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 first 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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1.0 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.

1.1 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'.

1.2 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 8 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 form (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 /BME 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.

1.3 Executive Summary of Joining Up Your Care

Our Five Year Strategy for JUYC sets out a 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'.

Our ambitions are to ensure:

- 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
- When people need care that can only be provided in a hospital setting, it is delivered in a timely and effective way.

Our strategic approach to delivering this vision will include a focus on the following approaches:

- **Clinical Programme Approach** - taking the budget for a specific condition and reviewing the whole clinical and care pathway from prevention to end of life, working out how we can get the best possible outcomes within the resources available;
- **Care Pathways** - focus will be placed on agreeing and delivering care pathways across our entire community;
- **Integration** – we believe that if we work better together as a community, in a more joined up way, we can transform the quality of peoples care; adopting a "**one system, one budget**" approach;
- **Effective Change Management** – a sustainable model to drive innovation, service redesign and development;
- **Focus on outcomes and the fundamentals of Quality;**
- **Ensuring best use of our resources.**

The key deliverables we would expect to see are summarised as:

- Focus on integrated community care through the role out of Integrated Community Teams and the Integration of some specialist teams. Increased focus on system wide integration, bringing in Mental Health components alongside, thus ensuring the patient is at the centre of our work (through the adoption of Living Well principles[1]).

[1] Living Well - a holistic model which places the person/patient/client at the centre, involves staff listening intently to what is important to the person and working creatively to seek solutions.

- Increased focus on Prevention and Self Care with an embedded approach across our work plan, alongside specific areas such as weight management, Health Living Pharmacies, Telecare, and Telehealth.
- Delivery of a consistent primary care offer with clarity regarding their role as part of the out of hospital care system, alongside the focus on new models of delivery within primary care and management for vulnerable patients over 75 years.
- Delivery of key changes within priority clinical programme groups, including Musculoskeletal, Respiratory, Ophthalmology, Paediatrics, Cancer, Cardiovascular disease, Frail Older People and Diabetes.
- Ensure further improvements to the urgent care system with a focus on the community model of care , managing patient flow at the front door, focus on integrated discharge to reduce overall length of stay and the use of care pathways across the system (such as the rehabilitation pathway).
- Ensure consistency of planned care through a systematic approach to demand management reducing variation, clarity regarding thresholds and utilisation of services and pathways including a focus on follow up care.
- Ensuring a collaborative approach to specialist commissioning, with well integrated pathways of care.

Our governance arrangements build on the existing health and social care community infrastructure to ensure we develop and deliver collectively as a community. Focus will be placed on robust programme management across the health and care community to ensure whole system delivery.

2.0 Context

2.1 Population, Demographics and Localities

The Health and Social Care community serves a GP registered health population of 624,000 and a resident population of 821,000. The

Gloucestershire Health and Social Care community is made up of Gloucestershire Clinical Commissioning Group (with 85 member practices grouped into seven localities), a single acute provider (Gloucestershire Hospitals NHS Foundation Trust), a single community provider (Gloucestershire Care Services), a single Mental Health provider (2gether NHS Foundation Trust) and one local authority (Gloucestershire County Council), along with representation from borough and district councils, the third sector and Health Watch.

There are a number of other NHS Service providers within the county (such as South West Ambulance Service), a number of private providers who offer NHS Services and an extensive voluntary sector. We have established relationships with all of these key additional providers who provide services in our county to ensure the best outcomes and value for money, whilst ensuring they remain an important component within our health community system.

2.2 Demographic change and its effect

In Gloucestershire there is already a significant proportion of the population aged over 65 years; and this segment of our population is also growing at a faster rate than most of the rest of the country. According to the latest Office for National Statistics (ONS) projections, the number of people aged 65 and over in Gloucestershire will increase by about 70% (or 78,300) between 2010 and 2035 and will account for nearly one third of the total population. In contrast, the number of young people and people of working age is likely to remain similar or even slightly decrease (see fig. 1).

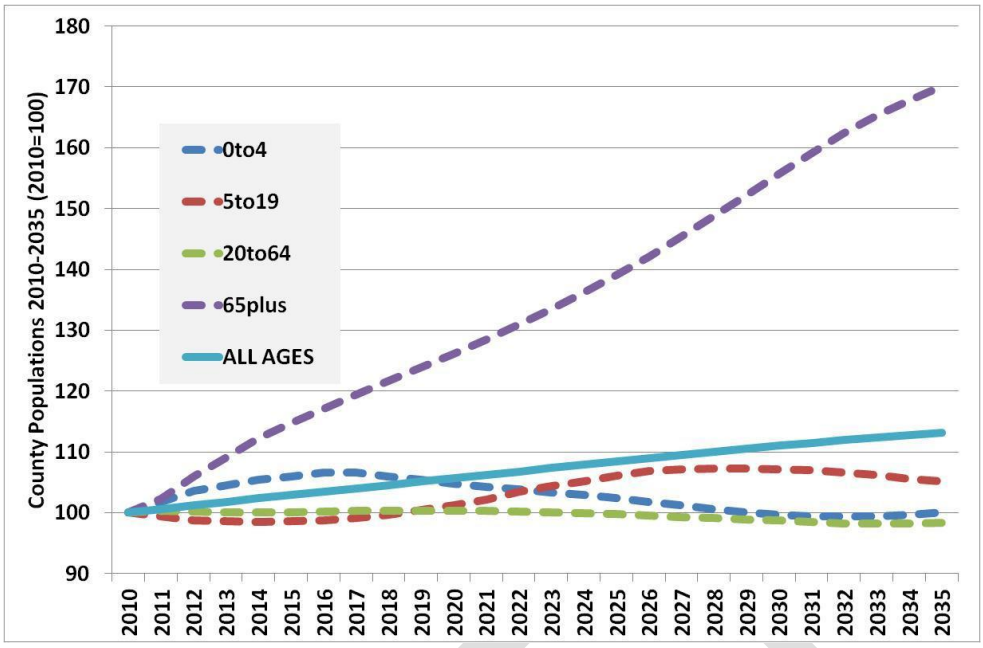


Fig. 1 – Projected percentage change in population demographics by age bracket – JSNA (ONS)

The number of people aged 90 and over is growing at an even faster rate and will double in just the next 15 years. This means that by 2035, people aged over 65 will account for well over a quarter (28.4%) of Gloucestershire's population. This is compared to less than a fifth (18.9%) in 2010.

National statistics show that people aged 90 and over require double the amount of care than a typical 70 year old. As life expectancy increases so will the number of people who will live with a long term condition (LTC) that limits their lifestyle such as dementia, heart disease, and respiratory problems. The number of people living with a limiting illness will increase by almost 60% in the next 20 years, and by 10% in the next 5 years alone. In Gloucestershire, over the next 20 years, the number of those living with diabetes and stroke is projected to increase by approximately 34%, and Coronary Heart Disease (CHD) 50% (see fig. 3). This growth will put additional pressure on individuals, their families/carers and services. If you have a long term physical health condition, you are two to three times more likely to develop depression.

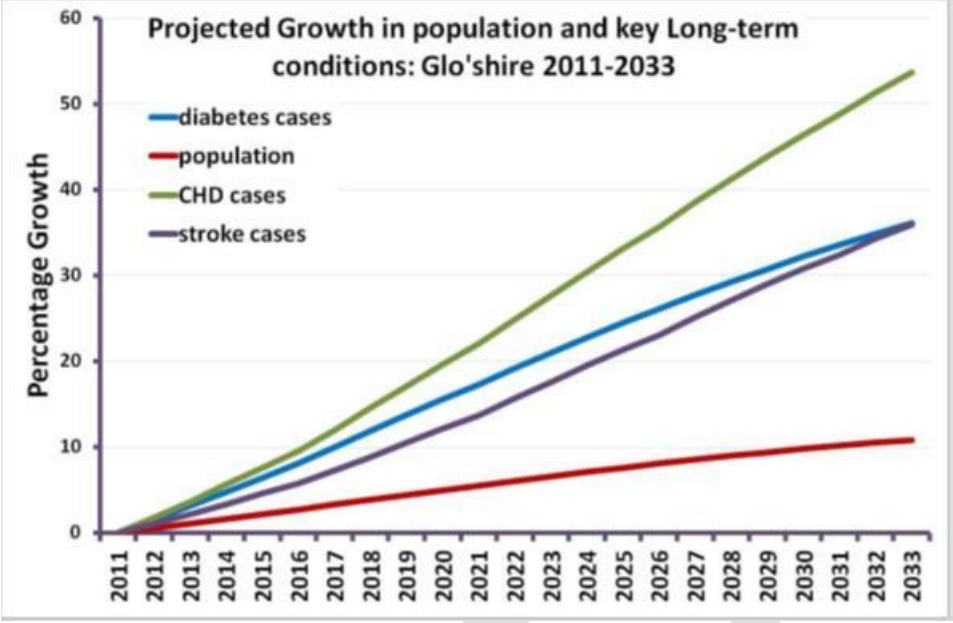


Fig. 3 – Gloucestershire projected growth in population and key Long term Conditions 2011-2033 – JSNA (ONS)

As a consequence of this demographic growth increasing pressure is placed on the health and care system. If nothing changes, emergency activity is expected to grow at 2.7% per year, resulting in the need for approximately 115 more beds across the county in five years time. In addition elective activity could grow by 1.8% per year, resulting in an additional 35 beds over the same time period. Radical change is required for us to managing the increasing demand in the system.

2.3 Health Inequalities

In Gloucestershire whilst the average life expectancy for men is 79.3 years and women it is 83.2 years across the entire county, there are noted differences between localities within our county (see fig. 4) with Gloucester City residents living fewer years than any other district. In Gloucester City on average men live to 78.0 years compared to 80.7 years in the Cotswolds. Women in Gloucester live 82.4 years compared to 84.4 years in Cheltenham. The life expectancy of Gloucester City residents is below the England average for both men and women.

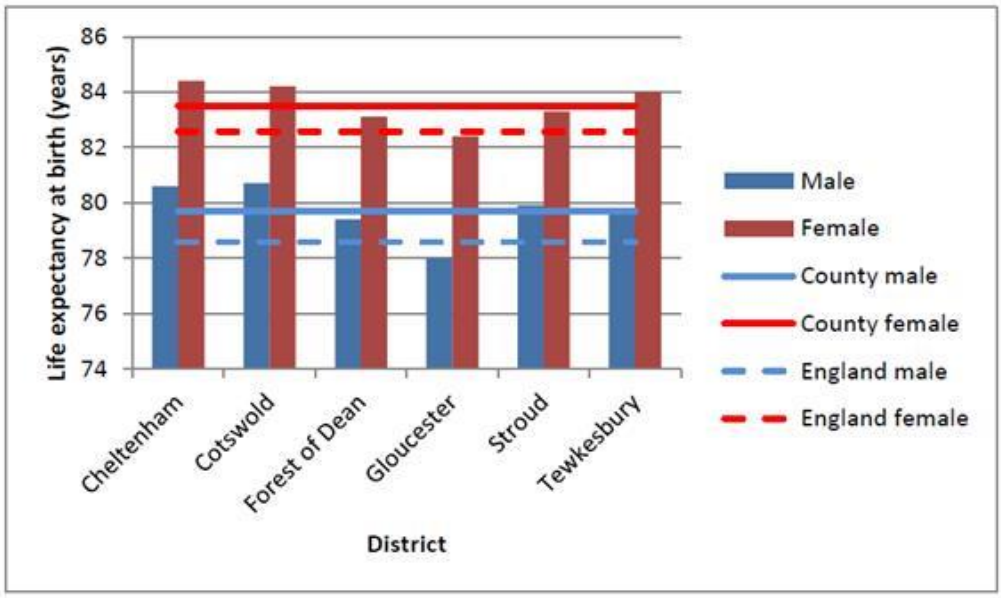


Fig. 4 – Life Expectancy for Males and Females in Gloucestershire (2008-2011) – JSNA (ONS)

Our strategy whilst identifying priorities across the Gloucestershire community will place a focus on locality commissioning; looking to address variation and health inequalities between our districts.

2.4 Gloucestershire Public Health Profile

Despite the challenges we face in future, Gloucestershire starts from a good baseline position as it is one of the healthiest counties in England. Despite this we need to make changes to avoid problems in the future alongside addressing areas within which we can identify improvements to be made. Whilst it is good news that people are living longer, unless they are also "healthy" for longer, it will place significantly more pressure on our health and care system.

The Public Health specialist in Gloucestershire County Council have worked with Gloucestershire CCG to further develop the Joint Strategic Needs Assessment (iJSNA) in order to ensure that the health and social care needs of our local population are analysed, fully understood and considered at both a countywide and locality level. We have considered the intelligence that the iJSNA provides us and this is reflected within our commissioning priorities at both a CCG and locality level.

The 2012/13 Public Health Annual Report highlighted the health facts shown below, which highlight some bespoke areas we will prioritise in JUYC to address variation and ensure improve the health of our population.

Alongside the countywide position each GP Commissioning locality in Gloucestershire has produced a Locality Development Plan, which is based on locality level intelligence from the iJSNA. This plan sets out the identified public

health priorities at a local level, and then details how the locality will respond to them; this will be in collaboration with local stakeholders. Localities will focus on specific areas requiring service redesign in an attempt to reduce localised inequalities and improve health and wellbeing. These developments may be bespoke to an individual locality or be developed across the entire community to ensure a collaborative approach to system wide priorities such as Integrated Community Teams; promoting a bottom up approach to service redesign, generating influence and shared learning. The joining up of locality and countywide analysis has also identified key common priority areas for which localities may work collaboratively to design and implement schemes to roll out across the county, share learning and co-design solutions around the patients.

2.6 Financial Resources

We know the financial resources available to us across health and social care will not increase at the same rate as the population and their needs are growing. We need to manage this challenge by finding ways to work differently together, supporting our population to stay independent for longer and to care for themselves, but with the ability to access care and support when required. The current financial system contains challenging requirements for all partners to meet such as Cash Releasing Efficiency Savings (CRES) and Quality, Innovation, Productivity and Prevention (QIPP) expectations; alongside a requirement to increase joint commissioning as part of the Better Care Fund[2]. This requires a different way of working to ensure a sustainable system providing quality care into the future.

2.7 Benchmarking

The challenges facing our health and care community are significant. However, benchmark and opportunity analysis shows there is potential for

[2] Better Care Fund - a single budget to support health and social care services to work more closely together in local areas plan agreed between NHS and local authorities

improvements across our system. Tools such as the Any Town model [3]provide challenge to the scope and breadth of our work plans, to ensure as a system we strive to improve outcomes for the population embracing evidence based change. Alongside this we have undertaken use national and local benchmarking analysis using available tools such as the Level of Ambition Atlas, the CCG Outcome Tool and Commissioning for Value packs including looking at best practice and upper quartile performance. The benchmarking has been shared with stakeholders across the health and social care community, including clinical programme groups, to assess the opportunities available and used to identify the priority clinical programme groups to contribute towards addressing the financial challenge. These are Musculoskeletal, Respiratory, Diabetes, Cardiovascular, Ophthalmology, Gastrointestinal, Children and Young People, Cancer and Mental Health.

Our position for urgent care admissions overall is already below national average (SAR = 96)[4], and whilst we are not a significant outlier we recognise there is still improvement towards top quartile performance; alongside specific areas to focus on (such a paediatric admissions for respiratory conditions).

3.0 Vision

This section outlines the vision, principles and values our health and care community has signed up to as part of JUYC; endorsed by our partners through Gloucestershire Strategic Forum, the Health and Wellbeing Board and the individual organisations' own governance structures; describing how we will deliver the central component of our strategic direction, truly integrated care for our population.

3 Any Town Toolkit, NHS England, January 2014 - high level health system modelling, allows clinical commissioning groups to map how interventions could improve local health services and close the financial gap

[4] Standardised Admission Ratio (SAR) – standardised rates of admissions to account for factors such as age, sex and deprivation, set against a benchmark of 100. A SAR of 100 means the number of admissions observed matches the number of admissions expected, if the SAR falls below 100, fewer people went to hospital than were expected. If the score is above 100, then more people went to hospital than were expected.

3.1 Our Shared Vision

A vital starting point for achieving transformational change 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 in Gloucestershire. The latest draft of this vision is stated below and will be endorsed collectively and also individually by each relevant organisation, by 31 March 2014.

Our shared vision for the next five years is distilled as:

"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.*

3.2 Our Ambitions

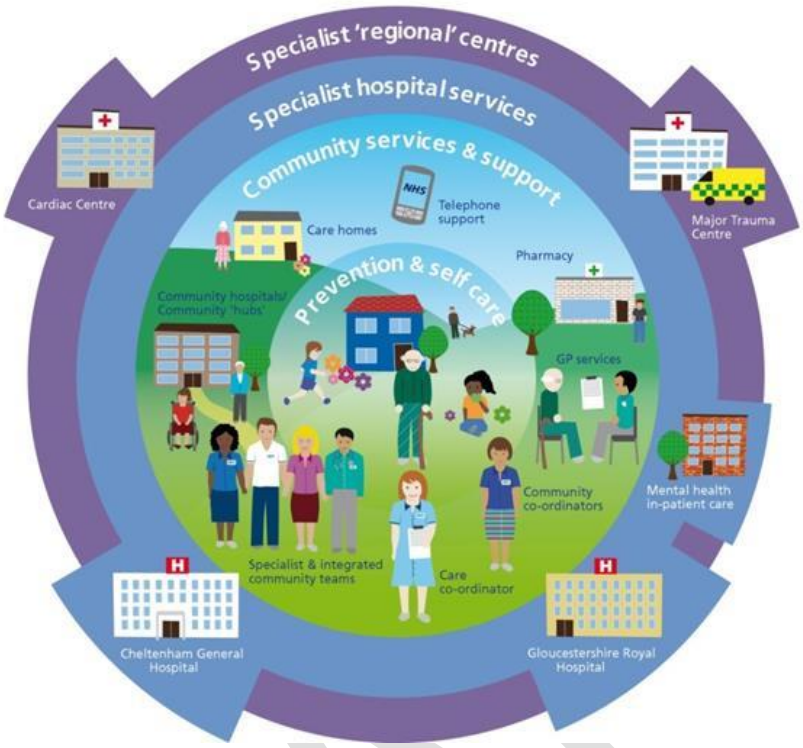
Underpinning our vision are the following ambitions:

- 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;

- 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:



3.3 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 whole, particularly on the use of secondary 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 though 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

3.4 What does success look like?

Through our strategic approach we will be looking to:

- Promote the best possible health outcomes for our population prioritising those of best value within the resources available.
- Ensure the individual is at the centre of care, and involved in decisions about their care.

- Reduce unnecessary steps in a patients individual care pathway, improving efficient, reducing waste and duplication.
- Ensure appropriate care is provided as close to home as possible, reducing avoidable urgent care admissions supported by alternative planned care pathways.
- Ensure equitable and accessible services seven days a week (as appropriate); promoting right care, in right place at right time.
- Ensure people have a positive experience of care.
- Ensure quality and cost effective services across our health & social care community; ensuring best use of our resources and assets.
- Work together for to ensure a transformative approach to delivering change; enabled through innovative approaches to contracting models.

4.0 Key Elements of Our strategy

4.1 How we will realise our transformational vision?

In order to realise our vision and ambitions for our population, the key elements of the mechanisms to deliver our JUYC strategy can be summarised as:

- We will use a **clinical programme approach for service improvement**; taking the budget for a specific condition and reviewing the whole clinical and care pathway from prevention to end of life, working out how we can get the best possible outcomes within the resources available. This approach will start right from prevention, bringing together a person's health and care needs;

- We will ensure a focus is placed on agreeing and delivering **care pathways** across our entire community, to make sure people receive seamless care in the right place, at the right time. In line with The Kings

Fund definition we will ensure *"Pathways spell out precisely what should be done and where the resources to do it are available";*

- **Integration** is a core component of both JUYC and the approach to the Better Care Fund in Gloucestershire. 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. JUYC will set out how we will achieve integration in Gloucestershire over the next five years.

Alongside these three key elements we will focus on embedding a **systematic approach to transformational change** alongside a shift in our thinking regarding quality services; whilst achieving the fundamentals of quality we will move to a focus on **commissioning for outcomes**. Ensuring **best utilisation of our resources** will be fundamental to our plans moving forwards.

4.2 The system priorities

The key deliverables within our strategy are grouped into the following priority areas:

- Increased focus on prevention and self-care
- Consistent 'Primary Care Offer'
- Integrated community based care
- Transformation of urgent care across all elements of our system.
- Evidence based planned care pathways, reducing variation and improving productivity across the county.
- Collaborative approach to specialised commissioning.

The following sections will explore the system priorities with further detail on how we will deliver our strategy (section 5) and the key deliverables (section 6).

5.0 How we will deliver our strategy

5.1 Quality

The focus of JUYC is to transform services in a way that improves outcomes for our population both now and in the future. Within this approach we will focus on:

- Improvement in outcomes (including the five domains and seven outcomes indicators as prescribed by NHS England[5]);
- Improving the health of people in Gloucestershire, not just managing them when they are ill;
- Maintaining emphasis on reducing health inequalities, including tackling variation between our commissioning localities;
- Working to ensure parity of esteem with equality between mental health and physical health;
- Ensuring the voice of our patients and public is core to informing our priorities and ensuring we deliver in line with our aspirations.

5.1.1 Focus on 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 LTCs
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring people have a positive experience of care

[5] Everyone Counts: Planning for Patients 2014/15 to 2018/19, NHS England, December 2013

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 aim to continue to build on this to further improve our performance.*

2. Improving the health related quality of life of the 15 million+ people with one or more LTC, 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 our performance.*

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 in comparison 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: *Based on an annual position Gloucestershire is in the mid quartile nationally and will aim to improve on this over the next 5 years.*

5. Increasing the number of people having a positive experience of hospital care: *Based on an annual position Gloucestershire is in the upper quartile and will look to sustain this over the next 5 years.*

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.

7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

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

- Increasing our Dementia Diagnosis rate. *The Dementia strategy in Gloucestershire as 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 to drive an increasingly outcome focussed approach to the commissioning and delivery of services, which is described in more detail in section 5.2.

5.1.2 Improving Health

In Gloucestershire we are endorsing commissioning for prevention as part of the transformative change in the system over the next 5 years. The 'Commissioning for Prevention Report' (published by NHS England in 2013) identifies a 5 step framework; which has been applied to portray the approach across Gloucestershire.

- ***Step One: Analyse the most important health problems at population level***

The joint priorities identified within the Health and Well Being Strategy (HWBS), previously within Your Health, Your Care (YHYC) and within this refreshed strategy named JUYC have been informed by public health information (including the Joint Strategic Needs Assessment (JSNA)).

Our HWBS identifies the focus is on 5 key risk factors for which we have joint plans to address including:

- Reducing obesity
- Reducing the harm caused by alcohol
- Improving mental health
- Improving health and wellbeing into older age
- Tackling health inequalities

These priorities are re-emphasised in this strategic plan. Health information has also been analysed in two different ways:

- **By Commissioning locality** - Each locality (made up of GP member practices) has been supported to understand the key health needs outcomes and future trends for their area to inform locality plans. This allows us to take account of variation across our geographical boundary at a more local level, reflecting the different health needs of rural, semi-rural and city populations;

- **By clinical programme area** – We have used national and local tools to benchmark performance for individual clinical programme group areas across the pathways from prevention to end of life. In addition we are developing local outcome frameworks to supplement nationally held information in order to further support analysis into the future.

As part of our approach we will continue to build on the analysis, with further work required to understand the local analysis of areas such as chronic disability and risk factors. The CCG is working with local strategic clinical networks to understand relative peer performance and potential to work jointly on key areas; alongside its own long term conditions and self-care programmes.

- ***Step Two: Working together with partners and the community, set common goals or priorities***

Working jointly within the health and wellbeing board we are focussing on the key priorities identified within the JSNA analysis; ensuring our strategic plans set out the priorities and how we will achieve improvements against the key risk factors identified within the HWBS. This will be underpinned by ensuring implementation plans are in place or delivery across the system.

In setting the priorities across programme areas we are taking an evidence based approach, with a clear focus on prevention. In order to take this work forwards in 2014/15 we will establish a programme for "healthy individuals", working with health and wellbeing partners, to develop shared ownership and understanding across the system, including individuals and their communities.

- ***Step Three: Identify high-impact prevention programmes focussed on top causes of premature mortality and chronic disability***

Using the JSNA, outcome indicators, evidence and best practice we will identify priorities to target areas of significant impact. Developments include:

- Gloucestershire has established key primary prevention programmes which we will continue to build upon e.g. for smoking cessation and weight management, the latter involving joint commissioning of tier 2 weight management services as part of the overall obesity pathway.
- We are working closely with communities and local councils to develop asset based community approaches to prevention.
- Public health will be working to support the primary care through raising awareness of appropriate diet, focussing on salt and fat intake. We will take learning from the current implementation of the NHS Health Checks programme to inform the development of more targeted approaches aimed at those at highest risk.
- A Cancer Early Diagnosis Programme will be rolled out to develop primary care to help achieve early diagnosis of cancer thereby resulting in better clinical outcomes and lives saved.

- ***Step Four: Plan the resource profile needed to deliver prevention goals***

As indicated in section 5.2 the clinical programme approach is a fundamental approach to commissioning for outcomes including the delivery of prevention, intended to:

- Commission based on entire pathways, reinforcing prevention at all stages;
- Focus on providing advice as to how we commission high value services within a given clinical area (including advising on areas for de-commissioning based on value added);
- Create sustainable systems and reducing unwarranted variation.

This is being reinforced by our partnership work as part of the Better Care Fund and emerging models of contracting (section 9.2) that aim to shift the allocation of resources from acute to preventative care.

- ***Step Five: Measure impact and experiment rapidly***

We will establish the prevention programme "healthy individuals" alongside other disease led clinical programmes, to focus on ensuring outcome measures and process key performance indicators are effectively utilised to support delivery. Improvements in care will not only focus on the very long term impacts, but ensure we can assess delivery more quickly as evidenced within our weight management programme.

As part of the development of our change management programme we will be developing systematic and innovative ways in which to trial solutions and rapidly measure success; supported through the use of patient reported outcome measures and patient stories.

5.1.3 Reduce Health Inequalities

As outlined in section 2.3, reducing health inequalities is a key priority within the Health and Wellbeing Strategy and remains a fundamental aspect of 'Joining up Your Care.' Alongside the countywide inequalities we are looking to address as part our outcome measures (see section 5.1), 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.

A key focus in this work will be alternative approaches to working with our local communities, using an Asset Based Community Development (ABCD) approach to understand the resources available in a community and build strong, sustainable communities. This work has started in many localities through the sharing of a well-being pathway for adults (often termed 'social prescribing'). We will be developing and taking a place-based approach to addressing poorer outcomes, initially focusing on our most deprived localities. This will be supported by an improvement in our understanding of the need in these areas that enables more sensitive and appropriate targeting of services and initiatives.

It is estimated that 15-20% of a life expectancy gap can be directly influenced by healthcare interventions. A number of evidence-based high impact interventions have been shown to work in tackling health inequalities and reducing the gap in life expectancy, including those recommended by the National Audit Office. These are: Increased prescribing of drugs to control

blood pressure, Increased prescribing of drugs to reduce cholesterol, Increase smoking cessation services, increased anticoagulant therapy in atrial fibrillation and improved blood sugar control in diabetes. These are picked up in the component parts of our plan.

5.1.4 Parity of Esteem

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, secondary 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.

5.1.5 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 in fig. 5), additionally these people have longer lengths of stay and a higher chance of readmission.

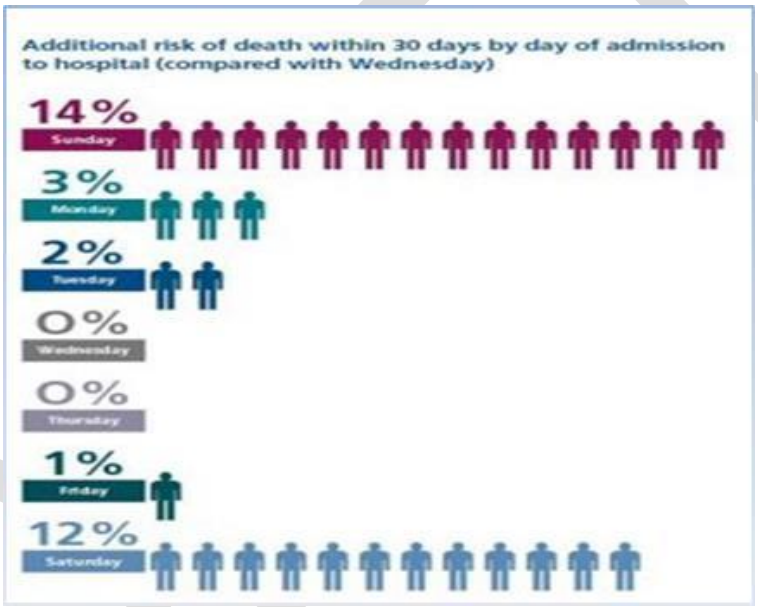
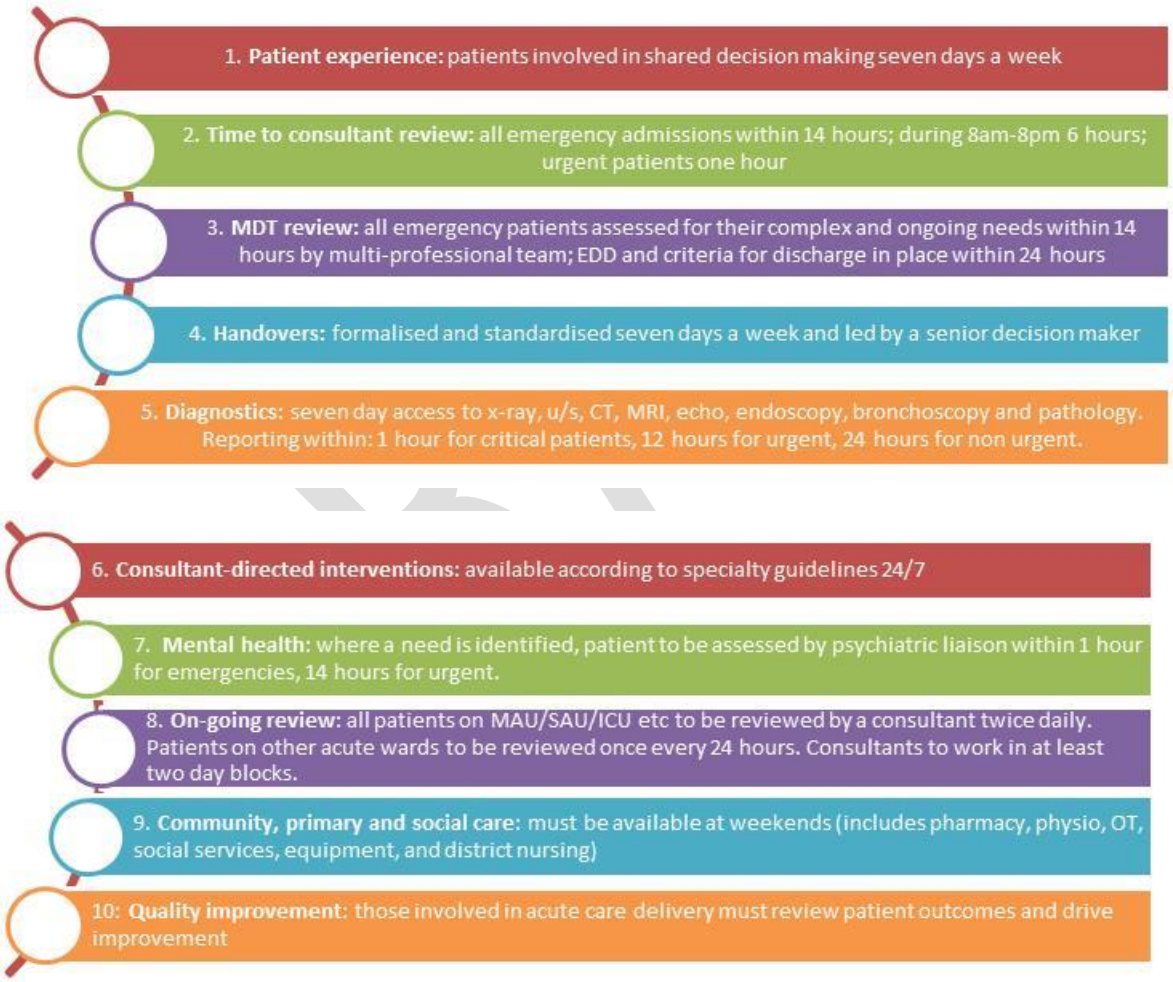


Fig. 5 – Royal Journal of Medicine Study on additional risk of death by date of admission

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 appropriate that 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 10 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 7 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 7 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.

5.1.6 Patient Engagement

Our overarching Vision is *"Joined up care for the people of Gloucestershire".* 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. In our Constitution we state that we will: "e*nsure effective communication and engagement with clinicians, patients, carers, community partners, the public and clinicians".* 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 frequently referred to as 'seldom heard' such as children and young people, or those with communications difficulties.

There are two elements to this approach: empowerment of individuals in terms of their own health and wellbeing and engaging citizens in service redesign and future change.

Successful delivery of the former means that we and our partners can demonstrate that individuals are fully engaged[6], 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.

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

Successful delivery of the latter means that the experiences and expertise of our local population are used to inform our strategic commissioning priorities.

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.

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

- 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 a 'seldom heard' or 'communities of interest', representing the nine protected characteristics[7], 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

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

- 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[8] 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.

5.2 Clinical Programme Approach

Over the last two years we have developed the clinical programme methodology as a fundamental approach to commissioning. 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.

The principles we work to are:

- Planning for our population, taking into consideration all relevant people and not just those that present/are referred;
- Utilising our budget based on clinical programme areas; focussing on providing advice as to how we commission high value services within a given (indicative) budget and disinvest in lower value activity to ensure best possible outcomes for our population;

[8] 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.

- Commissioning based on a pathways approach; reinforcing prevention at all stages;

- Focussing on shared decision making, alongside taking the views of patients and carers into account;

- Creating sustainable clinical systems and reducing unwarranted variation.

The approach is expected to drive clinical changes to commissioning informed by best practice, identified opportunities for change, using benchmarking and innovative thinking. This will potentially lead to innovative and integrated contractual and financial mechanisms, to deliver the aspired outcomes.

Within five years, we would expect the clinical programme approach to have delivered a number of key changes, including:

- System wide, shared outcomes for those patient/population groups prioritised and clear plans for those not yet addressed;
- Far greater reliance on self-care and preventative strategies, with people requiring less acute based care;
- Clear pathways of care, locally developed and based on national evidence of effectiveness and value, with mechanisms to ensure both visibility adherence;
- Developed contractual and business models that deliver in a more joined-up way across pathways.

5.3 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 is 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.

5.4 Integration

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 (as explored by The Kings Fund), our vision is 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'**

This vision is central to our approach within the Better Care Fund. 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.

5.4.1 The Challenge

The aim of integration is to ensure people do not find their care uncoordinated and fragmented, which is a significant risk as a consequence of the ever-increasing interfaces between a growing number of services and providers. Our plans to truly deliver integrated care will respond to this.

Integrated care and support won't be the end in itself. It is a way of organising health and social care to deliver high quality care resulting in better health and wellbeing, better outcomes and experiences for patients and service users, their carers and families. There is a need to create cultures of cooperation and coordination between the public, health, social care, public health, district and borough councils, other local services and the third sector. Collectively, our aim is to ensure organisational boundaries are less important than the outcome and experience for the person.

A big part of this will be working to ensure crises in people's care, which too often result in admission to hospital or a care home, are avoided. The aim is to get better at preventing deterioration in health, with increased understanding of the social context of known vulnerable adults in the first place.

There is a need to embrace fully the extraordinary potential presented by new technology and shared information. This can help local services to plan more effectively and will help doctors, care professionals and others to give people far better and far more tailored services. It will also give those who are able the ability to manage their own conditions, thereby increasing independence.

In essence, over the next 5 years we must respond to the challenges to ensure that services remain 'fit for purpose' and that people can continue to access the right, good quality care when they need it. We need to work with local communities and individual patients and carers and agreed the different ways support and care for people will be provided. It is clear from demographic challenges set out in section 2.2 that attention will need to be increasingly focused on those aged 65 years and over. Finally, changes needs to be

affordable and sustainable and provide the best service and financial return on investment.

5.4.2 Key deliverables

To support our vision of modern, integrated care the following key overarching deliverables are set out to guide our ambitions over the next five years: -

- We need to ensure 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.
- 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.

To make our vision a reality and to ensure our overarching deliverables are met out areas of focus are set out in section 4.

5.5 Effective Change Management

We will work across the Gloucestershire health and care community to develop a sustainable model to drive innovation, service redesign and development, based on best practice approaches to change management, learning from the experiences of the Health Board in Canterbury New Zealand

where substantial, effective transformative change has been delivered across the system. The principles in the Canterbury model which we would like to see embedded within Gloucestershire are:

- A “social movement approach” to developing the communication and “buy in” to our shared vision;
- Acknowledgement that only those within the system can effect change, recognising the importance of engaging and empowering staff “ on the ground”;
- Delivering collaborative training via an actual change project so participants could replicate this process thereafter and build relationships across the health and care system;
- Ensuring permission to innovate is made explicit following participation in the change management skills development, with the expectation that people will continue to innovate and feel supported to do so;
- Ensuring agreed, sustainable investment of time and resources involving clinicians and managers.

There is, alongside the Canterbury model, a substantial body of evidence within the NHS, social care, and international health systems and in other sectors on how to deliver large scale change. This demonstrates the benefits of developing a collective, strategic and organised approach across the system. In broad terms, this will involve developing our system leadership, improvement knowhow and change management skills.

Other models we will incorporate into our thinking and approach are:

- The NHS Change Model
- The National Skills Academy Leadership Qualities Framework
- The Academic Health Science Network (ASHN)

Alongside this, we will learn from one another across the health and care community, seeking additional expertise from partners, such as NHS Improving Quality (NHSIQ) and Central Southern Commissioning Support Unit.

We will work with health and care organisations to develop a bespoke Gloucestershire strategy to build the capability and capacity for change. It is suggested that this:

- Builds on the NHS Change Model and other existing similar social care models;
- Is delivered in a way that involves managers, clinicians and other professionals;
- Is sustainable and not a one off exercise;
- Covers the systems leadership/leadership for change; change management skills; and key improvement tools and techniques;
- Is supported by key strategic leaders and groups both in terms of time and resource but in creating the environment for change and innovation;
- Supports delivery of real projects, including through the development of relationships;
- Includes a commitment to develop joint process, outcome and patient experience measures to support this and any other supporting expertise required, such as Project Management and process engineering.

It is envisaged that the strategy will inform the specification and commissioning of bespoke training and support for Gloucestershire community, as well as informing a coherent approach to participation in existing and new opportunities.

5.6 Effective Utilisation of Sites and Services

We will work across the Gloucestershire health and care community to ensure optimal and efficient utilisation of services and resources, where appropriate offering services seven days a week in line with clinical standards (see section 5.1.5), working across all sectors from voluntary, social, primary, community and acute care. One of the priorities will be the development of a community services commissioning plan, which will include a focus on ensuring efficient utilisation of the range of community sites and services we have available to us. This will include a review of how we use 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.

6.0 System Priorities

6.1 Prevention and Self Care

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 (as outlined in section 5.2).

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.

6.1.1 Prevention

We will work with a broader range of providers, including healthy living pharmacies and the third 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.

5.1.2 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 pf Gloucestershire. We will work more closely with key patient groups, to better to 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.

6.2 Consistent Primary Care Offer

6.2.1 Primary Care Services

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 third sector with patients receiving the right service to meet their needs.

Covering a large population, primary care in Gloucestershire is delivered by 85 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:

- ***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.

- ***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 secondary care to primary care where it is evidenced, safe and appropriate to do so.

As outlined within the Better Care Fund flexible provision over 7 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 hours 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 7 day working and a further focus on supporting the urgent care priorities, particularly with the elderly (see section 6.5.1 below). 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 patient medical records will form the core data set to inform clinical decision making and will be available across the health community; without compromising data protection.

- ***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).

6.2.2 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 5 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 Integrated Community Based Care

Integration is a core component of the strategic approach in Gloucestershire; including the focus within the Better Care Fund. Whilst there are numerous definitions of integrated care within published literature (as explored by The Kings Fund), our vision is a modern 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 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.

To support our vision of modern, integrated care the following key overarching deliverables are set out to guide our ambitions over the next five years: -

- We need to ensure 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.
- 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.

To make our vision a reality we see our overarching areas of focus as:

- Service design (focusing on the Implementation of Integrated Community Teams);
- The successful implementation of the Better Care Fund;
- Developing new integrated commissioning functions that go beyond joint commissioning;
- Developing 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' where providers of more integrated services 'work together and respond together'.

6.3.1 Implementation of the Better Care Fund

NHS England and the Local Government Association have agreed a Better Care Fund to support the integration of health and social care. It is described as 'a single pooled budget for health and social care services to work more closely

together in local areas, based on a plan agreed between NHS and local authorities'. It is seen as an opportunity to take forward integration at scale and pace, being a significant catalyst for change. The Gloucestershire Better Care Fund plan is included as an annex with this document and the proposals set out within it are an essential component in delivering our modern model of integrated care. We have genuine commitment to partnership working to use the fund as a key vehicle for addressing the challenges health, social care and the wellbeing community faces in delivering a modern model of integrated care.

A key foundation of the Better Care Fund is to deliver the vision of our modern model of integrated care, by further strengthening and widening the scope of health and social care integrated community teams, building on the existing 800 plus multi professional health & social care registered, non-registered and administrative staff working across 20 Integrated Community Teams as the springboard for transformational change.

6.3.2 Developing integrated commissioning

As commissioners, GCCG and GCC 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 transformational change; 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 incentive 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.

6.3.3 One System, One Budget

As defined within the Better Care Fund proposal, based on national and international best practice, a key element in delivering our vision will be to develop specific plans across primary, community, hospital and social care that 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;
- 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.

6.4 Community Services and Support

Alongside an emphasis on integrated services for our population and a focus on prevention and self-care, the third key strand of 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.

6.4.1 Service Redesign

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:

- *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 4 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 end 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 (see section 6.2), increasingly teams will also be working closely with primary care to identify those people with a LTC, 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 our current 'Living Well' programme being piloted in two local areas of the County.

- *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 5 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 secondary 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 & social care partners.

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

- Comprehensive primary and secondary 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.

6.5 Specialist Hospital Services

6.5.1 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.

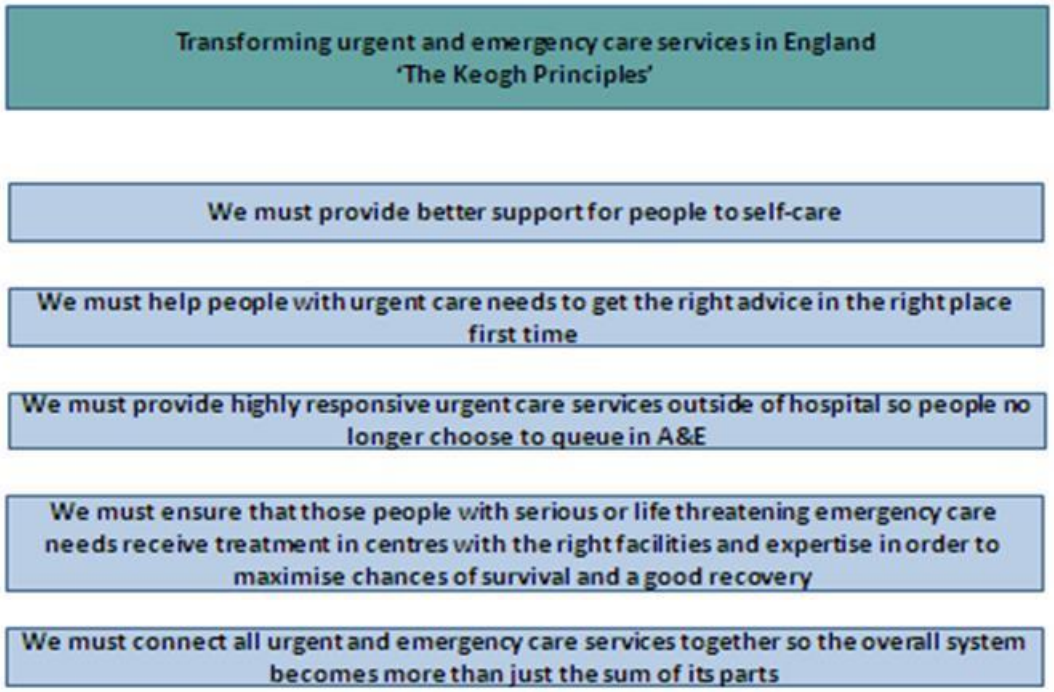


Fig xx – Bruce Keogh Report – 'Transforming urgent and emergency care services in England 'The Keogh Principles'

These principles have been applied to identify local priorities:

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

As described in section 6.1 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 GRH and CGH must be enhanced (as represented sections 6.1 and 6.4 through the enhancement of primary and community care). 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.

6.5.2 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.

6.6 Specialised 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 seamless 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 5 years.

7.0 Maintaining Focus on 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

7.1 Quality: The Fundamentals

The CCG's quality strategy sets out the approach to our journey for quality, providing clear expectations for all our provider organisations. System support for this strategy will be 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[9]. 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. Alongside the strategy we will have an annual quality implementation plan, with the key headings of patient experience, patient safety and clinical effectiveness.

Discussions regarding quality will be at the centre of our provider relationship, with a quarterly clinical quality review group for each provider contract in place, in conjunction with the provider contract board. Linkage between these two groups ensures quality and patient safety issues are integral to supporting continual learning and improvement in 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, all will have a completed quality impact assessment and equality and diversity assessment scrutinised by the CCG's quality team, before agreement and sign 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 early summer 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 (as highlighted in section 5.1.1), part of which we will introduce a Gloucestershire 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 will develop a close working relationship with the Care Quality Commission to ensure any concerning issues are raised immediately and working together we will work quickly to achieve resolution. Attendance of NHS England quality surveillance summits will enable us to share both soft and hard intelligence.

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

This contributes to our organisation's understanding of quality in our organisation and between our neighbouring organisations and providers.

7.1.1 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 are developing a wide range of patient experience information to be used to inform redesign of healthcare services. We are promoting and supporting clinical staff to implement shared decision making with their patients and carers, so 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 and our partners should be able to demonstrate that individuals are fully engaged , are co-providing their own health and wellbeing through well informed, and are involved in shared decision making between themselves, their carers, and their clinicians and other health and social care staff.

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

Communities would be contributing to the overall health and wellbeing of their geographical area or area of interest. We will have built upon the work done to engage with groups often referred to as 'seldom heard', referred to also as 'communities of interest' with regards to strategic developments (described above) to increase visibility and credibility within these communities. We believe through this we will improve contact with vulnerable individuals within communities, who are often quite socially isolated, so that we can understand better their needs, and commission services better tailored to meet these.

7.1.2 Patient Safety

Patient safety is a fundamental element within all of 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 will work together to promote a culture of transparency and co-operation, aiming to maintain a 'no blame' attitude so 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, care is delivered within an environment where our patients feel safe and we will ensure clinical areas are adequately staffed by individuals who are appropriately trained.

7.1.3 Clinical Effectiveness

The culture to which we aspire is where clinical effectiveness underpins the decisions we make. We are establishing systems and processes to ensure staff and clinical programme groups have up to date clinical evidence to support their work. We use evidence, guidelines and standards to identify and implement best practice, working with CPG on pathway development and review and utilise our ethical framework for decision making. We are working to ensure that patient outcomes become a key currency in future service specifications.

7.1.4 Staff Satisfaction

As defined in the national guidance staff satisfaction is an important indicator of quality, with happy, well-motivated staff resulting in 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 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 of how the whole system works. 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 ever changing roles effectively. It is therefore important that the 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 we will ensure staff satisfaction is a key priority for discussion with our main providers, through the clinical quality review groups. Informed by the most recent staff satisfaction results for each organisation, areas for improvement will be identified and underlying drivers discussed. Working together across providers will enable sharing of ideas and investigate what has worked and what has not worked; 2014/15 will commence this work programme. Areas of focus include:

- 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.

7.1.5 Safeguarding

We will ensure partnership working is promoted to safeguard children, young people and vulnerable adults within Gloucestershire. We will outline a serious 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 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.

7.1.6 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. The values and behaviours of Compassion, the 6 C's are: Care, Compassion, Communication, Courage, Commitment and Competent.

As well as the clear focus on the 6 C's, Compassion in practice sets out 6 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, 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.

7.1.7 Equality

Gloucestershire CCG is committed to taking the necessary action and working in partnership with Gloucestershire County Council and diverse communities across the county to ensure that. To support this, the CCG equality objectives are as follows:

- 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/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. Also to 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/reduction in health inequalities at the heart of commissioning cycle.

7.2 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.

7.3 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. Working with its partners, the CCG has identified a wide number of potentially innovative ideas based on quality, innovation, productivity and prevention. Over the next year we will prioritise these ideas using our ethical decision framework, and work towards an innovative way of delivery. It is important to maintain a register and outcomes of all projects to provide an organisational memory. It is envisaged to actively engage with the Academic Health Science Network and the pharmaceutical industry, working in partnership and so 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.

7.4 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 health services to enable them to take 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

8.0 Ensuring a Sustainable System

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 NHSE on 31st January 2014.

8.1 Five Year Financial Plan

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.

The CCG responsibilities include secondary acute care, community care, mental health and continuing health care. It will also have responsibility for prescribing

and some local primary care enhanced services. The CCG does not have any responsibility for the commissioning of very specialised services or for primary care contracts; these are the responsibility of NHS England.

8.2 Financial 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%	-4.5%	-4%	-4%	-4%

Activity Assumptions:

Demographic growth	2.2%	2.1%	2.4%	2.5%	1.4%

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

The investment plan focuses on enabling more patients to be supported in the community or closer to home. To support this strategy, the CCG will progress investments in community care, primary care, mental health and to further integrate working with social care over the term of the financial plan. This will enable the CCG to deliver the demand challenge that the NHS will face over the next 5 years.

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.

8.3 Where do we spend our money

During the last year the CCG has benchmarked its expenditure 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 the CCG's strategic plan.

8.4 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 national fund 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 elsewhere savings schemes must deliver transformational changes. Within Gloucestershire, there is a transfer of funds of £35,989k from the CCG into the BCF in 2015/16.

8.5 QIPP and CRES

In order to remain within its financial allocation and deliver the surplus requirement the CCG has to make QIPP savings of £84.9m 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	17.9	17.171	17.134	17.425	15.326
Provider Efficiency (estimated)	19.680	19.779	19.830	20.545	21.255

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.

8.6 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 CCG's 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 TAs, 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.

9.0 How will we deliver together?

9.1 System Governance

In order to deliver the wide scale system wide 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.

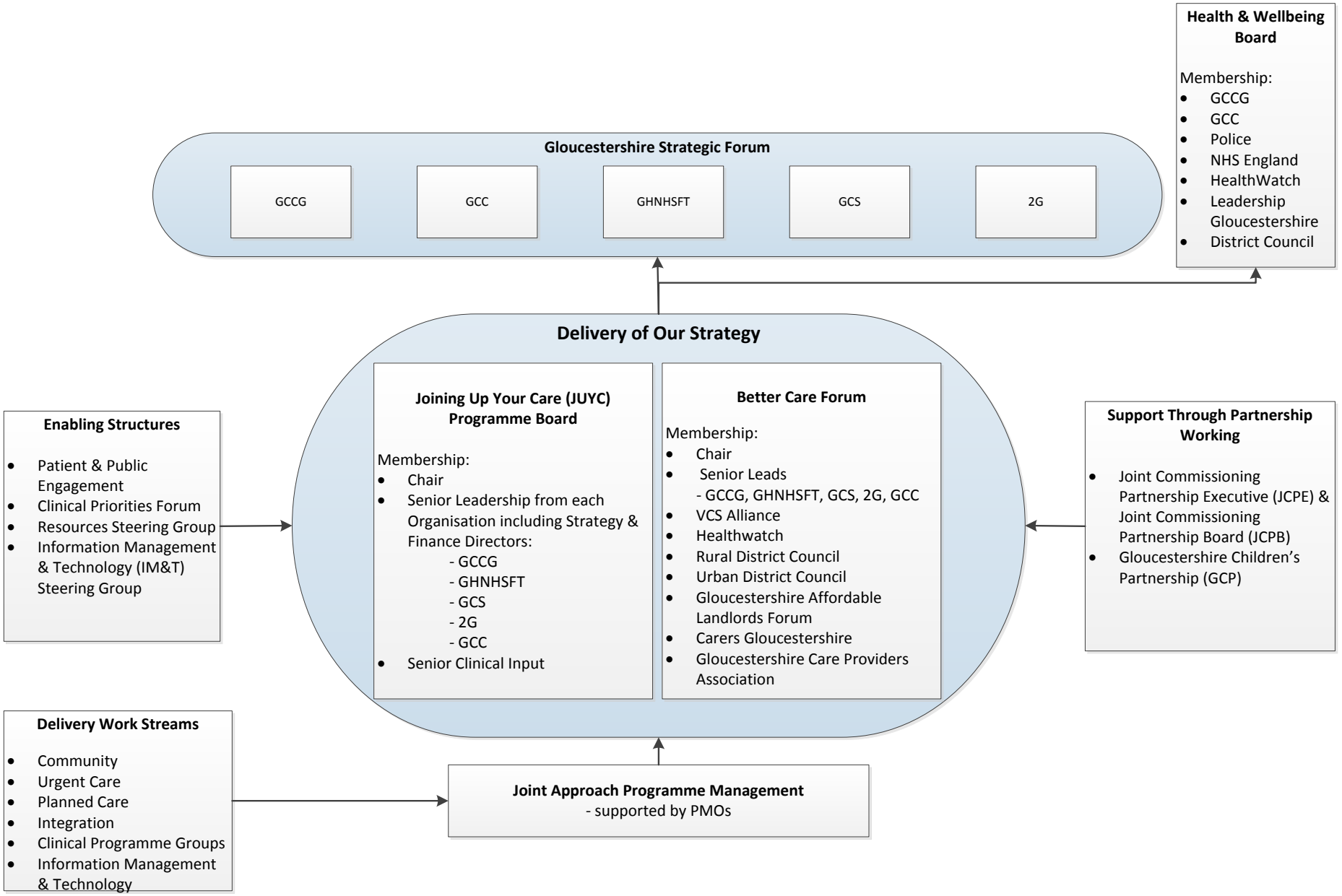


Figure 1 Gloucestershire Governance Roadmap

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.

9.2 Contractual Approaches

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 - Improved pathway coordination - Commissioner has 1 contract to manage	- How will patient choice be supported - Commission retains accountability for services commissioned, but is reliant on prime contractor holding subcontractors to account	- Risk share - Gain Share - Capitation funding (subject to PbR rules & code of conduct)
Alliance Contracting Separate contracts with individual providers but with shared objectives	- Reduced inefficiency - Improved pathway coordination	- Relies on strong working relationships between providers - Need to be clear about where responsibility for delivery lies.	- Risk share - 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 agreeing 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.

9.3 Programme Management

The Gloucestershire health community has established internal programme management arrangements within each organisation; with Gloucestershire CCG providing a lead liaison role in relation to the management of JUYC. To provide this function in a health community approach the CCG utilises its

established programme management framework, with established links across partners to provide transparency and assurance to the commissioning and provision of services. To enable prioritisation of developments, to ensure the appropriate allocation of resource, and to provide assurance that we are doing the right thing, at the right time, the CCG has developed and adopted a Prioritisation Framework. This ensures an effective, structured and defensible approach to making decisions and choices that can be interpreted across the health community.

The Prioritisation Framework was developed as the mechanism to prioritise ideas developed within Clinical Programme Groups, through strategic planning, locality plans and any other ideas formed in-year. This has been used to assess the priorities for engagement and to form the focus of our 5 and 2 year plans, in collaboration with our partners we will then agree the priorities across the community.

The programme management approach, through the governance structure, will be utilised to ensure robust delivery of the underpinning programmes of work.

9.4 Risk Management

As described in section 9.1, 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 (GSF). A risk register is in place which collates strategic, organisational and programme risks (as appropriate); with routine updates in place.

In relation to the 5 year strategy the following risks and mitigating actions should be noted:

Key Risk	Level of Risk	Mitigating Action
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.
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.