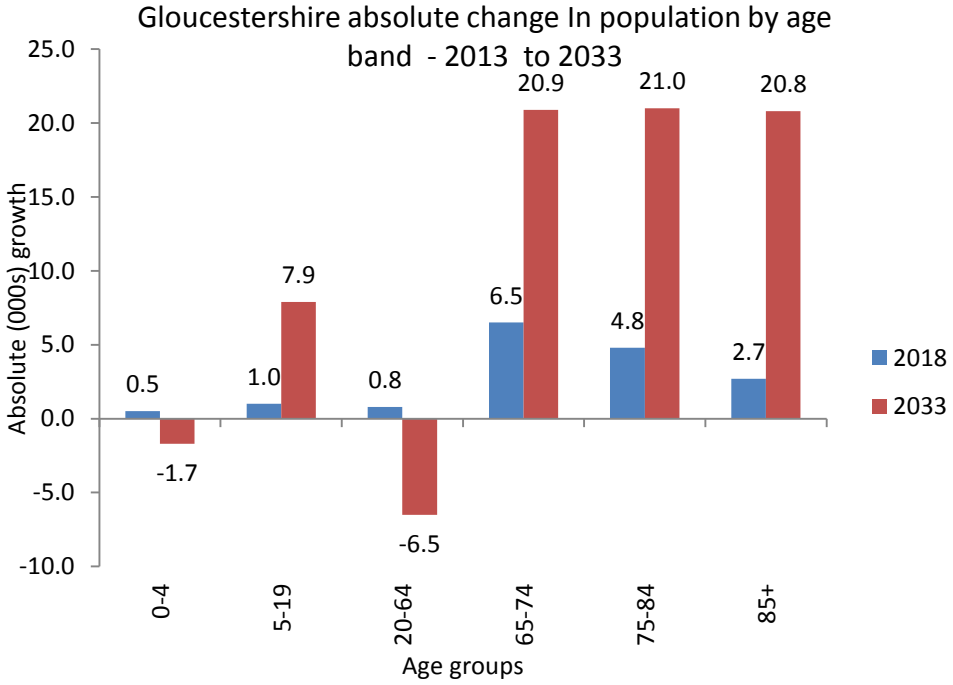

*Source: GCCG analysis of census data*

This growth is increasing fastest in the oldest age sub-group; those aged 85 and over, with a predicted growth of 15% to 2018 and 116% to 2033. Notably projected growth in 20-64 year olds is only 0.2% to 2018.




*Source: GCCG analysis of census data*

However, this percentage growth masks a fairly uniform absolute growth in the three over 65 age groups by 2033 – an extra 20,000 people will be in these age groups by this time. By 2018, there will be an additional 14,000 over 65s in Gloucestershire.




*Source: GCCG analysis of census data*

### Increasing levels of LTCs/multiple conditions:

An ageing population undoubtedly presents challenges for the health and social care system; although people are living longer, the additional years are not necessarily spent in good health. As life expectancy increases, so will the number of people who will live with a long term health condition that limits their lifestyle. The number of people in Gloucestershire aged over 85 with their day to day activities limited significantly by long term illness and disability is predicted to rise by over a quarter by 2021[7].

Currently it is estimated that 47,500 people over the age of 65 are living with a long term health condition in the county. This is projected to rise to 77,001 in 2030.

The most common significant health problem in those over the age of 80 living in the South West is heart disease, followed by diabetes and stroke. In 2012/13 there were:

- 10,199 patients in Gloucestershire on the Chronic Obstructive Pulmonary Disease (COPD) register;
- 19,963 patients on the register for Coronary Heart Disease (CHD); and
- 30,682 people on the diabetic register.

Nationally, care of people with long term conditions accounts for 70% of the money spent on health and social care in England.

### Under-diagnosis:

Actual prevalence of long term conditions is likely to be higher as some individuals will remain undiagnosed. For example, it is estimated that nationally there are around two million cases of undiagnosed COPD; with 10% of people only being diagnosed when they present to hospital as an emergency.

According to Quality Outcomes Framework (QOF) data since 2009 the county prevalence of COPD and CHD has been relatively stable; however the county is seeing an increase in the prevalence of diabetes.

[7] Understanding Gloucestershire, A high level analysis of need in Gloucestershire, 2013

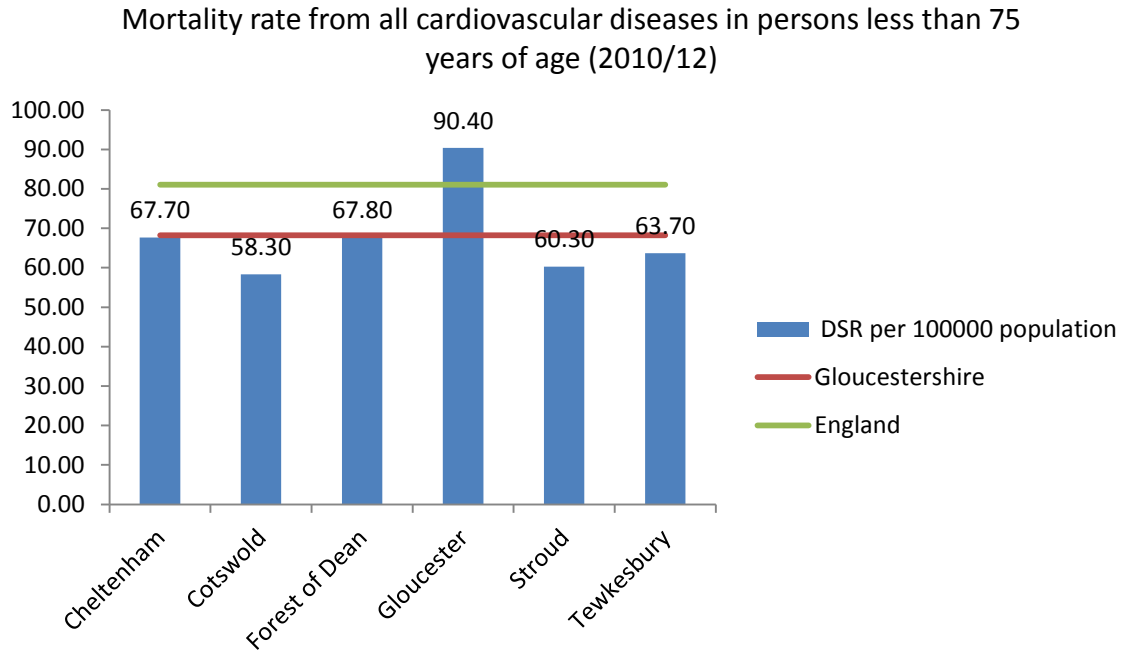
County uptake of the NHS Health Checks programme, which can assist with the early identification of cardiovascular disease in primary care in those aged 40-74, was 37.8% (2013/14). This is below the national average of 48.1%; indicating scope for improvement.

The ageing population is also a factor in the rising number of dementia diagnoses in the county. QOF data shows that there are currently 4421 patients registered with dementia; however national studies suggest that only around half of dementia cases are diagnosed and as such the actual number is likely to be significantly higher. Nationally, dementia prevalence is estimated to be 20% in those aged 80. Currently around 28% of adult social care users in the county have dementia.

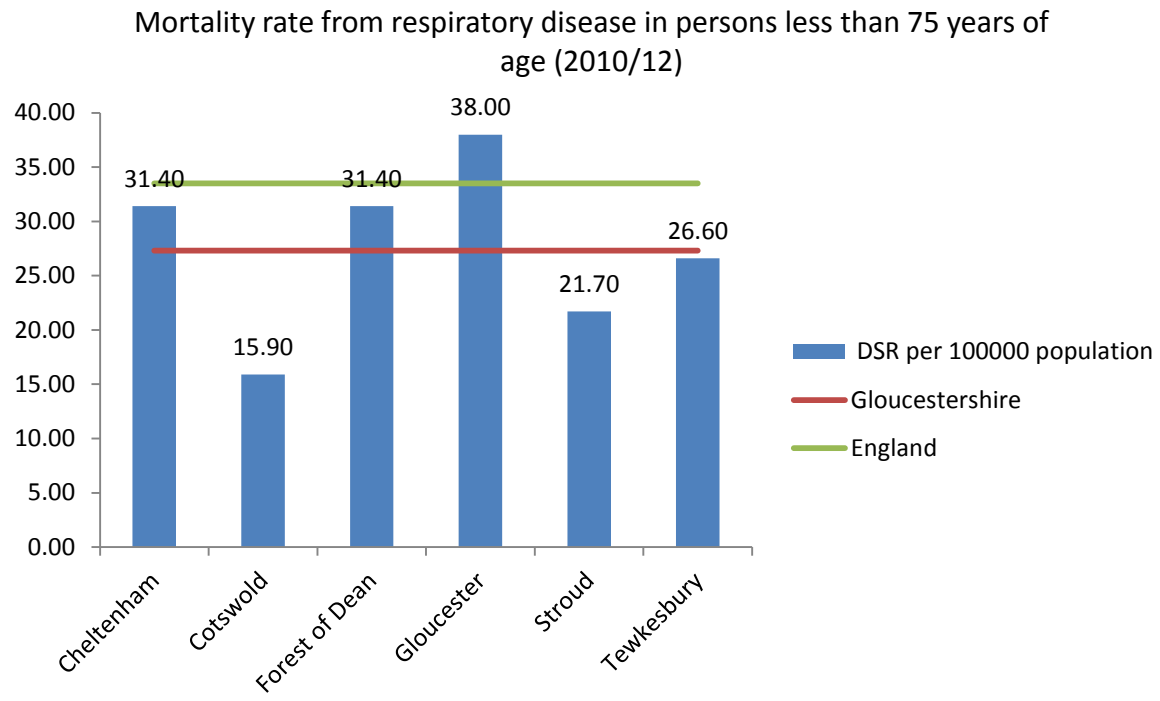
### Variability linked to deprivation:

While overall health in Gloucestershire is good, there are variations in health between localities and between different groups of people.

As illustrated by the figures below, rates of premature mortality from two of the county's major causes of death, Cardio Vascular Disease (CVD) and respiratory disease, vary across districts.




*Source: Public Health Outcomes Framework (based on ONS source data)*



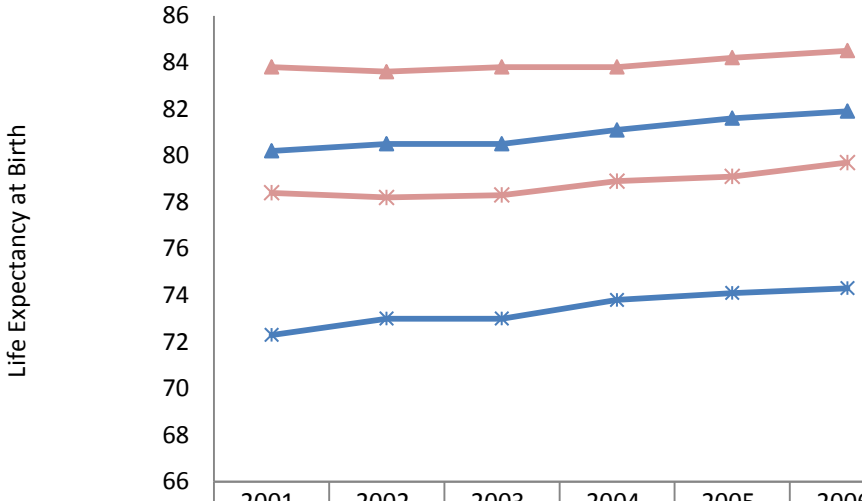

*Source: Public Health Outcomes Framework (based on ONS source data)*

Premature mortality from lung cancer in both males and females is significantly higher in the most deprived quintile of the county - mortality for all cancers by GP surgery increases relative to measured deprivation.

Much of the variation in health between localities can be explained by levels of deprivation. While overall levels of deprivation in Gloucestershire are significantly better than the national average, about 44,000 Gloucestershire residents (around 7% of the total population) live in areas that fall into the 20% most deprived in England (Index of Multiple Deprivation (IMD) 2010). These areas are mainly located in Gloucester and Cheltenham.

Evidence shows that people living in more deprived areas are more vulnerable to poor health outcomes and reduced life expectancy. Life expectancy is seven years lower for men and 4.8 years lower for women in the most deprived areas of the county compared to the least deprived areas. A man living in Gloucester for example can expect to live to 78 years, significantly below the national average, compared to a life expectancy of 81.2 years for a man living in the Cotswolds.

Life Expectancy by Deprivation in Gloucestershire over time




| | 2001-2005 | 2002-2006 | 2003-2007 | 2004-2008 | 2005-2009 | 2006-2010 |
|---|---|---|---|---|---|---|
| Most Deprived Males | 72.3 | 73.0 | 73.0 | 73.8 | 74.1 | 74.3 |
| Least Deprived Males | 80.2 | 80.5 | 80.5 | 81.1 | 81.6 | 81.9 |
| Most Deprived Females | 78.4 | 78.2 | 78.3 | 78.9 | 79.1 | 79.7 |
| Least Deprived Females | 83.8 | 83.6 | 83.8 | 83.8 | 84.2 | 84.5 |

*Source: ONS*

It is not just people living in geographic areas of deprivation that are prone to poor health outcomes. Certain individuals or groups of people also tend to be more vulnerable to poor health because of a combination of physical, mental and/or social factors.

People with learning disabilities, for example, experience poor health as often or more than the general population, but are less likely to seek or receive appropriate health care and often die at a younger age. It is projected that the number of adults (18-64 year olds) with moderate or severe Learning Disability in Gloucestershire will reach 1,977 by 2015. It is also projected that by 2030 the number of adults aged 70 plus using social care services for people with Learning Disabilities will more than double.

Other groups which evidence suggests may be more prone to poor health outcomes, include the traveller community (including Gypsies and Travellers); offenders; people with mental health issues and looked after children.

### Risk factors:

Overall county levels of smoking, higher risk drinking, obesity and physical activity are similar or better than the national average; 17.5% of adults smoke in the county, 24.7% are obese, 25.2% are classified as 'inactive' and 23.6% are drinking above the recommended levels (classified as increasing and higher risk drinkers).

However, rates vary substantially across localities and between groups of people:

- Smoking rates rise to 28.2% in those working in routine and manual professions in the county, and are as high as 36.9% among routine and manual workers in Cheltenham
- Gloucester and Cheltenham have significantly higher rates of alcohol related hospital admissions than the national average; and
- The percentage of adults classified as overweight or obese is significantly above the national average in Tewkesbury.

Obesity and alcohol are identified as priority areas for action in the Gloucestershire Health and Wellbeing Strategy.

The county rate of obesity has been steadily increasing in recent years in line with national trends. Alcohol related hospital admissions have also been steadily increasing over the last decade, though the latest data would appear to suggest signs of a downward trend.

Liver disease is associated with both alcohol consumption and obesity; and is one of the top causes of death in the South West. While lower than the national average, the county rate of premature mortality from liver disease has followed an upward trend over the last ten years; with the highest mortality rate in Gloucester.

Again research suggests a strong correlation between unhealthy lifestyle behaviours and deprivation. Rates of both obesity and alcohol related hospital admissions are significantly higher in the county's more deprived neighbourhoods, which highlights the importance of targeted prevention work.

## Annex 2: Maintaining focus on the essentials

There are a number of essential elements that will apply to all of the characteristics of every successful and sustainable health economy:

- Quality: The Fundamentals;
- Access;
- Innovation; and
- Technology

### Quality: The Fundamentals

The CCG's quality strategy "Our Journey for Quality" was presented to the GCCG Governing Body in January 2014. The strategy describes definite expectation by the CCG of clear expectations for all our provider organisations. System support for this strategy has been sought through the final quarter of 2013/14. The strategy incorporates the findings and recommendations from the two Robert Francis inquiries, the recommendations from the Berwick Report and the recommendations from the Winterbourne View Report[8]. Our organisation actively considers, in an ongoing process, our approach to quality to ensure we do the right thing, at the right time for the right patient. An example of this is the joined up working of CCG quality and contracting functions to ensure quality aspects e.g. patient safety – healthcare associated infection rates, proactive monitoring of patient safety incidents, are considered and incorporated into the contracts. GCCG members attend the main provider Internal Governance Committee Meetings, where potential issues and trends are identified and proactively in partnership are resolved. To translate the Quality Strategy into an actively used plan, a Quality Implementation Plan, with the key headings of Governance, Patient Safety, Patient Experience/Staff Satisfaction, Clinical Effectiveness, Outcomes, Compassion in Practice (6C's), Safeguarding and Innovation and Research has been developed and adopted. The implementation plan will be refreshed annually, both in terms of

[8] Transforming Care: A national response to Winterbourne View Hospital, Department of Health Review: Final Report, December 2012

outcomes achieved and consideration of actions to be undertaken in the forthcoming year incorporating recent national guidance and evidence. This demonstrates that the CCG is systematically horizon scanning and keeping up to date.

Discussions regarding quality are at the centre of our provider relationship, with a separate quarterly Clinical Quality Review Group for each provider contract, in conjunction with the provider Contract Board. Linkage between these two groups assures quality is integral to supporting continual learning and improvement in safe patient care. Bi-monthly organisational quality reports are submitted to the CCG's Integrated Governance and Quality committee (as per the approved constitution), as a formal subcommittee of the CCG's Governing Body who assure strong governance is in place. We hold quality summits twice a year to undertake a stocktake of the quality of services provided locally.

When designing and revising new services, a Quality Impact and Sustainability Assessment and Quality and Diversity Assessment is completed and signed off as part of the QIPP approval process. We are developing system wide quality measures focusing on outcomes for patients/clients. These will be in place by autumn 2014 and will be evaluated in terms of benefit and meaningful information in spring 2015. We will continue to work towards the achievement of the CCG Outcome Indicator Set of measures, part of which we will introduce within the CCG Quality Assurance Framework linked to the National CCG Outcomes Indicator Set. This approach will contribute to understanding and informing local patient outcomes and experience. This will be in place by June 2014.

We continue to develop a close working relationship with the Care Quality Commission ensuring any concerning issues are raised immediately and working together we work quickly to achieve resolution. Attendance of NHS England at the Quality Surveillance Group enables us to share both soft and hard intelligence, and is a valuable resource.

### Patient Experience:

Through organisational leadership we are committed to develop and embed the culture of learning from patient experience throughout the health and

social care community in Gloucestershire. We have developed and continue to develop a wide range of patient experience information which is used to inform redesign of healthcare services. We are promoting and supporting clinical staff to implement shared decision making with their patients and carers, ensuring patients are fully involved and informed about their care and options.

Ensuring patients have a great experience of all their care means that we must be able to demonstrate that individuals are fully engaged, are co-providing their own health and wellbeing, well informed, and are involved in shared decision making between themselves, their carers, and their clinicians and other health and social care staff. We recognise there is a lot to do, and are actively working in this area. Actions have been identified in the Quality Action Plan and the outcomes will be reviewed in Q4 2014/15.

Such a health and social care system will proactively include patients and citizens as equal contributors at the centre. Individuals will be familiar and comfortable with the concept of personal responsibility for maintaining individual health and wellbeing and providing regular and honest feedback to organisations commissioning and providing services for them, on the understanding that such feedback will be used to improve future patient experience.

Communities will begin to contribute to the overall health and wellbeing of their geographical area or area of interest. We will build upon the work already done to engage with groups often referred to as 'seldom heard' and 'communities of interest' with regards to strategic developments to increase visibility and credibility within these communities, and gain an understanding of services as perceived by these groups. We can then be better positioned to commission user friendly services.

### Patient Safety:

Patient safety is fundamental to all our services, ensuring that the services provided to our residents minimise the potential for harm and that lessons are learned from any adverse incidents that do occur. The community works together to promote a culture of transparency and co-operation, to maintain a 'no blame' attitude and thus encouraging open and transparent reporting of

incidents. We work in partnership to ensure infection control measures are in place and high standards of cleanliness achieved, in an environment that is adequately staffed by individuals who are appropriately trained and where our patients feel safe. This includes quality measures such as monitoring infection rates, being included in all service specifications.

### Clinical Effectiveness:

Clinical effectiveness based on sound clinical evidence eg NICE guidelines and Quality Standards adherence underpins the decisions we make. We have established systems and processes to ensure staff and clinical programme groups have up to date clinical evidence to support their work. We use NICE accredited evidence, guidelines and standards to identify and implement best practice, working with CPGs on pathway development and review and utilise our ethical framework for decision making. We aspire to continue and improve on patient outcomes as a key currency in future service specifications. Supporting of staff education is a key component of strong clinical effectiveness, and the encouragement to provide high quality mentorship.

### Staff Satisfaction:

National guidance states categorically that staff satisfaction is an important indicator of quality, with happy, well-motivated staff providing and delivering better care and happy patients. Creating a culture of high staff satisfaction will engender a patient facing approach of high quality care, ensuring the highest levels of patient experience, patient safety and clinically effectiveness.

In the 2008 a summary report from the Healthcare Commission found that clinical poor leadership was a problem in nearly all organisations they investigated for service failure. This has subsequently been reinforced by the findings outlined in the Francis & Berwick reports in 2013.

It has been observed that high performing organisations have a style of leadership which devolves its power and responsibility to individuals and teams. They further nurture a more participative and decentralised management style. Effective organisations have all levels of staff involved in decision making, through this, there is potential for an increase in quality improvement, job satisfaction, efficiency and effectiveness. A key to continuously improving service quality is the need for staff to be developed

and offered training and education to equip them to perform their roles effectively. It is therefore important that organisational leaders support their staff to have the opportunity to develop their skills and for personal advancement and contributing to increasing staff satisfaction.

Within Gloucestershire staff satisfaction surveys are a key priority for discussion with our main providers, and are routinely discussed at the Clinical Quality Review Groups. Working together across providers enables the sharing of ideas and investigate what has worked and what has not worked; to date identified areas of focus are:

- Provider focus on Francis recommendations including regular active staff feedback focus groups, and the demonstration of outcomes from the staff;
- Francis recommendation of a common culture of Staff leadership;
- Introduction of Friends and Family Test for staff;
- Consideration of NICE Guidance on a safe NHS staffing levels (currently in development and will be available from August 2014);
- Staff Training – Building in adequate time for training;
- Access to quality mentoring, and appropriate time to access;
- Continual staff development and support for advancement, using appraisal and personal development plans;
- Development of a culture that values staff feedback, demonstrating a listening approach with action taken based on staff opinions and suggestions.

### Safeguarding:

We ensure partnership working is continued to be promoted to safeguard children, young people and vulnerable adults within Gloucestershire. This is achieved by our continued membership and active participation in the Local Safeguarding Children's Board and Adult Safeguarding Board. We are working on the development of a series of principles and ways of working that are equally applicable to the safeguarding of children, young people and of adults in vulnerable situations; recognising that safeguarding is everyone's

responsibility. As part of the Quality Strategy the importance of clear roles and responsibilities, up to date policies and procedures, the role of education and training and how we will be held to account locally and nationally are all emphasised to ensure safeguarding is promoted within all of our work. Robust monitoring of the health component of the MASH (Multiagency Safeguarding Hub) through Clinical Quality Review Groups and feedback to partner agencies will occur when the Gloucestershire MASH is fully operational. A newly developed Safeguarding Strategy will be implemented in summer/autumn 2014.

### Compassion in Practice:

In December 2012 the Compassion in Practice (6C's) was launched, setting out the values on which a culture of compassion and care can be developed across the NHS and Social Care in conjunction with the NHS Change model. It brings together the key drivers to improve the quality and compassion in the NHS and the values and behaviours of Compassion; the 6 C's: Care, Compassion, Communication, Courage, Commitment and Competent.

As well as the clear focus on the 6 C's, compassion in practice sets out six areas of action to concentrate our efforts and create impact for our patients and the people we support:

1. Helping people to stay independent, maximising well-being and improving health outcomes.
2. Working with people to provide a positive experience of care.
3. Delivering high quality of care and measuring outcomes.
4. Building and strengthening leadership.
5. Ensuring we have the right staff, with the right skills, in the right place.
6. Supporting positive staff experience.

The 6 C is the engine through which to deliver Compassion in Practice. It brings together the key drivers to improve quality of care. If patients are involved in the real time monitoring of their care they can be supported to improve their own health and well-being. If staff are routinely engaged in discussions and professionally accountable then they will share core values and strive to

provide high quality compassionate care. Individual actions by all of us will collectively deliver this large scale change and have the greatest impact for patients and carers.

Practically GCCG ensures that 6Cs have been actively incorporated into all provider contracts, including reviewing each provider's 6Cs action plan. Locally we have implemented a health community Nursing Director's Forum where sharing good practice and ideas will contribute to the drive for 6Cs in Gloucestershire.

### Equality:

Gloucestershire CCG is committed to taking the necessary action and working in partnership with Gloucestershire County Council and diverse communities across the county. This is supported by the CCGs Equality Objectives:

- To develop a fresh strategy and action plan for promoting equality, diversity, human rights, inclusion and reduction in health inequalities, including the implementation of the revised Equality Delivery System;
- To increase awareness of the importance of promoting equality and reducing health inequalities within the CCG and across member practices;
- To improve the quality of, and accessibility to, the demographic profile of Gloucestershire by protected characteristics. Identify variations in health needs to enable staff to undertake meaningful equality impact analysis on their pieces of work as they develop;
- Support staff to put equality and reduction in health inequalities at the heart of commissioning cycle.

### Access:

Access to NHS services for our local population is an essential factor in the joined up, high quality care we aim to provide in Gloucestershire. The NHS Constitution pledges that patients have the right to access health services and will not be unlawfully discriminated against in the provision of those services (i.e. on the grounds of gender, race, disability). Locally measures have been put in place to ensure that our services meet these required standards, such as patients are able to access services within the required waiting times, with

their preferred provider (where appropriate) and that our services meet our local health requirements informed by the Gloucestershire Joint Strategic Needs Assessment.

In Gloucestershire the equality of access to services is a key component in the consideration and development of our services, with an initial focus at the point of designing and scoping our services. As part of our local programme management framework Equality and Sustainability Impact Assessments are completed for all areas of service redesign, to assess ideas against a range of local and national measures that consider both positive and negative impacts upon our patients and local population; setting out what can be done to mitigate any negative impacts.

Our focus on equality of access to services embodies the intelligence of local public health priorities and our commitment to the NHS Constitution, to improve outcomes and ensure safe services. Across both health and social care we remain aware that minority groups need specifically tailored services which suit their circumstances to enable them to access them. When planning engagement or consultation activities regarding service development or change, we undertake Equality Impact Assessments on our plans for engagement and communications in order to identify any groups who are likely to require targeted activities. A range of methods are employed to engage with such groups, frequently referred to as 'seldom heard' such as recruiting 'community surveyors' to undertake on the ground engagement within communities of interest.

### Innovation:

Innovation and research is an indicator that an organisation is committed to adopt new innovative ways of working which can increase quality and maintain or reduce costs. Over the next year we will prioritise our ideas using our Ethical Decision Framework, and work towards an innovative way of delivery; maintaining a register and outcomes of all projects to provide an organisational memory. We will actively engage with the Academic Health Science Network and the pharmaceutical industry, working in partnership and mutually benefitting from the skills and resources available from these sources.

We intend to investigate and take advantage of the regional innovation fund support and learning and to develop innovative projects that will be suitable for bidding to the local regional innovation fund, either in partnership or as a single entity.

Our interest in research will be supported by;

- Establishing a robust framework to enable and support clinical research and development;
- Working across the whole patient pathway including with the local authority, local providers, Public Health England and local GPs, to improve outcomes and spread innovation and economic growth;
- Understanding and supporting research that is taking place within our providers; and consider active support through our commissioning processes;
- Engendering a culture of encouragement for research and innovation, working with the Gloucestershire collaborative for clinical research and development;
- Increasing innovation through streamlined behaviours and processes, horizon scanning and encouragement to become early adopters where effective and appropriate, to understand potential clinical innovation and actively work with the Academic Health Science Network;
- Developing links with local universities to support research, audit and education.

## Annex 3: Clinical Programme Approach: Summary