Cornwall and the Isles of Scilly

Starting well, living well and ageing well

NHS Kernow
Operational Plan 2015/16

We welcome feedback on our plans, please send any suggestions on how the Operational Plan could be improved to janet.popham@nhs.net.

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Executive summary

This plan represents the priorities for NHS Kernow for the 2015/16 financial year. The plan takes direction from our 5 year Strategic Plan (2014-19), and responds to the National must-do's and direction of travel, as set out in both the NHS Constitutional Standards and Five year Forward View. In 2015/16 we must address the issues yet to be resolved and secure a sound and sustainable footing for our vision.

Performance - 2014/15 saw increasing pressures on service provision, with the delivery of key performance targets falling below national expectations, and extended and repeated periods of system-wide escalation of alert status. Recovery of these performance standards is a must, and this is the key thrust of this plan.

Finances and value for money - Both commissioners and providers, across health, social care and the voluntary and community sectors, are facing financial constraints, and so 2015/16 must start to make tangible progress in reducing the cost per capita of care. This plan sets out a range of schemes to improve value for money from the services we commission. As our current plan does not achieve the business rules set by NHS England, this plan is supported by our financial recovery plan.

Transformation - We must also continue the journey we started in 2014/15 towards a different model of care, and improving our approach to commissioning, through integration and joint working with fellow commissioners. This plan sets out key objectives that must be achieved during 2015/16 in support of our vision for integrated provision and commissioning.

Key commissioning intentions - To address the challenges outlined, we are structuring our intentions across 3 main areas, and have assessed the anticipated impact of these upon the organisations who provide services, the way we commission services, and the populations we serve.

- Unplanned Care – urgent and emergency care services
- Planned Care – elective care services
- Cross cutting themes. – primary care, mental health, children's, Continuing Healthcare, care homes etc.

For each area we describe the priorities for delivery in 2015/16 for improving performance, value for money and transformation.

Strategy - Our strategy, carried over from our 5 year Strategic Plan, is for integrated care that is shaped locally by communities to meet local needs and that increases the focus on prevention, early intervention and independence. 'Integrated Care Communities', with the help of voluntary sector partners, will build social capital to invest in health and well–being and combine behavioural change with a new model of care and support.

Coordinating care and support around the individual, their carers and families, we will where ever possible, move healthcare out of hospital settings into community settings. Expanding the roll-out of our Living Well approach will enable this 'bottom up', and mainstreaming this approach will drive it at greater scale. Our vision for out of hospital care is one of coalitions of accountable providers coalescing within a community, bringing together integrated community teams, aligned with a local urgent care hub and clustered around multiple GP practices. It is responsive to individual needs and relies on resilient interconnections between health, social care, voluntary sector, independent sector, public health, pharmacies, the police and local people.

Executive summary

Our delivery priorities

Key constitutional standards and areas of performance requiring improvement are summarised below:

Unplanned care standards

- Waiting time in the Emergency Department
- Whole system flow and discharge pledges
- NHS 111 performance
- Ambulance response times
- Stroke pathway

Planned care standards

- Waiting time between referral to treatment and treatment
- Waiting for diagnostics
- Cancer waiting times
- Improving access to psychological therapies

Cross cutting standards

- Dementia diagnosis rate
- Healthcare acquired infection – MRSA
- Clostridium Difficile

Whole system alignment

During 2014/15 we have strengthened the governance and strategic alignment arrangements between NHS, Social Care and voluntary and community sector organisations – both service commissioners and service providers. NHS Kernow supports two Health and Well-Being Boards, one for Cornwall and one for the Isles of Scilly, and we have ensured our interface with the two councils is as consistent as possible, whilst reflecting very different populations and needs.

A key example of this is the **children's services review and procurement,** which involved both councils, NHS England and NHS Kernow. The children's community services currently commissioned by the four organisations, and delivered across a range of providers, are being aligned into a compatible and coherent procurement process.

Sitting under the Health and Well-Being Board in Cornwall, the **Systems Resilience Group** has been used to align understanding and assumptions around the 2015/16 planning round.

Acting as the anchor for setting our expectations and ensuring engagement with a whole system approach to systems performance, contract negotiation and strategic change, the SRG is becoming a vital forum for developing a whole system approach to improvement.

However, whilst this has been beneficial to some degree, perhaps due to the current financial constraints all organisations are facing, the lower than average allocation for 2015/16, and the operational pressures within the system, individual organisational positions and risks are limiting our progress in aligning around a shared plan, which is deliverable and affordable to all partners. Achieving this is a priority for the first quarter of 2015/16.

Flowing from the System Resilience Group, we are re-establishing joint projects for delivering QIPP and Cost Improvement Plans, and improving performance against key constitutional standards. For each standard not being achieved, recovery trajectories are being negotiated to ensure aligned assumptions on demand and capacity. Where this has not been achieved, such as NHS 111 and waiting times in the Emergency Department, it remains a key priority for resolution during the first quarter of 2015/16.

Executive summary

Governing Body ownership

This operational plan has been driven by the requirement of the Governing Body to have a clear, concise and compelling set of objectives to focus delivery for 2015/16. Given the range of challenges and opportunities, and the constraints on resources, an important aspect for the Governing Body was regular involvement in the prioritisation of objectives, and the alignment of clinical and managerial resources behind these.

Each theme or workstream has a clinical Governing Body lead assigned to it, as well as an executive Director. The Governing Body have held frequent development sessions to receive progress on the plan to inform its shape and focus, meaning that formal sign off has been informed by an iterative process of engagement and ownership.

Having now set out our key priorities for 2015/16, the Governing Body Assurance Framework is being developed to ensure alignment with this plan, and performance reporting and controls mechanisms assessed to ensure they govern the delivery of the plan. Informing the plan, and critical to its delivery, the Network Leadership Group brings together locality commissioning GPs, to drive ownership of the priorities in our 10 localities.

Introduction

The NHS nationally and locally is experiencing major change and challenge. This Plan reflects the demographic and financial challenges that are now part of day to day service delivery.

It has to reconcile increasing demand for services and increasing costs with a limited budget. Performance suffers as demand rises unless quality, productivity and efficiency improves. Rising demand is placing pressure on a workforce that is already at risk from recruitment and retention difficulties.

We must improve performance to ensure the standards of service set out in the NHS constitution are sustainably delivered. Where other areas perform better we must understand what they are doing differently that could be right for people here and change the way we work. We must manage demand, increase productivity and increase capacity without increasing cost.

The gap between the commissioning budget and the cost of care in 2015/16 is estimated at £19.9million – even with addressing this shortfall we are will not meet the financial planning business rules, limiting our ability to invest in some areas.

We have to take action to reduce costs to the level of care we can afford. This will have a significant impact on providers, who also have to meet Government targets to be more cost effective. Risks to the stability of the market will have to be managed.

We are working with commissioner partners and a coalition of providers to deliver solutions. In 2015/16 we will combine a relentless focus on patient flow and quality standards with working smarter to increase productivity and efficiency and starting to roll out our new model of care and support.

We will ensure people receive the right care and support at the right time with a smooth transition from one provider to another.

Organisations and communities across Cornwall and the Isles of Scilly are committed to extending the principles, values and learning from our *Living Well* pioneer programme.

We initiated our change programme in 2014/15 and have trialled new ways of working. In 2015/16 we will implement our new model of integrated care and support in three Integrated Care Communities[1] and by the end of March 2016 it will be operational in three localities with a combined Practice population of 190,000.

It includes new ways of providing care and support shaped by local people and local practitioners to meet local needs, provide better outcomes for people and cost less. It recognises the voluntary sector as an equal partner in providing care and support and our pioneer work has seen the development of a social movement for change in how people and communities take responsibility for health and well-being and are co-producers in care and support.

As an organisation NHS Kernow needs the capability and capacity to balance system leadership of transformational change with building system resilience, commissioning major procurements, and management of contract performance.

[1]The characteristics of Integrated Care Communities and the core components of our new model of care and support are described in our Blueprint..

Preparing our annual Operational Plan

This plan is organised across eight sections:

1. We have looked at what we need to deliver in-year towards achieving our local five year strategic plan and NHS England's five year *Forward View.*

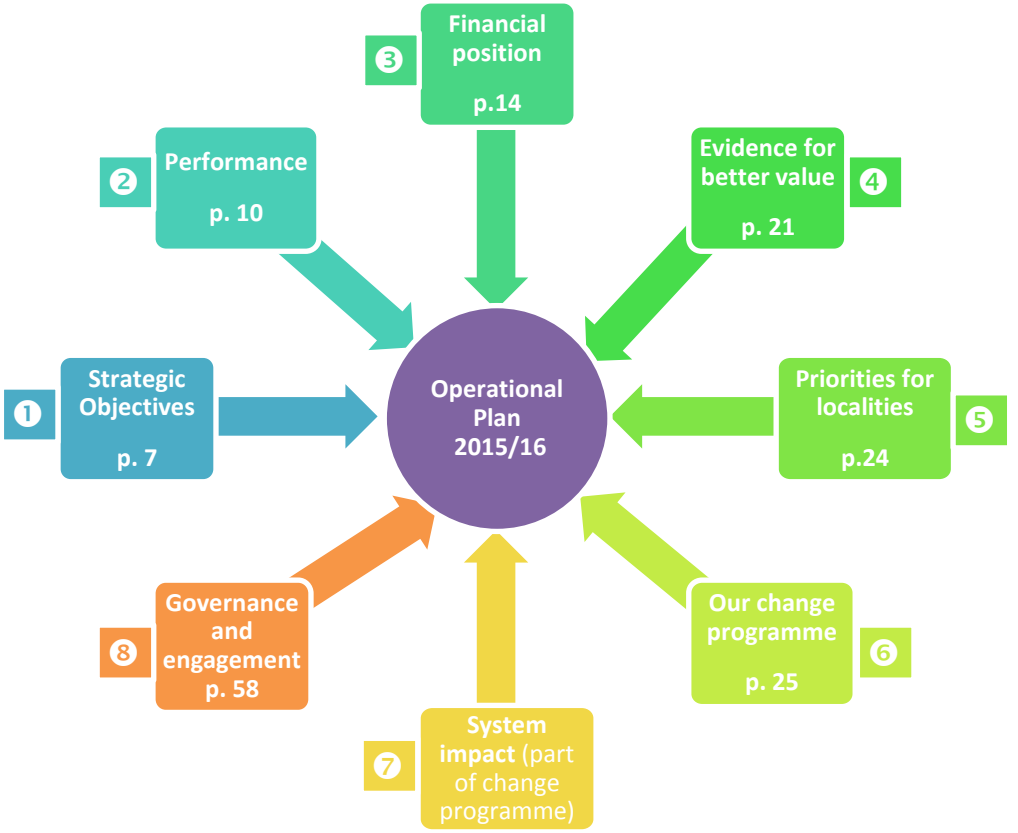
2. We have looked at how well we have performed in 2014/15 and identified what improvements we need to make to ensure we achieve
    a) the standards required in the NHS Constitution
    b) the level of ambition we set ourselves for 2015/16 for outcomes for people and the level of activity across the system

3. We have looked at our financial position and calculated the gap between income and expenditure and the level of savings needed to comply with business rules.

4. We have reviewed the evidence from local audits and trials, benchmarked ourselves against other areas and reviewed national case studies to identify potential ways of delivering better value.

5. The priorities identified by our localities in discussions with local people and practitioners have shaped our plan alongside system wide priorities and national requirements.

6. Taking all the above into account we have determined priorities for change in 2015/16 and updated our change programme.



7. We have assessed the impact of the changes we are proposing on the system and quality outcomes.

8. We have reviewed governance and delivery arrangements to check that both are robust enough to ensure delivery of our Plan for 2015/16.

1 Strategic objectives

Our strategy[2]

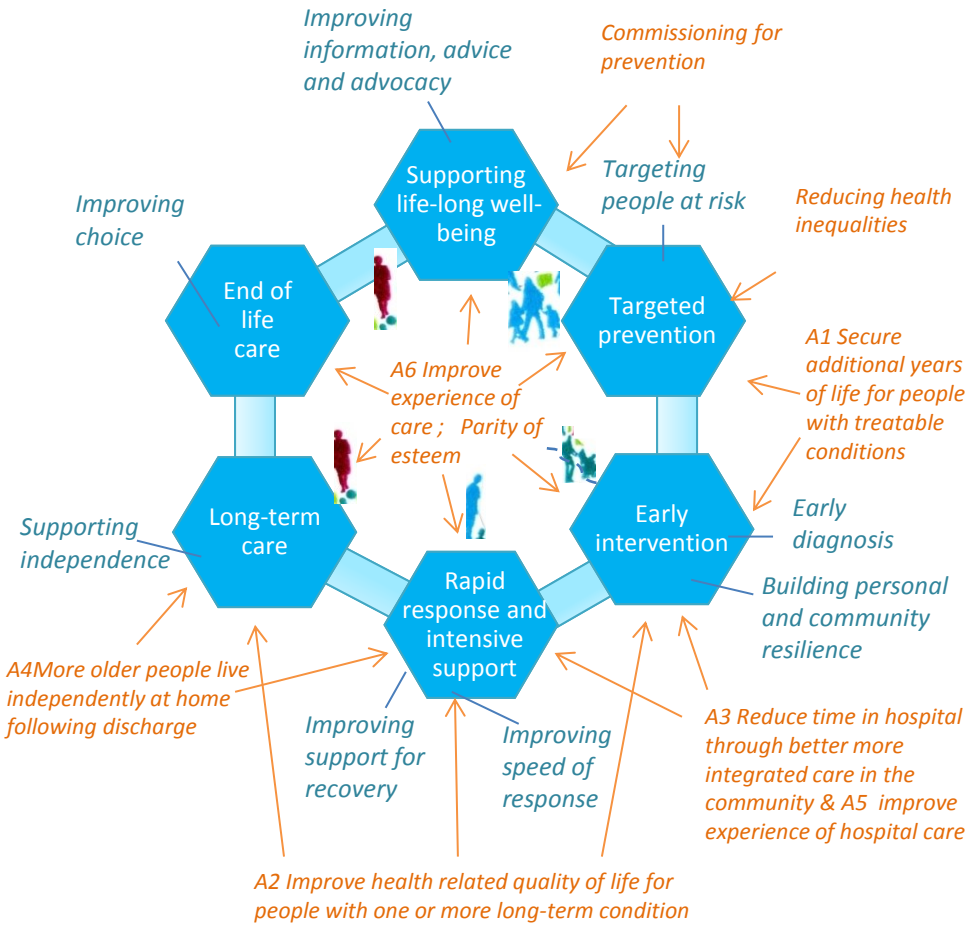
Our strategy is to implement integrated care that is shaped locally by communities to meet local needs and that increases the focus on prevention, early intervention and independence.

Integrated Care Communities[3], with the help of voluntary sector partners, will build social capital to invest in health and well–being and combine behavioural change with a new model of care and support.

Coordinating care and support around the individual, their carers and families, we will wherever possible, move healthcare out of hospital settings into community settings.

Our vision for out of hospital care is one of coalitions of accountable providers (of physical and mental health services) coalescing within a community, bringing together integrated community teams, aligned with a local urgent care hub and clustered around multiple GP practices. It is responsive to individual needs and relies on resilient interconnections between health, social care, voluntary sector, independent sector, public health, pharmacies, the police and local people.

As part of our Pioneer approach we have already seen first-hand the additional skills, capabilities and capacity the community can offer. We need to actively capitalise on this energy, enthusiasm and commitment to create sustainable communities of the future.



We have developed this shared framework with colleagues in Cornwall Council, to identify the areas of common interest – it is helping to drive a more integrated approach to commissioning, as well as shaping integrated provision. It is also designed to deliver the seven ambitions identified by NHS England as key outcomes all health systems should achieve with each element contributing to improved experience of care and support and parity of esteem.

[2]Set out in detail in our five year Strategic plan

[3] The name we have given to communities taking ownership of their health and well-being and working with a coalition of providers to improve care and support in their local area

1 Strategic objectives

The level of ambition we are seeking to achieve in 2015/16 is set out in the following extract from our five year strategic plan:-

Ambition	Measure	Baseline	Est. 2014/5	Est. 2015/6
A1 Secure additional years of life for people with treatable mental and physical health conditions	Potential years of life lost per 100,000 population	1894	1833	1778
A2 Improve the health related quality of life of people with one or more long-term conditions	Health related quality of life for people with long-term conditions	72.8	73.5	75.0
A3 Reduce the amount of time people spend avoidably in hospital through better and more integrated care in the community outside hospital	Rate of emergency admissions for acute conditions that should not usually require hospital admission (composite indicator)	1523.6	1523.6	1511.4
A5 Increase the number of people having a positive experience of hospital care	Patient experience of in-patient care – negative responses per 100 patients from the CQC Inpatient Services Survey	154.1	152.9	150.6
A6 Increase 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	Patient experience of GP out-of-hours services - based on % of people responding 'Good' or 'Very Good' to the question: 'Overall, how would you describe your experience of out-of-hours GP services?'	5.6	5.5	5.4

Life expectancy is around the average for areas comparable to us and better than the mid point for England. We are, however, just worse than both for disability free life-expectancy. This is likely to be associated with the fact that we have a significant level of concentrated deprivation in some neighbourhoods and is where we need to target prevention.

We are better than most comparable areas in terms of quality of life for people with long-term conditions, but worse than the mid point for England, suggesting there is still room for improvement. This is a key element of our *Living Well* transformational work with voluntary sector partners and local communities.

We are better than comparable areas and the England mid point for annual rates of emergency admissions with one exception which is emergency paediatric admissions.

Available data for the year to November 2014 shows activity is on track for unplanned hospitalisation for chronic ambulatory care sensitive conditions, but slightly over plan for emergency admissions for acute conditions that should not usually require hospital admission and for unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s .

We have actions in our plan for 2015/16 to review pathways where 'unqualified admissions' have been identified as the result of a clinical audit and a project focused on reducing avoidable paediatric admissions continues into 2015/16.

Our focus in terms of in-hospital care is on reducing length of stay and improving discharge, given our performance issues with the flow of people through the system. Both will contribute to improving people's experience of hospital care.

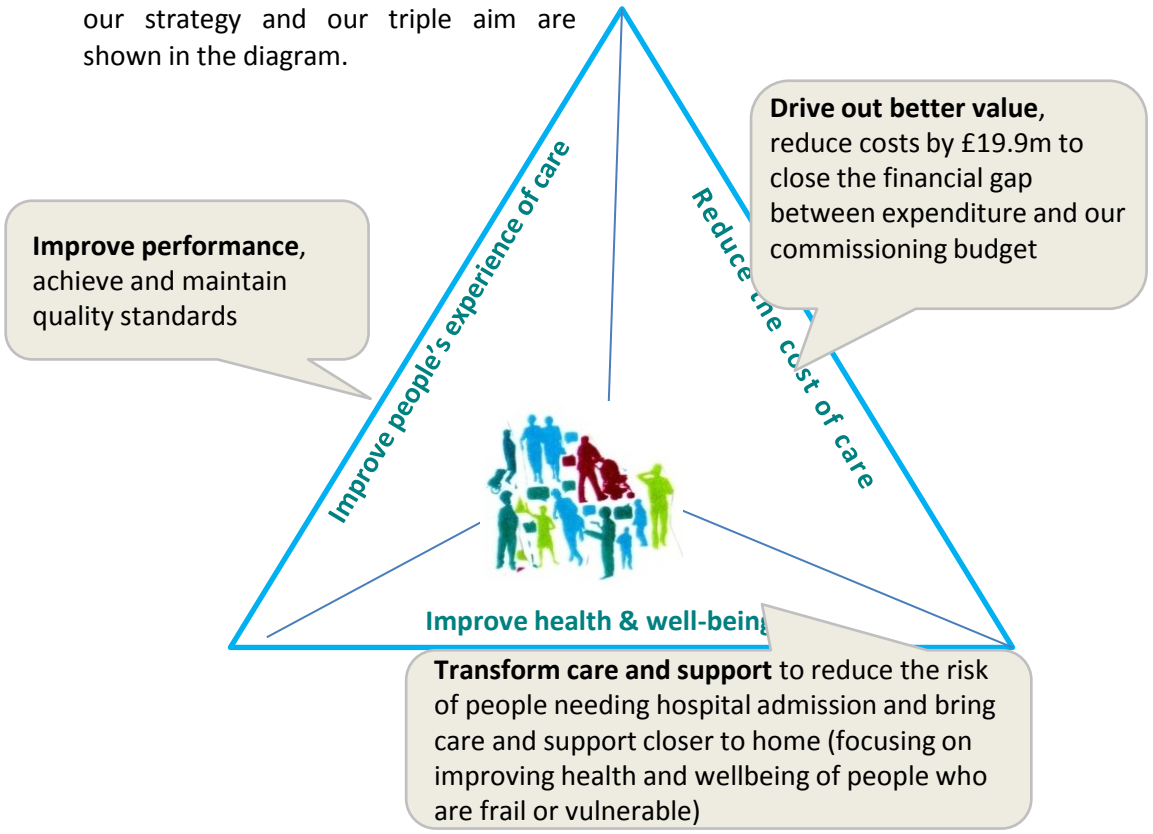
We have issued a new contract for out of hours services and actions that will improve people's experience of the service are included in the driving out better value section of this plan.

1 Strategic objectives

Our triple aim

We have a triple aim to improve health and well-being, improve experience of care and reduce the cost of care in combination.[3]

Our top priorities for 2015/16 to deliver our strategy and our triple aim are shown in the diagram.



Improve performance, achieve and maintain quality standards

Drive out better value, reduce costs by £19.9m to close the financial gap between expenditure and our commissioning budget

Transform care and support to reduce the risk of people needing hospital admission and bring care and support closer to home (focusing on improving health and wellbeing of people who are frail or vulnerable)

Implementing the five year *Forward View*

Our pioneer work in partnership with the Councils and the voluntary sector is empowering people to manage their own conditions and we are developing networks of care and support to help them.

We are piloting urgent care in the community with the help of the Prime Minister's Challenge Fund and our planned care services are moving towards commissioning outpatient services in the community. These three things in combination mean out of hospital care is becoming a much larger element of provision of health services in Cornwall and the Isles of Scilly.

The Children's Services Review will bring together into one service multiple community pathways to ensure seamless care coordinated around the child and their family.

Our strategy recognises the fundamental role of primary care within community based services with practices acting as a focal point and having the ability to adeptly wrap care and organise support services around individuals with a view to maintaining each person's independence for as long as possible.

We aim to transform both delivery and commissioning**.

[4]The reasons for this re explained further in our five year strategic plan

** Our blueprint for our new model of integrated care is included at annex 4

Performance

We have experienced significant performance pressures in 2014/15.

To deliver the standards of care embedded in the NHS constitution, performance needs to be improved for:-

Unplanned care standards

- Waiting time in the Emergency Department
- NHS 111 performance
- Ambulance response times
- Stroke

Planned care standards

- Waiting time between referral to treatment and treatment
- Waiting for diagnostics
- Cancer waiting times
- Improving access to psychological therapies

Cross cutting standards

- Dementia diagnosis rate
- Healthcare acquired infection – MRSA
- Clostridium Difficile

Unplanned care standards

Waiting time in the Emergency Department

The standard required by the NHS Constitution is that 95% of people attending the Emergency Department are admitted, transferred or discharged within 4 hours of their arrival at the Department.

The Royal Cornwall Hospital was last able to achieve the standard in November 2012 and since December 2012, has been below the standard for every month, except August 2013.

Performance fell this year from 91.67% in November to 88.9% in December i.e. worse than December 2013 (91.22%) At its lowest it was 76.89% in September. As at 19th January, month to date performance was 82%.[4]

The Emergency Department standard is an important measure of quality and a proxy for how well the unplanned care system is working.

Timely delivery of urgent acute healthcare is important for patients, whilst overcrowding can lead to compromised standards of privacy and dignity and delays in getting people back to their normal place of residence. Failure to achieve the standard reflects the cumulative delays across the health and social care system.

The Emergency Care Intensive Support Team has recommended a strong focus on flow and discharge[5], which is reflected in the performance improvement part of our programme for 2015/16.

The System Resilience Group has approved a recovery plan. The recovery plan includes compliance with internal professional standards, improving performance feedback and predictive management, managing demand and throughput, and improvements for effective discharge management[6]. The Royal Cornwall Hospital has provided a revised trajectory.

The hospital has strengthened its leadership capacity, with the appointment of a new Chief Executive and Chief Operating Officer.

[4]NHS Kernow Performance & Intelligence service: Report to the Finance, Performance & Quality Committee 23 January 2015
[5] Report of the Emergency Care Intensive Support Team, 25th November 2015
[6] Royal Cornwall Hospital A&E Performance Recovery Plan 2014/15 (copy in the annex).

The System Resilience Group has agreed discharge pledges to ensure a focus on flow between settings of care. Key to this is taking action to reduce delayed transfers of care. February performance has failed to achieve the target of a 50% reduction because of complex workforce challenges and a shortfall in care home and home care capacity.

Actions being taken are:-

- A multi-agency daily review of delayed transfers of care by reason with weekly reporting at senior level
- A 'Getting ready to go home' task and finish group to implement Emergency Care Intensive Support Team recommended patient flow bundle
- A new director of operations in Community Services improving onward care team and community hospital referral, list management, reporting of delays, transfer and discharge processes and implementing a predictive community hospital bed management tool.
- A Care home and home care task group is focusing on a reduction of delays caused by a shortage of provision

NHS 111

NHS 111 is currently struggling to deliver against the 60 second response time target, especially at weekends and bank holidays. Executive level discussions are taking place between the four commissioners and the provider on improving how calls are directed.

The provider has a Quality Development Plan that is being reviewed on a weekly basis by commissioners. It is a consolidated list of all actions they are taking to improve performance covering demand management, workforce, operational management, the service model, leadership and governance.

To address current delays for clinicians, an interim healthcare professional call handling service has been implemented for practitioners and will be mainstreamed in June 2015 as part of the new GP out-of-hours service.

Ambulance response times

There is an on-going issue with ambulance response times caused by a combination of increasing activity and workforce shortages.

Activity has been building during 2014/15 and at November, when the service failed all three key response targets, activity was 8%[7] above the same period in 2013/14. At the same time, despite a recruitment campaign, high turnover rates have been leading to vacancies in the 999 service, most of which are paramedics, linked to a national shortage. Targets were not met again in December. Performance has improved for the Red 1 target in January and the South West Ambulance Service is predicting that it will achieve the target by the end of 2014/15. It is not expecting to achieve the Red 2 and A19 targets by the end of the year.

Stroke

Poor performance of the stroke pathway is a high priority for the System Resilience Group, which is undertaking a whole system pathway review. It has been affected by other bed pressures as part of wider problems of system flow for unplanned care. A recovery plan is being developed with the Royal Cornwall Hospital and partner providers, which will be implemented in 2015/16.

[8]NHS Kernow Performance & Intelligence service: Report to the Finance, Performance & Quality Committee 23 January 2015
[9]NHS Kernow Performance & Intelligence service: Report to the Finance, Performance & Quality Committee February 2015

Planned care standards

Waiting time between referral to treatment and treatment

The standard is that 90% of patients admitted to hospital for planned care will have started treatment within a maximum of 18 weeks from referral. The standard was achieved for 4 of the 9 months to December[8] and performance ranged from 88.03% to 89.99% for the other 5 months. The standard was achieved in December.

In addition, there should be no patients waiting for more than 52 weeks for treatment and 48 people had experienced that situation in the 9 months to December. We are now reviewing these patients on a month by month basis to ensure they have a treatment plan in place.

The Royal Cornwall Hospital Trust has had a backlog of patients waiting for treatment throughout 2014 for people who require both admission to hospital and those who do not need a stay in hospital.

The total backlog in November was 843, above the planned trajectory of 774. This was due to the Trust treating shorter wait or urgent patients rather than backlog patients.

Specialties at the Royal Cornwall Hospital that did not achieve the standard, where people were waiting for more than 18 weeks in November were:

- Trauma & Orthopaedics
- Ophthalmology
- Cardiology
- General Surgery
- ENT
- Gynaecology

The worst performance against the standard and the highest number of people kept waiting was in Trauma and Orthopaedics.

Mitigating action is being taken during 2014/15 by transferring people to the Independent Sector utilising national funding from NHS England, Monitor and the Trust Development Agency: there is £2.5m to transfer 780 patients until 31 March 2015, although uptake by patients is slow. These are people who have waited between 8-16 weeks and who can be treated before they breach the standard.

Plymouth Hospitals Trust has also had a backlog during the whole of 2014, which has been increasing since June and is above the planned trajectory. Staffing issues and non-elective activity has been impacting on capacity. It is unlikely that the Trust will achieve the standard by the start of 2015/16. This will require further action in 2015/16 to be agreed with NEW Devon as the lead commissioner.

Waiting for diagnostics

The standard is that 99% of patients should be seen within 6 weeks for a diagnostics test. This has not been achieved to date in 2014/15 with performance ranging from 96.73% to 98.89%. There was a significant capacity issue at the Plymouth Hospitals Trust that has been addressed and performance has improved significantly.

Cancer waiting times

There is a target that 95% of people should have a first outpatient appointment within two weeks of being referred urgently with suspected cancer by a GP. The target has been achieved for 4 out of 9 months and been underachieved for four months ranging from 93.5% to 94.7%. In December achievement dropped to 91.3%.

There will be an added pressure on performance in 2015/16 when the National Institute for Clinical Excellence issues guidelines this year broadening referrals into the two hour wait category in addition to the national cancer awareness campaigns that will also produce peaks in demand.

Cross cutting standards

Improving Access to Psychological Therapies

We are meeting the access rate targets, but recovery needs further improvement . Current recovery rates stand at 40%, which is below our own and the national target of 50%.

Following advice from the national Intensive Support Team we are introducing a data quality dashboard to improve data recording and providers have been advised how to improve data quality and reconciliation of national and local data.

We are considering an investment opportunity for providers to undertake an audit of non-recovered patients to highlight areas for improvement.

New quality measures are also being installed within the 2015/16 contract. Currently the contract is prohibiting improvement, through perverse incentives, but the end of Any Qualified Provider contract offers us a chance to redesign the service in order to address these.

We believe that a full review of the current service and redesign in anticipation of the post AQP contract will allow us to reach the target of 50% during 2015/16.

Dementia diagnosis rate

Improving dementia diagnosis rates is a current national priority for NHS England with the ambition that the national average diagnosis rate will reach 67% by April 2015. In January we had reached 56.67% and the national diagnosis rate was 58%.

We are implementing additional protocols to accelerate our progress

1. Data harmonisation (" cleaning up" coding on dementia registers)
2. Care home case reviews
3. Reconciliation of secondary care registers/data with primary care

We are working closely with local, regional and national commissioners and providers to ensure we are adopting all best practice guidelines to accelerate our diagnosis rates in a safe, controlled and clinically appropriate manner. This will ensure diagnoses are made and given in a timely, robust and sensitive manner.

Clostridium Difficile

Investigation and learning from cases of *Clostridium difficile* infection (CDI) has developed and progressed during 2014/15.

Building on the collaborative work within our whole system CDI plan a care bundle approach to evaluating care and identifying lapses has been designed and standardised across Devon & Cornwall. This is used for cases identified after 72 hours of admission to acute or community hospitals.

This approach supports strict stewardship compliance and maintains focus on the need to review proton pump inhibitors.

Feedback to primary care has been implemented for all cases raising awareness of risk factors and stimulating reflection about antimicrobial prescribing choices.

This links to the antimicrobial resistance agenda which has gained pace and weight in 2014/15.

GPs are receiving prescribing surveillance feedback to individual prescriber level and this has stimulated discussion and debate and evidence of reduced prescribing is emerging.

The 2015/16 objective challenges us to achieve further reductions and plans are in place to refine learning systems following the publication of new guidance.

3 Financial position

The financial position in 2015/16 is a challenging one and we are only able to plan for a small £0.5million surplus, falling short of the required 1% surplus of £7.3million, and excluding the national requirement for Clinical Commissioning Groups to hold a 1% headroom reserve. This position has been exacerbated by

- A very poor growth allocation compared with the national average - the joint lowest as a result of the national 'fair shares' funding calculation
- The resource support requirements to ensure continuation of high quality community services
- NHS Property Services charging and funding pressures

These three things have a significant impact on our 2015/16 plan (over £20million in total, when comparing to average national growth levels on available Clinical Commissioning Group resources for 2015/16).

The Plan does not achieve the core business rules requirement of delivering a 1% surplus. There is therefore a requirement for a Financial Recovery Plan that will set out milestones and deliverables to return us to compliance with business rules.

An organisational review is underway to ensure the organisation is focused on delivery of this challenging plan including the successful delivery of QIPP, building on the lessons of 2014/15.

We plan to deliver 2.7% (£19.9m) savings in 2015/16 which is essential to ensure delivery of the financial position for 2015/16 and beyond.

The running costs funding reduces from £13.5million to £12.2million, in line with the national requirement for a 10% reduction.

Investment in growth

NHS Kernow is well above England for over 50s (*fig 1*) the key age range for both elective and non-elective care - this weighting in age demography puts us at a significant cost disadvantage.

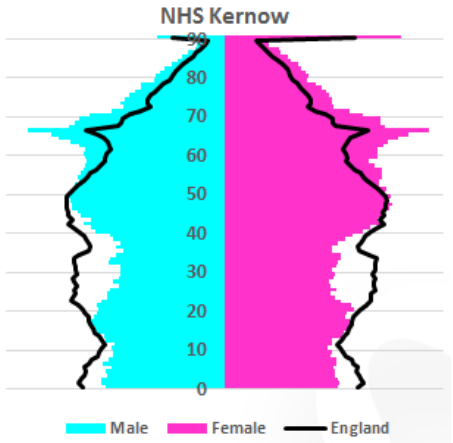


Figure 1

Our activity demand for 2015/16 is primarily based on the Office of National Statistics predicted population shifts.

The % growth in our population by age band is shown in *figure 2*.

The highest growth areas are predicted to be in people aged in their late 60's and early 70's. This has a particularly significant impact on emergency admissions as our activity and spend is heavily weighted to older people.

Overall the population NHS Kernow serve is predicted to increase by 0.95% in 2015/16 and this is similar for the next 5 years.

Once we apply the ONS growth prediction to our activity split by age, the additional non-elective growth we can expect in 2015-16 increases to 1.5%. Additional pressures have resulted in an average growth rate of 2.3% over the last three years, which has been applied for 2015/16.

The growth rate in planned care is 2.7% comparing year on year, but taking into account counting and coding changes it is 0.1%

This has formed the basis of our demand modelling across all points of delivery. The percentage growth is applied at an age and casemix level and therefore varies by health resource group, specialty and admission type.

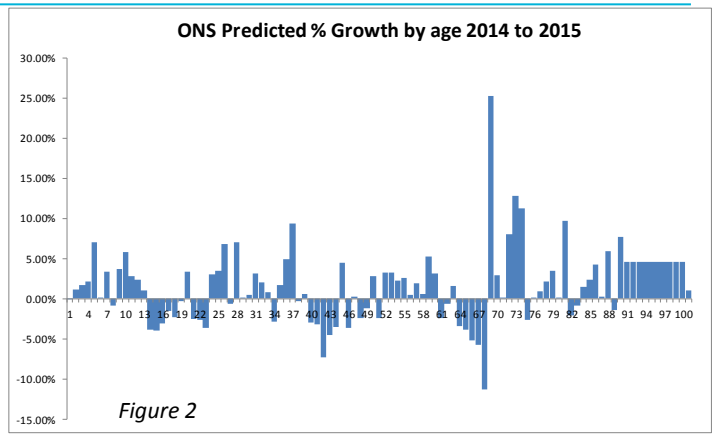


Figure 2

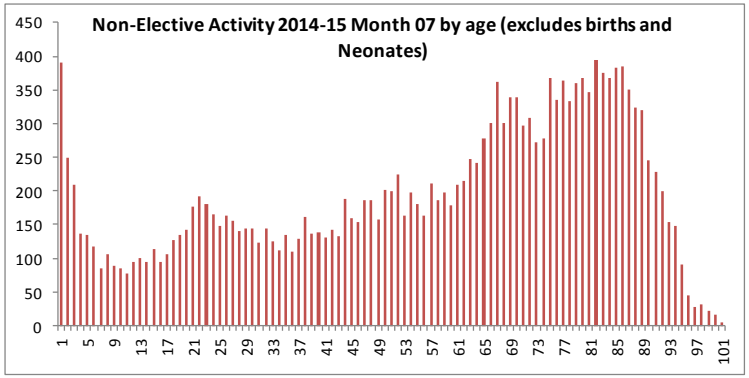


Figure 3

Investment in cancer services

In addition to the growth above, NHS Kernow has built in additional levels of activity to the activity associated with the diagnosis and treatment of cancer.

This has been estimated using local intelligence and liaising with clinical leads. A growth of 3.5% has been applied.

For high cost drugs and devices we have built in growth of 16%. This equates to an investment of £1.3m.

Investment in reducing waiting lists

In addition to applying straight demographic growth, we also need to consider the impact on this year's activity on the overall waiting list size and the resulting backlog.

Although we normally start the activity plan using the forecast outturn for the previous year, if this activity has not been enough to deliver a balanced capacity and demand position, then this will result in a growth in the overall waiting list.

This year, as an example, at the Royal Cornwall Hospital Trust the total waiting list for first outpatient appointments has grown by 1,320 cases in the first 7 months of 2014-5. Full year impact is an estimated 2,262 cases.

The growth in the inpatient list has also been significant. In the first 7 months of the year it has grown by 131 cases.

We have built admitted backlog reduction/dealing with latent demand into our activity planning assumptions for our plans with our main providers.

We have also built in additional activity to address the outpatient waiting list growth and follow-up backlog at the Royal Cornwall Hospital .

In addition to this there has been an historic issue within the Ophthalmology service at the Royal Cornwall Hospital and we have commissioned an additional 2,500 follow-up appointments from the Trust.

3 Financial position

New out of hours service

Funding is set aside to cover the expected contract sum for the new out-of-hours contract.

The 'over 75s' (£5 per head budget)

NHS Kernow remains committed to delivering effective services for older people. Our *Living Well* work has been exploring new ways of supporting people in the community to avoid unnecessary admissions and create a better quality of life overall.

Historically an investment reserve of £2.75m was identified to support service innovation in this area. The financial constraints now facing the Clinical Commissioning Group mean that it is not feasible to create this funding source at this point, unless the schemes can also demonstrate a clear and swift reduction in admissions or other treatment costs, releasing cash.

In this context, we no longer are able to set aside an 'investment reserve' to fund these initiatives but will continue to work with localities to develop schemes that are cost-neutral or better to meet the needs of the older people of Cornwall and the Isles of Scilly.

Growth in continuing healthcare

Growth in continuing healthcare demand has been estimated at 2.5%, but this had been eliminated and a further £3.2million cost reduction has been included.

Growth in primary care prescribing

Primary care prescribing has nominal growth of 4.5% but the plan anticipates this being mitigated by QIPP and savings to hold expenditure below 2014/15 levels.

Other cost reduction

A further target for cost reduction and savings by rationalising a group of other small contracts has been modelled at £2million. Significant levels of savings have been targeted in the acute sector, across both elective and non-elective care.

Other specific savings targets have been set across specialist placements, and the estates funding gap.

The financial recovery plan

The Financial Recovery Plan continuies to be developed and a further draft is expected by 31 May. Considerable focus is being placed upon this plan organisationally and will be central to our corporate objectives in 2015/16 and beyond.

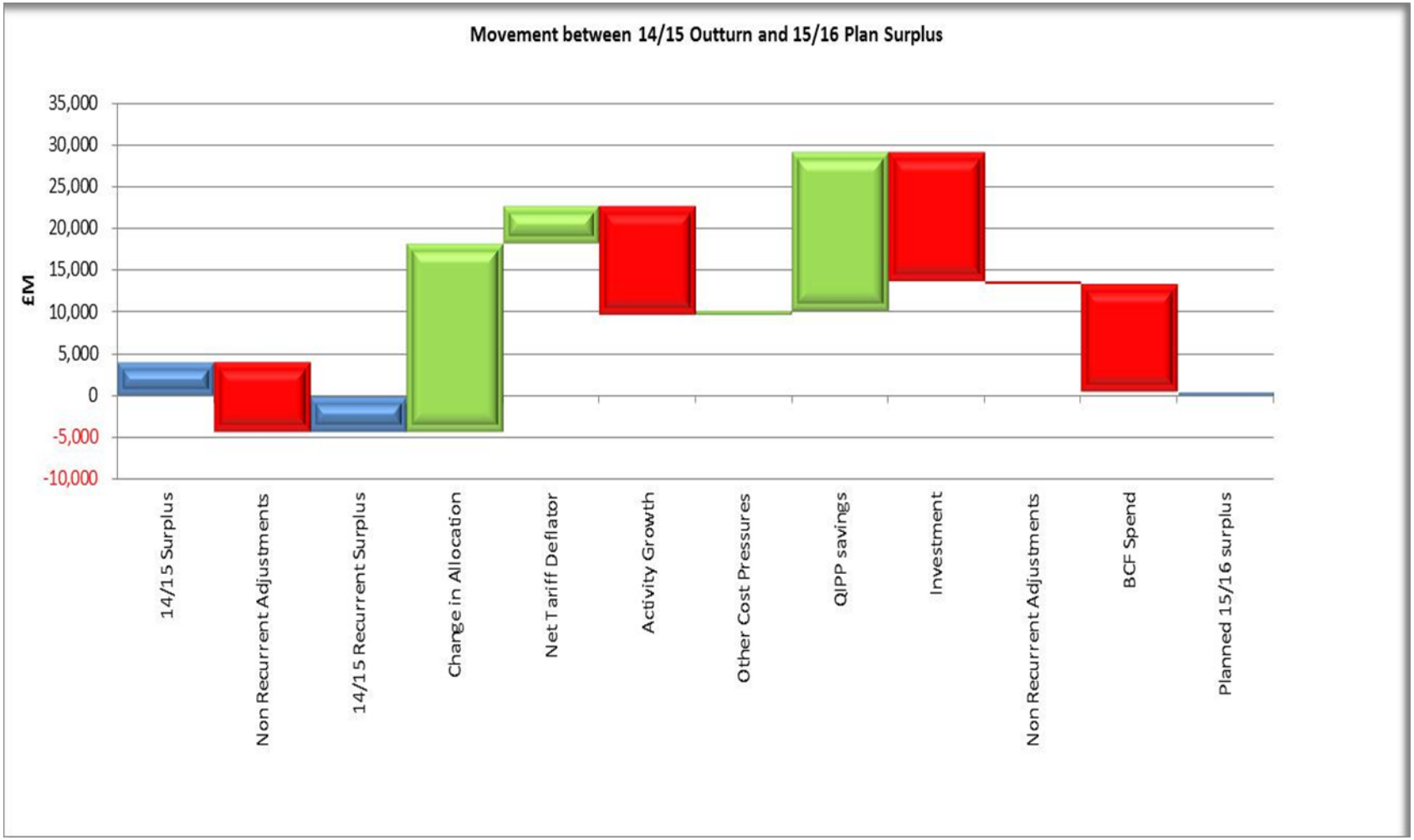
The Clinical Commissioning Group is also developing and driving a system wide approach to financial recovery in recognition of the financial challenge facing the Healthcare Community.

In developing and delivering our plans for better value we aspire to move as soon as possible to the top 10% in the Country for all better value related indicators.

Key messages

- 15/16 Plan delivers a small £500k surplus
- No headroom reserve
- Estimated impact of enhanced tariff offer is approximately £1.3m above national funding provided.
- Delivery of a £19.9m, 2.7% QIPP is required within this plan
- Current plan regarded as high risk given levels of QIPP and risk on variable contracts.

3 Financial position



Investments

Operational Resilience and Capacity Planning

We received additional funding in 2014/15 to increase capacity over the winter period. This was invested to increase capacity in key areas in order to improve flow through the system. In line with national guidance, key schemes have been continued in April 2015. The impact of this investment is being monitored and will be evaluated early in 2015/16.

The funding has been included in our base budget allocation for 2015/16, and reflected in contract negotiations with key partners. Overall, our financial commitments to local hospitals, supporting community services, mental health liaison and incentivising reductions in delayed transfers of care will exceed the earmarked sum within our 2015/16 funding allocation.

Prime Minister's Challenge Fund

This is additional non-recurrent funding we received in 2014/15, for which there has also been an extension in 2015/16 to enable us to test options for increasing access to GP primary care services. These will be evaluated during 2015/16 to determine which ones will deliver best value to be considered for commissioning on an on-going basis.

Enhanced Tariff Offer

During the initial preparation of plans for 2015/16, we based our proposals on the draft national tariff arrangements. These included an expectation of 3.8% efficiency within providers and a move to paying 50% (instead of 30%) of tariff price for emergency admissions above 2008/09 levels.

The draft tariff was objected to by a significant number of providers nationally and this led to a revised 'Enhanced Tariff Offer' being issued by NHS England. Most of our providers have elected to move to the enhanced tariff offer arrangement for 2015/16 as it reduces the efficiency expectation to 3.5% and moves the proportion paid on the emergency admissions up further to 70%.

We estimate that this revised offer will add approximately £3.3million to our expenditure in 2015/16 – national funding of £2million has been made available to us as a contribution to this gap, but the remainder has had to be factored into our overall Plan position.

Other options

We are also exploring with voluntary sector partners the potential opportunities offered by social impact bonds.

Cornwall also has access to European Funding and we are exploring with Cornwall Council and other partners opportunities for this to be used to support development of the labour market .

3 Financial position

Delivering Better Value theme and plan title	Plan value 2015/16 Gross savings (£000's)	Investment (£000s)
Achieving upper quartile performance in planned care		
- Outpatient new to follow up ratios (pages 35-6)	1,728	-
Reducing avoidable admissions and attendances in unplanned care		
- Paediatric non-elective admissions (page 34)	422	-
- Alcohol care team and pathway (page 49)	480	133
- Avoiding non-elective admissions	1,660	-
Medicines optimisation		
-prescribing (page 38)	4,960	-
-Blueteq implementation (page 38)	1,700	
Better value in individual patient placements (page 37)	4,700	
Investment to delivery prescribing, patient placements		756
Technical and contractual changes		
Community projects - small contracts review	2,000	
Property services reduced charges	300	
Learning Disability placement costs	368	
MRI knees and spine	302	
Marginal impact of local acute schemes	643	
Procedures of limited clinical benefit	438	
Dermatology	119	
Other minor RCHT schemes	38	
ED diversion	60	
Total value	19,918	889

List of Delivering Better Value schemes and technical and contractual changes that will deliver QIPP savings

Evidence for better value

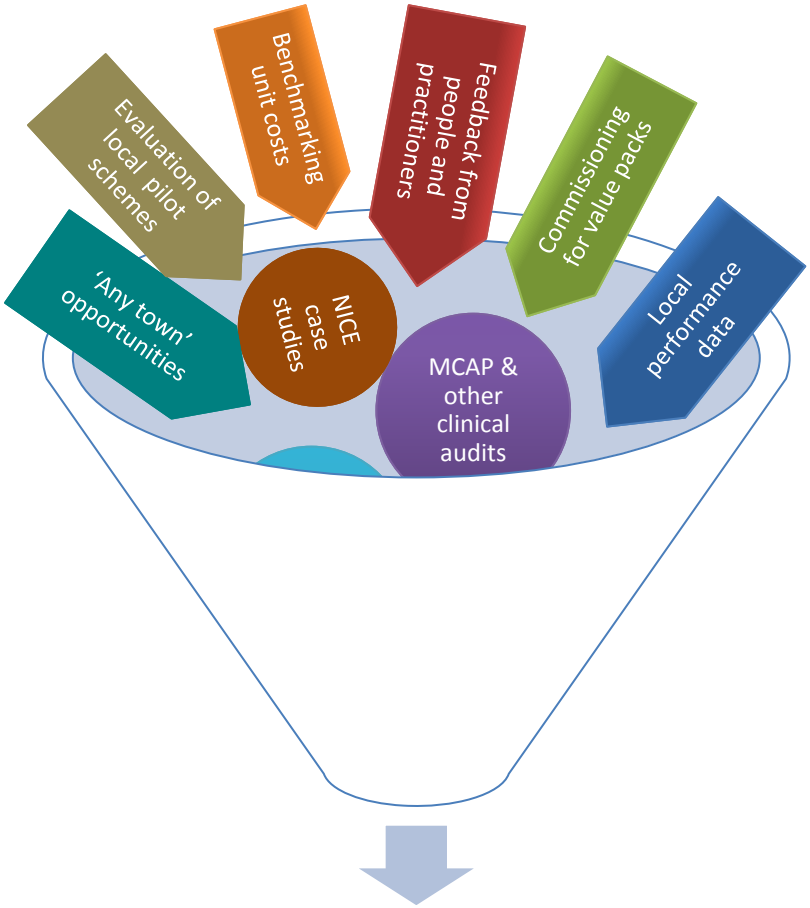
Assume needs updating?

Evidence that has been reviewed to identify the key issues and opportunities for 2015/16

Our operational priorities for 2015/16 are based on evidence drawn from

- Projected demographic growth
- Independent assessments by national teams of our delivery of emergency care and improving access to psychological therapies
- Clinical audits
- Inspections by the Care Quality Commission
- Activity and costs benchmarked against comparable areas
- Feedback from local people and practitioners
- Learning from local trial schemes and evaluation of pilots
- Our local performance monitoring reports
- A review of best practice examples implemented in other areas

Modelling of bed capacity across the system is currently being commissioned and will inform later iterations of our five year Strategic Plan and Operational Plans.



4 Evidence for better value

The local context for change and a stock take of the results of local audits and commissioning for value information was set out last year in our *Case for change* accompanying our five year strategic plan.

In seeking to drive out better value, we need to consider that Cornwall:

a) Is a peninsula with many small rural settlements and rural isolation - the 'market' for choice and competition is therefore limited.
b) Has significant 'hot spots' of concentrated deprivation
c) Has a weak and low-waged economy

To target action to achieve better outcomes and better value we need to look at:

1. The age profile of our population – we need to focus on the challenge of an ageing population
2. The prevalence of certain diseases – we have an above average prevalence of depression, obesity, asthma, coronary heart disease, stroke, cancer, chronic pulmonary disease, heart failure, epilepsy and dementia

Outcomes benchmarking information from the 'commissioning for value pack' showed where we could do better compared to our peers or the mid point for England. These are:

- Years of life free from disability
- Health related quality of life for long term conditions (as good as our peers but just under the England mid point)
- Emergency admissions for children with lower respiratory tract infections
- Patient experience of GP out of Hours services
- Patient experience of dental services

Local people and practitioners gave us feedback through events run by our GP Practices and common themes were the importance of communicating better, joining things up, increasing prevention and early diagnosis, making GPs more accessible and valuing voluntary work.

Long-term trends in the commissioning support packs showed that growth in both planned and unplanned admissions has been significantly less than the national average. Current trends in hospital admissions have shown:

- The average cost of an emergency admission is 20% higher when co-morbidities are present and the number of co-morbidities are linked to frailty
- From age 70 onwards, 60%-70% of all patients admitted have a co-morbidity with an increase in resources for patients over the age of 70
- The two primary co-morbidities within older people's admissions are dementia and congestive heart failure.
- Patients aged 65+ tend to have longer lengths of stay and the over 75s have a high number of admissions.
- In community hospitals in-patient beds are primarily used by people following an acute hospital stay and most common admissions are stroke, hip trauma, urinary tract infection, and pneumonia.

In the commissioning for value packs, compared to the best five among a peer group of ten we have higher numbers of planned admissions for circulation problems and trauma and injuries. Planned admissions cost more for:

- Circulation problems
- Musculoskeletal problems
- Cancer
- Neurological problems
- Gastrointestinal problems
- Endocrine problems

We have higher numbers and higher cost of unplanned admissions for circulation problems, trauma and injuries and genitourinary problems.

4 Evidence for better value

Current benchmarking Cornwall and the Isles of Scilly against other comparable areas shows us as a significant outlier in musculoskeletal problems and treatment.

Standardised admission rates for Orthopaedics are higher than the national average; the assumption that needs to be tested is that the main reasons for this is the amount of available capacity and unexplained variability in referral and treatment thresholds.

Orthopaedics is a major part of the provision by the Independent Sector and Independent Sector providers of elective care have seen some growth in market share, largely due to the impact of shorter waiting times than NHS providers and NHS Choice.

Indicator	Value	England	Similar 10	England Min	Spine chart	England Max
▶ Respiratory System Problems - COPD						
▶ Respiratory System Problems - Asthma						
▼ Musculoskeletal System Problems (Excludes Trauma)						
% of people (over 45) who have hip osteoarthritis (total)	11.57	10.87	10.82	9.57		12.06
% of people (over 45) who have knee osteoarthritis (total)	19.09	18.19	18.09	14.68		20.81
% of people (over 45) who have hip osteoarthritis (severe)	3.51	3.21	3.20	2.32		4.00
% of people (over 45) who have knee osteoarthritis (severe)	6.63	6.09	5.97	3.90		7.96
Primary hip replacements per 100,000 population	191.10	131.42	150.72	44.08		191.10
Primary knee replacements per 100,000 population	134.82	131.37	130.82	32.24		216.89
% of osteoporosis patients aged 50-74 years with a fragility fracture treated with an appropriate bone-sparing...	91.11	91.87	90.85	66.67		100.00
% of patients aged 75+ years with a fragility fracture treated with an appropriate bone-sparing agent (OST 03)	70.85	72.53	69.19	51.82		97.87
Spend on primary care prescribing for Musculoskeletal problems per 1,000 weighted population	6,239	5,995	5,872	3,042		9,142
Pre-treatment EQ-5D Index: hip replacement	0.383	0.351	0.372	0.147		0.485
Pre-treatment EQ-5D Index: knee replacement	0.443	0.409	0.447	0.204		0.549
Spend on elective and day-case admissions for Musculoskeletal problems per 1,000 population	45,017	36,491	38,438	17,451		56,662
Spend on non-elective (emergency and other non-elective) admissions for Musculoskeletal problems per 1,00...	3,174	3,702	3,629	2,242		6,594
Health Gain EQ-5D Index: hip replacement	0.419	0.438	0.432	0.276		0.584
Health Gain EQ-5D Index: knee replacement	0.317	0.318	0.317	0.229		0.449
Emergency readmissions to hospital within 28 days for patients: hip replacements (%)	3.66	5.57	5.99	2.71		9.86
▶ Trauma & Injuries						
▶ Genitourinary - Renal						

4 Evidence for better value

The ratio of follow up outpatient appointments to first appointments across a range of specialties at the Royal Cornwall Hospital when compared to national averages also highlights potential of up to £4.4m in savings if the specialties achieved upper quartile performance.

Clinical referrals from NHS 111 or from GPs or other healthcare professionals need to be understood and managed, with variations analysed for opportunities.

Although standardised admission rates are mainly below expected levels (a score of 100), a sample of activity shows variation between GP Practices from 70.26-142.32 with 6 above 110*.

Our 70 GP Practices operate different models of care: some provide walk-in facilities, others have a telephone triage system, others offer a booked appointments system. There are also workforce issues that may already be affecting some practices.

The Emergency Care Intensive Support Team recommended a comprehensive review of primary care delivery to clearly define its role in unplanned care.

They also recommended home visits early in the day so that patients arrive at the acute hospital when the majority of decision makers are still on site and a review of access to extended hours in primary care.

The Emergency Care Extensive Support Team recommended an extension of ambulatory care pathways and national case studies** show potential to substitute ambulatory care for in-patient admissions.

Implementing care pathways for patients who need admission will deliver improved outcomes for patients, and free up capacity for the hospital through great coordination and proactive planning of resources.

During 2014/15, clinical leaders have developed a suite of care pathways for presentations highlighted by MCAP™ audits conducted at the Royal Cornwall Hospital.

The audits identified the follow areas where 31% -36% of people in hospital were `medically unqualified'*** to be admitted:-

- Chest pain
- Pneumonia
- Heart failure
- Headache

The benefits from this work need to be evaluated and fully realised and the care pathways extended to 'out of hospital' parts of the system.

To further provide assurance of opportunities for improvement, we have commissioned the following review:

- Modelling of high impact interventions from national best practice;
- Using the 'Anytown Lite' tool published by NHS England, an estimate of further potential financial savings from schemes not implemented;
- Assessment of peer and national benchmarks to estimate where activity may be higher or lower than comparator economies
- Estimation of intervention gross and net savings opportunities to drive our Delivering Better Value programme.

*NHS Kernow Performance & Intelligence service: Practice Activity Summary April – July 2014
** Directory of Ambulatory Care
*** The medical condition they were seeking help with did not need acute care and could have been treated in an alternative setting

5 Priorities for localities

Shared ambitions for 2015/16

Our ten GP Localities * are leading development locally of our new model of care – bringing together practices, communities and providers of health and social care services to coordinate care around individuals.

Priorities across all localities are :-

- Improving links with community care providers ;
- Information sharing and interoperability as a critical enabler for system-wide change
- A wish to own change in their local area with Practice based 'patient lists' and multi-disciplinary teams providing the basis locally for Living Well

The *Living Well* prototype projects in Newquay, Penwith and East Cornwall are enabling those localities to harness resources available within the Voluntary and Community Sector.

They have also helped local partners come together to explore and develop integrated processes and information sharing across multi-disciplinary teams.

These three localities covering a Practice population of approximately 190,000 are in a strong position to lead the way in developing Integrated Care Communities** and a suitable infrastructure for their management. They will provide valuable learning that will support other communities to progress their planning.

Localities are at different stages of preparation for change. There are also differences in geography, facilities and needs, which all have a bearing on their local priorities. Some localities have a well formed approach to community team development whilst others have a focus on facilities and services.

Local priorities for 2015/16 include:-

- Refining the format of local multi-disciplinary team and HUB meetings to improve mental health services
- Implementing a poly-pharmacy function to deliver comprehensive medication reviews for the over 75s
- Better access to minor illness services
- Expanding the number of elective procedures provided in the community
- Closer cross-border working with Devon primary care
- Expansion of services at community hospitals (Intra venous therapies, blood transfusions, dressings, International Normalised Ratios – averaged times for blood clotting)
- Supporting care within nursing homes
- Develop a 'Community Watch' approach empowering people to support people
- Identifying available community and voluntary resources
- Developing urgent care and an ambulatory care centre in Camborne/Redruth and an on-site social care coordinator
- Improve access to child, adolescent and adult mental health services

Isles of Scilly

Because of the unique geography and transport issues, the priority for 2015/16 is to continue the expansion of diagnostic facilities and staff training to increase the capability to supporting patients without transfer to the mainland. Services are already well co-located with strong partnership working across health, social care and voluntary services, with 2015/16 providing an opportunity to review estates for further integration of services and teams.

* The 10 GP Localities formed from the natural practice communities shaped over the years. Focusing on commissioning, rather than provision., each GP Practice has a mandated GP to represent their practice, and in each locality, a GP is nominated to act as the Locality lead GP. This structure is being used as the foundation for driving networks of provision now too. **Described in our Blueprint

6 Our change programme

Our priorities for 2015/16

Current issues with performance and the evidence of potential for better value mean that two of our priorities for 2015/16 are to improve performance and drive out better value to build the foundation for transformation.

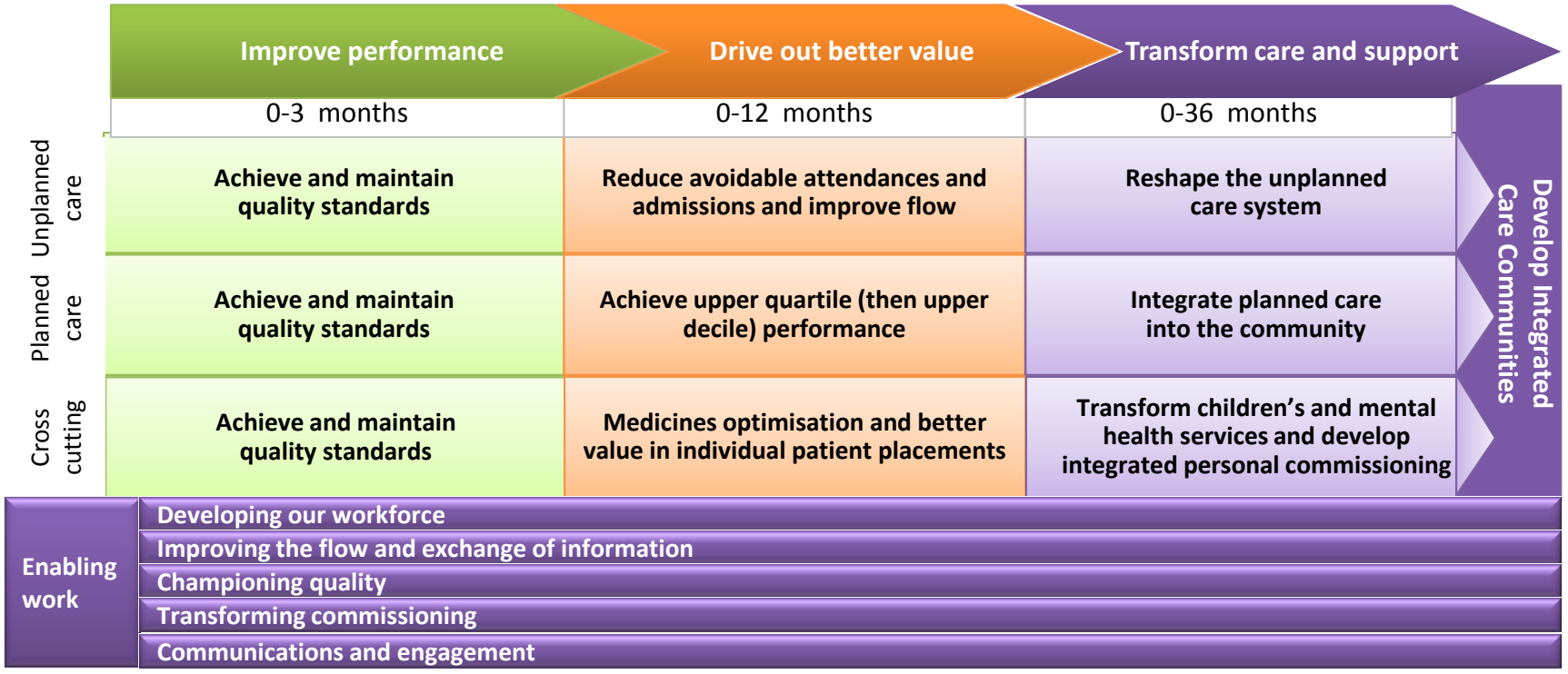
Performance issues need to be urgently resolved and this is continuation of work started in 2014/15. Schemes to deliver better value will need longer time to develop and mobilise and are likely to realise benefits part way through 2015/16.

Extending our innovative pioneer work and delivering our local element of the first year of the five year Forward View is our third priority and is focused on transforming care and support for those who are frail/vulnerable to reduce their risk of being admitted to hospital during the year.

The diagram below sets out the over-arching structure for our change programme and programme objectives for the unplanned and planned care systems and other cross cutting areas of the Clinical Commissioning Group's responsibility.

These are expanded upon in the following section of our plan, and this structure is used to shape the allocation of resources and reporting of performance.

Our change programme



Improve performance

Unplanned care

Achieve and maintain quality standards

Improve NHS 111 performance and achieve the 60 second call answering standard

Actions in 2015/16

- Improve recruitment and retention of call advisors and a change to the workforce model
- Improve streaming of people at the point of calling NHS 111
- Increased use of clinicians for people with complex needs, either in the call centres or through remote clinical triage
- Direct streaming of 'at risk' patients with special patient notes, from NHS 111 to the Out of Hours service
- Clinical review of non-life threatening 999 ambulance dispositions (so called green 999 dispositions)
- Improve the interface with the new Cornwall Health out of hours GP service
- Continuation of a dedicated team working in NEW Devon CCG to continuously update the Directory of Services and full demographic and clinical validation twice a year.

Increasing stakeholder engagement

- With primary care and other providers
- With locality commissioning teams
- With the Local Medical Committee and the Health Overview and Scrutiny Committee of Cornwall Council

7 System impact

- Only people needing triage are handled through the NHS Pathways system
- Improved call answering performance
- People receive a better service and NHS Pathways dispositions are validated
- Reduce avoidable ambulance call-outs, freeing capacity for those most in need
- Making better use of GPs in remote clinical triage, in the Out of Hours service
- Stakeholders understand and support the changes needed and there is increased confidence in the service
- People with urgent care needs get the right advice in the right place, first time

Improve performance

Unplanned care

Achieve and maintain quality standards

Ambulance response times

South Western Ambulance Service NHS Foundation Trust did achieve Red 2 and A19 targets by the end of 2014/15 so recovery action needs to continue in 2015/16.

Action being taken by the Ambulance Trust that will continue in 2015/16

- Additional clinicians in the clinical hubs to increase the number of 'hear and treat' outcomes for each call
- Further develop local action plans to increase the see and treat rate
- A recruitment campaign to address recruitment and retention challenges
- A university partnership to develop current staff into the grade of paramedic

System resilience funding is also being used in the current year to support delivery by increasing capacity with private ambulances, overtime and agency staff. A decision on the use of system resilience funding in 2015/16 will depend on an evaluation of all the resilience schemes during the first quarter of 2015.

❼ System impact

- A reduction in avoidable ambulance call-outs
- Future potential to further develop the role of paramedics to be able to treat more people at the scene
- Fewer avoidable conveyances to the Emergency Department
- Ambulance capacity released to support those requiring ambulances
- Emergency Department capacity released to treat patients, and improved Emergency Department 4hr target performance
- Improved recruitment and lower attrition rates for paramedic staff, leading to improved productivity and outcomes

Improve performance

Unplanned care

Achieve and maintain quality standards

Waiting time in the Emergency Department

Actions reflect priorities identified by the Systems Resilience Group from the recommendations of the Emergency Care Intensive Support Team*

Joint action in 2015/16 to further improve flow

- Proactive case management of frail vulnerable people through multi-disciplinary teams across health, social care and the voluntary sector.
- Improve efficiency in `front door' services at the Royal Cornwall Hospital (Emergency Department, Acute GPs, Medical Admissions Unit, Ambulatory Care Unit)
- Increase 7 day working
- Implement safer patient flow processes across the system
- Achieve system discharge pledges adopted by the Systems Resilience Group
- Implement and standardise effective discharge management protocols (local CQUIN**)
- Improve whole system escalation
- Improve availability of care home places and home care
- Review of people who have been seen by the Emergency Department to determine whether they could have been treated in primary care to inform development of primary care (in and out of hours)

❼ System impact

- Increased resilience to peaks in demand
- Reduced demand coming through the front door of the Emergency Departments
- Only those patients whose medical needs require it are admitted to an in-patient bed
- Eliminates unnecessary and avoidable delays for patients and beds become available sooner
- Reduce the number of people waiting for packages of care or a place in a care home (delayed transfers of care)
- Escalation status is reduced, staff morale is improved and patient experience is improved
- Single point of entry to patient transport system and consistent standards of service
- Improved capacity and capability of the domiciliary care and care home sector

* Report of the Emergency Care Intensive Support Team to NHS Kernow, 25/11/14.
** Commissioning for Quality and Innovation payments.

Improve performance

Unplanned care

Achieve and maintain quality standards

Stroke

Direct admission to the stroke unit remains a significant challenge due to constraints within the complete stroke pathway. This materialises in patients who have completed their acute phase of the pathway and then queue on the stroke unit awaiting community stroke rehabilitation and therefore occupy a stroke unit bed beyond their acute phase.

Approximately 24% of patients at the Royal Cornwall Hospital are admitted directly to the stroke unit against a National average of 58% and against the national quality standard of 80% of all confirmed strokes. Currently 48% of stroke patients at the Royal Cornwall Hospital spend more than 90% of their stay on the stroke unit against the national average of 83% spending 90% of their time on the unit. The Royal Cornwall Hospital is focusing on providing a comprehensive action plan demonstrating requirements needed and confidence levels in resolving the performance by 16th March 2015.

Key changes required for 2015/16

The Trust is asked to focus on exploring possible contributions to delays that impede patients spending 90% of their stay on the stroke unit.

- Demand and capacity for sufficient beds on the stroke unit.
- Consider the moving immediate post thrombolysis care to the stroke unit and explore capacity within the Stroke Early Supported Discharge Team, to ensure there is sufficient capacity to meet demand within that service.
- A Service Development and Improvement Plan has been included in the contract for 2015/16

7 System impact

- Increased capacity
- Increased proportion of patients treated in the right care setting
- Improved outcomes for patients

Plymouth Hospital Trust is also experiencing similar issues with compliancy and in January shared a proposal for service redesign for the whole stroke pathway. This will be shared with the Royal Cornwall Hospital Trust for synergies to ensure that the collective Trust and Community settings provide system improvements that enable a sustain stroke performance across Cornwall in the short and medium term.

Improve performance

Planned care

Achieve and maintain quality standards

Improving performance in waiting times

The capacity and flow issues in the unplanned system are affecting specialities delivering planned care- this is impacting on delivery of the Referral To Treatment and waiting time standards. Both actions to improve flow and discharge in unplanned care and the in-depth review of surgical capacity in planned care, will help resolve the issues. We also need to prepare for the impact of new guidelines from the National Institute for Clinical Excellence to increase the number of people who are diagnosed early with cancer.

Action in 2015/16

- Continued patient level focus on Referral To Treatment standards and tracking of patients at the two acute hospitals
- Reduce the backlog of patients waiting over 18 weeks for treatment
- Implementation of a ring and remind service for all elective procedures (supported by local CQUIN) – patients will be contacted the week before and again two days before surgery – baseline data is required for each specialty so that improvements can be clearly measured. Includes an action plan with trajectory detailing phased implementation across specialties with those with highest cancellation rates first.
- A Service Development and Improvement Plan for cancelled operations has been included in the 2015/16 contract with the Royal Cornwall Hospitals Trust
- Preparation for guidance from the National Institute for Clinical Excellence that will be broadening referrals in the 2 week wait category for cancer treatment, including demand and capacity analysis for diagnostics.

7 System impact

- Fewer people treated beyond the NHS constitutional standards for planned care.
- All patients receive adequate notice of their procedure
- Fewer cancelled operations with any late cancellation slots recycled and filled in advance reducing cancellations on the day
- Fewer non-attendances at mental health clinics
- An increase in referrals in relation to cancer for certain tumour sites.

Improve performance

Cross cutting

Achieve and maintain quality standards

Improving performance in mental health services

Action in 2015/16

A new commissioning approach to IAPT and a review and redesign of the service

- Encouraging the use of the stepped care model
- Increasing the level of recording of provisional diagnosis
- Encouraging NICE guideline treatment lengths and longer sessions
- On-going conversations with providers to improve rates

The contract stipulates that at least 75% of adults should have had their first treatment session within 6 weeks of referral, with a minimum of 95% within 20 days.

A requirement that more than 50% of people experiencing a first episode of psychosis will receive treatment within two weeks will form part of the 2015/16 quality schedule in the mental health contract

A Service Development Improvement Plan for the acute trusts (mental and physical health) to report on the current position against best practice requirements for liaison psychiatry and co-produce a development plan

A patient reminder service at Cornwall Partnership Foundation Trust (supported by a local CQUIN)

Access and waiting time standards included in the contract are emergency referrals seen within same day contact, urgent within 5 days, routine within 28 days.

On-going support for people with dementia including Primary Care Dementia Practitioner Service providing comprehensive, personalised support from diagnosis through to end of life; proactive case finding in care homes; implementation of end of life dementia pathway in care homes; proactive screening at primary care to those over 60 years in the 'at risk' category; comprehensive Cornwall-wide Memory Assessment Service; acute and Community Hospital Dementia Liaison Service; specialist Care Home Dementia Liaison Service; Cornwall-wide memory café network; Cornwall-wide Cognitive Stimulation Therapy Groups; telephone and face to face befriending scheme; dementia specific Support Workers for Carers; dementia Link Nurse Network; activity groups in community hospitals.

7 System impact

- The Any Qualified Provider licence comes to an end in September 2015
- Removal of perverse incentives that are inhibiting IAPT service improvement and provider development
- Improved outcomes for people using the IAPT service
- Effective levels of liaison mental health services across acute settings

Improve performance

Cross cutting

Achieve and maintain quality standards

Improving performance in mental health services for mothers; children and young people

Action in 2015/16

To develop a Transformational Plan to deliver a new model of CAMHs across Cornwall and the Isles of Scilly

To embed training to professionals in contact with children and young people

To ensure schools have support and guidance around self harm and mental health

To evaluate the Bloom project in Penwith as part of a new model

To better use outcome data to determine the needs and resources

To align the commissioning of mental health services across the CCG and Council

To put in place agreed pathways across eating disorders and self harm; crisis intervention across community and acute providers

7 System impact

- New model of a comprehensive CAMH service is developed that will use community assets to their fullest
- Reduction in self harm
- Increase in professionals skills and confidence in identify and intervening early
- Robust data collection systems are in place that can be used to demonstrate impact and improved outcomes
- Better care of young people with eating disorder

Drive out better value

Unplanned care

Ambition 6
Increase the number of people having a positive experience of care outside hospital

Reduce avoidable attendances and admissions and improve flow

Improve the GP out of hours service

During 2014/15 we have been re-procuring the Cornwall GP our of hours service, since the early termination of the contract with the previous provider. The last quarter of 2014/15 and the first quarter of 2015/16 will be focused on the safe transition from the old to the new provider, Cornwall Health. The handover date is 1st June.

Actions in 2015/16

- Maintain or improve performance against the National Quality Requirements
- Develop the performance baseline to assess improvements against new additional key performance indicators currently being developed
- Implement the new end of life register for out of hours, and special patient notes for the top 2% of 'at risk' registered patients
- Enhance access for patients who live close to the borders with Devon
- Improve the interface and information flow with in-hours GP services
- Improve the joint working between NHS 111 and the out of hours service to increase the proportion of patients whose 111 call is triaged by clinicians in the out of hours service

7 System impact

- Direct access for people and families on the end of life register to an out of hours doctor
- Real time access to information about a person's wishes at end of life for clinicians in partner services and organisations
- Either GPs from Devon Doctors doing home visits in Cornwall, or patients accessing clinics in Devon, improve patient access
- Increased proportion of 'at risk' patients transferred directly from NHS 111 to the Out of Hours provider
- Increased coordination between unplanned care providers
- Helping people with urgent care needs to get the right advice in the right place, first time

Drive out better value

Unplanned care

Ambition 3
Reduce time in hospital through better more integrated care in the community

Reduce avoidable attendances and admissions and improve flow

Changes to care pathways

We are reviewing care pathways that have high levels of activity to determine (a) what improvements can be made in primary and community care to avoid hospital admissions when acute facilities are not needed and (b) assess the opportunities in ambulatory care.

Unplanned paediatric admissions

- New pathways for the top 6 most common unplanned admissions, training for GPs and advice sheets for parents
- Out of hours planned reviews of acutely unwell children (organised by GPs in hours)
- Additional dedicated consultant capacity to provide advice to GPs and ensure cover at peak times, until 10:00pm and at weekends
- An acute rapid response clinic for children

Preventing 'unqualified' admissions

- Review the 'out of hospital' parts of high activity pathways to prevent 'unqualified' admissions: chest pain, pneumonia, heart failure, and headache
- South West Ambulance Service urgent care car working with care homes to reduce admissions from that route (Supported by a local CQUIN to the Ambulance Service)

Ambulatory care

- Evaluate current ambulatory care

7 System impact

- A reduction in 'unqualified' admissions to acute care, and reduced length of stay for patients in acute and community based care
- Sharing of best practice across GP Practices reducing variations in Standardised Admission Rate levels for unplanned admissions
- A shift of hospital resources towards see and treat rather than overnight admissions for conditions for which ambulatory care is appropriate

Drive out better value

Planned care

Achieve upper quartile (then upper decile) performance

Reshaping outpatient services

We are applying a set of key principles

- To ensure that **every contact adds value** to patients and to maximise the potential of available capacity to meet referral to treatment commitments to patients as well as appropriate follow up care.
- To implement for all patients that are fit for the future
- ***There are no follow ups by default***. Follow up is only provided where there is demonstrable clinical value to the patient.
- ***Where follow up care is indicated, face to face will not be the default mechanism for providing follow up care***; this will be commissioned only where there is a need for a physical examination or test or where the patient is identified as potentially vulnerable and therefore benefitting from a face to face contact.
- ***Where follow up care is required appointments should be patient initiated by default*** and routine follow up intervals will be commissioned only where clinically indicated or to support vulnerable patients. Where follow up care is of value to the patient it will be provided in the most cost effective and sustainable way, considering mode, frequency, setting and the most appropriate person, using specialist expertise only where there is a demonstrable need.
- ***Where patients are identified as not requiring a follow up*** they are discharged back to Primary Care with a clear management plan.
- **Clinical Prioritisation -** Patients who have the highest clinical need are identified, and the management of the process ensures compliance with clinical need.

Drive out better value

Planned care

Achieve upper quartile (then upper decile) performance

Reshaping outpatient services

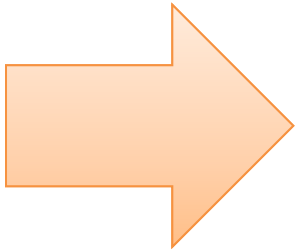
Actions in 2015/16

Redesign of pathways for the following specialties to improve ratio of follow up appointment to first outpatient attendances, the work will be undertaken in phases

- Tranche 1: Orthopaedics, Nephrology, Clinical haematology, Rheumatology, General Surgery
- Tranche 2: Pain Management, Breast Surgery Paediatrics, Cardiology, and Gastroenterology
- Tranche 3: Hepatology, Dietetics, Dermatology, Neurology and Paediatric Audiology

<u>Orthopaedics (supported by a local CQUIN)</u>

- Expansion of the virtual clinic approach piloted on a small scale in 2014/15 – face to face follow ups are prospectively targeted and changed to virtual appointments with the patient's agreement.
- Introduction of a new virtual fracture clinic which will review/triage all referrals to the fracture clinic



⑦ System impact

- Reduction of unnecessary face to face follow ups
- More people self-manage their recovery
- Increased use of information technologies replacing, where appropriate, traditional face to face appointments
- Shift of some follow up appointments to primary care with advice available remotely from consultants
- Earlier decision making
- Patients signposted to the right consultant in the fracture clinic, preventing unnecessary duplication

Drive out better value

Cross cutting

Better value in individual patient placements

Review of options for people in high cost placements

A number of mental health patients receive treatment out of Cornwall. We will review these to see if there is an opportunity for local specialist mental health services to provide support and reduce the number of people sent out of Cornwall or reduce the length of time they spend away. There is an over reliance on expensive agency options in care homes to provide one to one support to manage risk of falls, aggression/violence, sexual inappropriate behaviour and other potential risk issues. Some of these risks could be reduced by planning care more appropriately. The high use of transient staff within care homes can lead to inconsistency in quality of care. There has also been a 50% increase over the last eighteen months in referral rates and packages for individuals living in their own homes requiring medication prompts.

Actions in 2015/16

- Repatriation of mental health patients who have been referred out of Cornwall for treatment (Supported by a local CQUIN)
- Continue clinical scrutiny on individual funding requests / exceptional treatments panels
- Review of 1:1 support in care homes, including improving controls over spending, scoping current and potential use of assistive technologies and looking at how risks are managed and the risk management culture in care homes.
- Improve the pathway for referrals and processing of requests for funded medication prompts and look at alternatives such as assistive technologies and fully utilising community resources

❼ System impact

- People receive care and support closer to home
- Reduction in number of enhanced packages of care
- Fewer transient staff in care homes
- Improved consistency in quality of care in care homes
- Increased use of assistive technologies as appropriate
- Improved coordination of medications management

Drive out better value

Cross cutting

Medicines optimisation

High quality, evidence-based, safe and cost effective prescribing

The Prescribing Team support GP Practices to make cost-effective choices in prescribing.

No significant drug patents expire in 2015/16, which means savings from straightforward drug switching alone are unlikely to be sufficient.

More patient-centred work is needed. Stopping medicines where clinically appropriate when people have been given multiple medicines and being more specific about drug treatment targets can reduce costs without compromising quality of care.

People are also likely to benefit from an improved quality of life and a reduction in episodes of acute care.

Actions in 2015/16

- Polypharmacy reviews
- Prescribing support technicians work in GP Practices to help them identify cost–effective choices of medicines.
- Visits to care homes to give advice and undertake medicine reviews
- Stoma reviews and dressings formulary compliance
- Review prescription order processes
- Synchronisation of prescription medicines
- Specialist pharmaceutical advice to patients
- Real-time intervention of prescriptions issued inadvertently for hospital-only drugs and expensive special unlicensed medicines
- Review and management of oral nutritional supplements
- Patients with rheumatoid arthritis enabled to self-treat at home with infusions instead of attending hospital
- Service Development and Improvement Plan for implementation of Blueteq system with the Royal Cornwall Hospital to ensure prescribing is in line with local and national guidelines.
- Support for people with long-term conditions to effectively manage their medicines with a focus on diabetes, respiratory conditions and mental health.

7 System impact

- Improved coordination of medicines management
- Improved medicines management in care homes
- Medications rationalised for individuals and problematic medicines stopped
- High quality, evidence based, safe, and cost effective prescribing in line with NICE and local guidance
- Reduced waste in medicines, estimated at £2-3m per annum in Cornwall

Transform care and support

Unplanned care

Ambition 3
Reduce time in hospital through better more integrated care in the community

Reshape the unplanned care system

Developing a rapid response and intensive support in the community

The Urgent and Emergency care review sets out the following vision:-

'Firstly, for those people with **urgent but non-life threatening needs** we must **provide highly responsive, effective and personalised services outside of 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. Secondly, for those people with **more serious or life threatening emergency needs** we should ensure they are treated **in centres with the very best expertise and facilities**, in order to **maximise their chances of survival and a good recovery'.**

A key part of the review's proposals are to greatly enhance urgent care services provided outside of hospital.

As part of the Prime Minister's Challenge Fund, we have been trialling an extension of services at some of our community hospitals to see how they might operate as urgent care centres to complement our existing urgent care centre provided by the Royal Cornwall Hospital Trust in West Cornwall. The components of our proposed urgent care services outside of the acute hospitals are set out in our Blueprint for our future model of care and support (annex 3).

Actions in 2015/16

- Bed capacity and reconfiguration modelling
- Extension of trials from 2014/15 into 2015/16 to allow for a full 6 months testing
- Evaluation of the Prime Minster's Challenge Fund pilot schemes
- Subject to those evaluations, extend the provision of urgent care centres
- Participation by our Systems Resilience Group in the Urgent and Emergency Care network from April 2015

7 System impact

- Increased coordination of unplanned care services (Minor injury/illness units, out of hours GP services, voluntary sector support)
- Diverting people from attending the Emergency Departments of our acute hospitals
- People have improve outcomes and an improved experience of care

Transform care and support

Planned care

Integrate planned care into the community

Orthopaedic services

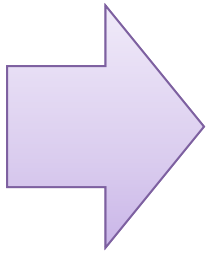
We are embarking on a 2-3 year project of reviewing surgical capacity, specialty by specialty. It will detail current service provision across all providers. It will assess local need and then capacity to provide treatment locally as close to patients' homes as feasible. Exploring options to provide treatment in a variety of settings including primary care settings, community hospitals or facilities provided by the independent sector.

The top four specialties with the highest number of day case procedures and outpatient appointments (more than double any others) that could take place in a community setting are: Orthopaedics, Rheumatology, Ophthalmology, and Gastroenterology. Activity from other specialties that could also be included comes from: Dermatology, Cardiology, General Surgery, Gynaecology, ENT and Urology.

There is already a Musculoskeletal Interface Service in the community, which could have its scope expanded and can provide conservative management and a triage service to hospital services. This is a complex project, which although underway in 2015/16 is unlikely to deliver benefits until 2016/17.

Actions in 2015/16

- Review of surgical capacity in orthopaedic services and identify opportunities to provide treatment in local non-acute settings
- Develop a pathway for lower back pain, which includes self-management advice and comprehensive management plans for GPs and patients
- Increase the scope of the Musculoskeletal Interface to include spinal conditions



❼ **System impact**

- Increased opportunity for conservative treatment as an alternative to surgery for musculoskeletal conditions
- More non-complex day surgery takes place in local facilities
- Releases capacity in centrally based acute facilities to focus on those needing those facilities
- Increased access to diagnostics locally
- Reduced travelling for people with impaired mobility
- Improvements in how people self-manage their conditions

Transform care and support

Integrate planned care into the community

Ophthalmology – an integrated end to end pathway for people with chronic eye disorders

Planned care

Demand has increased 18% over five years, driven by an aging population, prevalence of diabetes, guidance from the National Institute of Clinical Excellence and advances in medical treatments and technologies. It is almost wholly an outpatient and day case service.

People treated are predominantly older with chronic sight conditions that may result in irreversible deterioration of vision or blindness.

Many are patients for life with repeat attendances at clinics for injections.

Part of a review of capacity across all specialties starting in 2015/16, looking at local need and then capacity to provide treatment as close to home as feasible.

Actions in 2015/16

- A Service Development Improvement Plan to develop a one-stop glaucoma assessment service – review and redesign (where appropriate) of the pathway with agreed identifiable outcomes (local CQUIN)
- Redesign of a new glaucoma pathway to transfer monitoring of less severe conditions from the hospitals to GPs and/or optometrists
- A one-stop see and treat service for cataracts based in community locations
- A Service Development and Improvement Plan with the Royal Cornwall Hospital and local treatment centres to co-produce a post-operative cataract pathway and service
- A review of options to achieve a sustainable Lucentis service
- A review of provision of emergency eye clinics to consider extending the service to be delivered by optometrists
- A review of people's needs by locality and of capacity to provide treatment in each locality

7 System impact

- A shift from care provided in acute hospital facilities to care provided in the community.
- Reduction in attendances for people on the glaucoma pathway
- Improved experience of care
- Improved outcomes for people

Transform care and support

Cross cutting

Ambition 2
Improve quality of life for people with long-term conditions

Transform children's and mental health services and develop Integrated Personal Commissioning

Transforming how we support individuals with very complex needs

As part of our Better Care Fund plan and our approach to joint case management (between health and social care) we have created a pooled budget with Cornwall Council for 60 individuals with very complex needs. We are also part of a national programme trialling Integrated Personal Commissioning.

Actions in 2015/16

- Joint review by NHS Kernow and Cornwall Council of the 60 individuals with very complex needs for whom budgets have been pooled
- Joint development of outcome focused care plans and the offer, where appropriate, of personal budgets (health and/or social care)
- Identify a further cohort of joint clients whose support will be reviewed in 2016/17
- The national Integrated Personal Commissioning Programme will roll out in Cornwall with a focus on vulnerable people attending the Emergency Department who may have mental health and/or substance misuse needs.
- Improving transition from paediatric into adult services (where appropriate) including a CQUIN with the Royal Cornwall Hospital Trust and the Cornwall Partnership Foundation Trust covering
  - ✓ An agreed protocol in place for transition
  - ✓ A transition champion
  - ✓ Completing the SW Strategic Clinical Network dashboard

7 System impact

- Commissioning of care for individuals with very complex needs is more person centred and delivers better outcomes for them
- Coordinated care and support for people with very complex needs
- Standardised and equitable transition preparation across all patient groups
- Improved patient experience, patient self-management skills, concordance and improved medicine management at the point of transition, and moving forward in life.
- Improve family support in moving to adulthood
- Reduce the number of young people disengaging from health services during the adolescent period.
- Reduction in attendance in the Emergency Department and reduction in length of stay for secondary complications

Transform care and support

Planned and unplanned care

Ambition 3
Reduce time in hospital through better more integrated care in the community

Developing Integrated Care Communities

Locally led development of community teams providing integrated care and support

Our ten GP Localities are leading development locally of our new model of care. At the heart of all Locality Plans is a commitment to working in partnership with providers across health, social care and the voluntary and community sector to develop services that are seamless and tailored around the needs of each individual. There is an ambition to share data, protocols and tools to achieve greater interoperability and improve working relationships.

This is a phased approach starting with small steps that will lay the foundations for delivering Integrated Care Communities. All localities are taking action during 2015/16 to improve community-based care and two (Penwith and East Cornwall) are implementing Integrated Care Teams in full (covered by the next two pages).

Actions across all localities in 2015/16

- Improving links with community care providers
- Improving data sharing and interoperability across local community providers
- Improving multi-disciplinary team working arrangements, including the effective management of Multi Disciplinary Team meetings
- Providing personalised care management, with shared paperwork across practices and community teams
- Developing links with the voluntary and community sector, to strengthen communities and empower people to live well.

❼ System impact

- A reduction in unplanned admissions to acute care
- A reduction in hospital length of stay
- Improved access to multi-disciplinary team care management
- Improved access to mental health and specialist services
- Improved access to community and voluntary sector services.

Transform care and support

Planned and unplanned care

Ambition 2: Improve quality of life for people with long-term conditions

Ambition 3: Reduce time in hospital through better more integrated care in the community

Developing Integrated Care Communities

East Cornwall Locality

The Locality is planning to implement a fully functioning Integrated Care Team* in 2015/16, bringing together health professionals from primary care, community nursing and community mental health with social workers and voluntary sector coordinators. The aim will be to provide more patient focused and proactive care, but also to reduce duplication and improve efficiency. East Cornwall's approach of looking more holistically at a person's health and wellbeing is at the heart of its Locality Plan and takes a step towards parity of esteem (see annex 3 for a brief assessment against the tests for parity of esteem). People in East Cornwall who are frail or vulnerable (thought to be around 4% of the population) will be identified, have care plans in place and have their care coordinated by the Integrated Care Team.

Actions in 2015/16

- Creation of an Integrated Care Team (described in the following diagram)
- Identification and care planning and coordination for all frail or vulnerable people
- Development of shared pathways, processes and tools to support the journey to full interoperability across providers of care and support**
- Develop a community map so that the range of opportunities in the community is known to all
- Three practices are enrolled on the Productive General Practice Programme and will share learning with other practices
- Implementation of frailty standards
- Implement a new model for MSK referrals

7 System impact

- A reduction in unplanned admissions to acute care
- GP Practices providing medical leadership of an Integrated Care Team
- Coalition of provider organisations (as a forerunner to a Multispecialty Community Provider for adult care and support)
- Coordination of care between General Practice and community health services, community mental health services and specialist services
- Practitioners working across traditional boundaries to provide continuity of care in partnership with people, their carers and communities
- Voluntary sector practitioners embedded in integrated teams
- Increase in conservative management of musculoskeletal conditions

*Described in our blueprint for our new model of care and support that is shaped in each locality according to local needs and assets (annex 3).

** Detailed steps to establish an Integrated Care Team are described in our Roadmap

The team supports people in their usual place or residence

Developing Integrated Care Communities

East Cornwall Locality

An Integrated Care Team for East Cornwall

Integrated community teams supporting natural geographic communities in East Cornwall

A cluster of GP Practices working together to provide medical oversight of a community team

Rosedean surgery

Other community teams
- Torpoint
- Callington & Gunnislake
- Launceston
- Looe
- Saltash

Network of community support

Based in Liskeard as the service centre for surrounding settlements

Liskeard community team

Proactive support and advice for care homes

Pensilva

Oak tree surgery

Co-located, sharing administrative support an d working with a single patient record

GPs
Practice nurses
Community matron
District nurses
Community Psychiatric Nurse
Social worker
Voluntary Sector Coordinator
Memory Assessment Practitioner
Pharmacist
Physiotherapists
Occupational therapists

Decisions are taken locally on the tactical deployment of resources

Locally based support for community teams

Rapid response team

Integrating Acute Care at Home, Early Intervention Service, CPFT Home Treatment Team, STEPs, equipment coordination

Welcome home team (voluntary sector)

These teams and specialists need a larger catchment population than the community teams to be viable but will operate consistently over a local area so that they are well known to the community teams

Specialist palliative care team

- Care of the elderly consultant
- Consultant Psychiatrist
- Specialist nurses (COPD, Diabetes, Cardiac ,etc.)
- Dementia liaison nurses (working in care homes)

In-hospital team at Plymouth supporting these communities

- Onward Care Team
- Dementia Liaison Nurse
- Frailty Nurse

The Integrated Care Team for East Cornwall is a combination of the community teams, locally based support teams and the in-hospital team. It is drawn from a coalition of providers with a single manager having oversight of it.

Transform care and support

Planned and unplanned care

Ambition 2
Improve quality of life for people with long-term conditions

Ambition 3
Reduce time in hospital through better more integrated care in the community

Developing Integrated Care Communities

Penwith Locality

The Penwith Locality is planning to further develop its relationship with partners across health, social care and the voluntary sector. The relationships are already there, and work is underway to strengthen them with a shared vision and values statement that all partners can sign up to, in delivering seamless access to personalised care and support. The Locality Plan recognises the critical role of Primary Care in understanding its practice population, identifying patients who are at risk, and providing a central coordinating function to enable them to access the right care and support services to meet their needs and preferences. Focus for 2015/16 will be on the delivery of integrated community teams, organised around practice clusters, to deliver the living well model of care.

Actions in 2015/16

- Develop shared care management pathways and tools
- Improve data sharing and interoperability across providers (including multidisciplinary team meetings)
- Recruit a new healthcare assistant coordinator post within general practice, outreaching into the community to provide proactive support and a bridge between services.
- Further develop the voluntary and community sector and consolidate its links with the care system.
- Improving medicines optimisation and pharmacist involvement in multi-disciplinary team meetings
- Improving data collection across practices, to inform service developments

⑦ System impact

- A reduction in unplanned admissions, emergency department attendance and hospital length of stay
- Improved access to multi-disciplinary team care management
- Improved access to mental health and specialist services.
- Coalition of provider organisations working together, providing outcome focused Integrated Care Teams
- Voluntary sector practitioners embedded in integrated teams
- Improved support for patients in care homes or receiving care at home.
- Improved support for carers.

*Described in our blueprint for our new model of care and support that is shaped in each locality according to local needs and assets.
** Detailed steps to establish an Integrated Care Team are described in our Roadmap

Transform care and support

Cross Cutting

Ambition 1
Secure additional years of life for people with treatable conditions

Ambition 2
Improve quality of life for people with long-term conditions

Developing Integrated Care Communities

Living well with long-term conditions

We will support people to live well and age-well with one or multiple long-term conditions, promoting early intervention and ensuring they feel confident to play a greater role in managing their own condition(s). An increasing number of people are being diagnosed with cancer and that is also now being seen as a long-term condition with survival and living well with cancer improving with earlier diagnosis.

Actions in 2015/16

- Improve diabetes screening and consider the development and implementation of a whole system integrated care pathway for people with diabetes
- Participate with Public Health in a pilot programme to target people with identified pre-diabetes towards combined lifestyle and weight management interventions
- Focus on reducing and minimising the risks of cardiovascular disease, focusing on lifestyle and early detection of conditions such as atrial fibrillation, transient ischaemic attack, dementia
- Support for GPs in early diagnosis of cancer through Macmillan funding of two GP posts working alongside primary and secondary care colleagues
- Implement a cancer survivorship recovery package that includes a Holistic Needs Assessment with associated care plan and treatment summary for cancer patients (supported by a local CQUIN) as recommended by the South West Cancer Network.
- Increase provision of pulmonary rehabilitation and peer support for people with chronic obstructive pulmonary disease.

7 System impact

- Individuals have knowledge of their own condition and the healthcare system and know where to go for help
- Individuals are diagnosed in a timely manner
- Reduced use of health and social care services as people become more resilient and less at risk

Transform care and support

Developing Integrated Care Communities

Improving health – commissioning for prevention

Cross Cutting

Ambition 2
Improve quality of life for people with long-term conditions

A call to action: commissioning for prevention starts with four questions

- How can the NHS become a wellness service?
- How can we prevent premature mortality?
- How can we prevent chronic disability or reduce its impact?
- What prevention programmes could improve financial sustainability?

The table shows the framework that has been provided for use in commissioning prevention and we have used it to describe what we have already done and will do in 2015/16.

1 Analyse key health problems	2 Prioritise and set common goals	3 Identify high impact programmes	4 Plan resources	5 Measure and experiment
Our analysis is set out in our *Case for Change* for our 5 year strategic plan. The age profile of our population, deprivation and rural isolation combined mean we are focusing initially on adults who are frail or vulnerable	There are two threads to what we are commissioning (a) Preventing premature mortality and chronic conditions; (b) Reducing the impact of chronic conditions	Our initial high impact programme has been the *Living Well* pioneer work intervening to reduce the impact of chronic conditions.. It provides multidisciplinary and multi-sector support to people at risk to prevent them reaching a crisis.	The financial impact of our pioneer work is currently being modelled and there will be a full evaluation in 2015/16 of the work that will guide its roll out across the rest of Cornwall and the Isles of Scilly.	As part of the outcomes framework for our Living Well pioneer, people with chronic conditions assess their quality of life against certain criteria before and after their participation.
Benchmarking has shown we have high costs of planned and unplanned care. An analysis showed hospital care was more expensive when co-morbidities were present	The Health and Well Being Board in 2014/15 endorsed (a) Focusing prevention on 5 behaviours that lead to 5 diseases (b) Our *Living Well* pioneer	In addition in 2015/16 we will consider reshaping our support for people admitted to hospital because of excess alcohol consumption as part of the 5 behaviours & diseases work.	The experiences of individuals supported by the pioneer work suggests a reduction in demand for acute services is likely, but the extent will not be known until after the evaluation.	In 2015/16 we expect Integrated Care Communities as they develop to experiment further locally with how to prevent the 5 behaviours and to define their own outcomes

Transform care and support

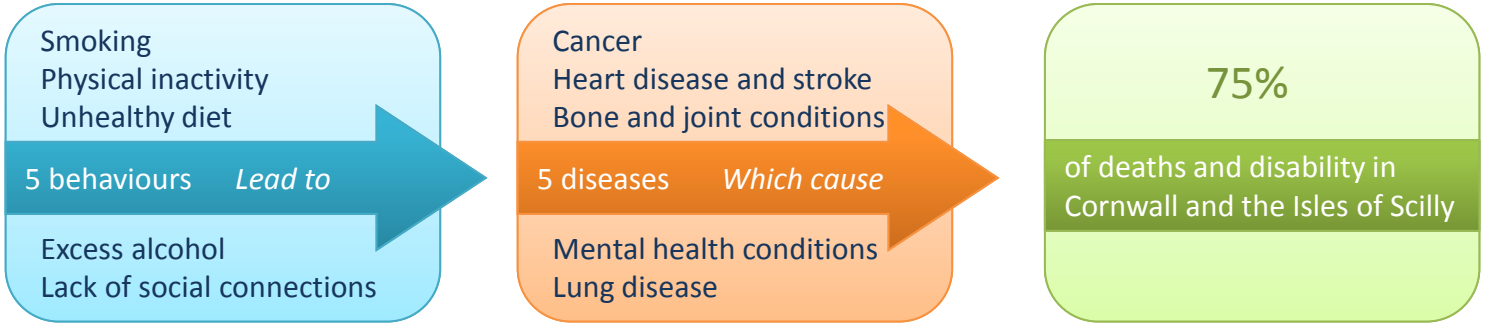
Cross Cutting

Ambition 1
Secure additional years of life for people with treatable conditions

Developing Integrated Care Communities

Improving health

This model is in our 5 year strategic plan and is an adaptation of 'Live Well, San Diego' which is a comprehensive ten year public health initiative involving widespread community partnerships to address the root causes of illness and rising healthcare and social care costs. We see a partnership approach to tackling behaviours as key to preventing demand on services over the longer-term. This will be led by partnerships within our Integrated Care Communities as they develop. There are also specific actions NHS Kernow will take that will complement it.



Actions NHS Kernow will take in 2015/16

- Participate in the Cornwall Healthy Weight Strategy group
- Review tier 3 weight management services
- Participate in the refresh of the Healthy Weight Strategy and Action Plan (led by Public Health), which will have locally agreed ambitions with associated outcome indicators
- Improve the uptake of NHS Health Checks
- Remodel existing resources to create an Alcohol Care team and redesign the acute element of the alcohol care pathway
- Co-produce with Public Health a dual diagnosis strategy – Mental Health/Alcohol
- The physical health sub-group of the Mental Health Expert Reference Group has a work plan to reduce smoking

⑦ System impact

- In the longer term a reduction in diseases associated with an unhealthy diet
- An increase in prevention and early intervention in relation to people who are currently admitted to hospital as a result of alcohol related problems and a reduction in admissions/repeat admissions from this group of people

Enabling change

Supporting the whole of the change programme

Developing our workforce

A high performing, highly productive compassionate workforce ready to implement change

This will include liaising with the Local Education and Training Board on workforce planning. There are a number of workforce issues that need resolving – retention issues among care homes and domiciliary care providers, recruitment issues with GPs and Hospital Consultants and Community nursing. Whole system groups (Resource Group, Human Resources Group, and Workforce Group) are tackling various aspects of these issues). Practitioners across health, social care and the voluntary sector will be valued and supported to deliver high-quality, compassionate, joined-up care and work in partnership with the people they are helping. Their experience and insight will influence how care and support is provided and they will be supported to maintain their own well-being.

Actions in 2015/16

- Identify gaps in capacity and skills to meet current requirements to improve performance and drive out better value
- Identify workforce needs of our new models of care
- Map current resources against future requirements
- Improve recruitment and retention, sharing recruitment strategies and having joint recruitment campaigns
- Continuing to develop our GP Leadership programme to build skills for leading integrated care and support and encourage participation in the South West Leadership Academy's collaborative leadership programme
- Training for volunteers and community groups
- A system wide strategy to develop the unqualified workforce and training for Healthcare Assistants
- Multi-agency mental health first aid training (supported by a local CQUIN jointly for our acute, community and mental health NHS providers to develop and deliver a course to primary care, acute, community and third sector staff).
- Increase access to the *Living Well* induction training
- Training of Associate Physicians with sponsorship from Acute providers – a new clinician supporting hospital based Doctors

7 System impact

- Workforce capability and capacity matches demand
- A workforce resilient to peaks in demand
- A high performing workforce
- A highly productive workforce
- A workforce understanding our *Living Well* approach and ready to implement change
- Changes to skills, culture and behaviours that support people to take greater responsibility for managing their own care
- An increased understanding of mental health issues across the workforce

Enabling change

Supporting the whole of the change programme

Improving the flow and exchange of information

Information governance and information technology supporting information sharing

The ability to share information is at the heart of coordinated care and support. In order to do so we need to have information sharing protocols in place and enable information to be transferred across IT systems so that practitioners can view a person's care plan and care record at the point of care.

Actions in 2015/16

- Increase the proportion of GP referrals sent electronically to providers to at least 80% by 31 March 2016.
- Increase use of the electronic prescribing system by GP Practices.
- A project has commenced in 2014/15 and will continue in 2015/16 to give access to information held in primary care to other practitioners (with appropriate information sharing agreements)

Information to be shared

- ✓ Care plan
- ✓ Patient details
- ✓ Acute medication
- ✓ Allergies
- ✓ Repeat medication

Services to be given access

- ✓ Hospital pharmacy department
- ✓ Emergency Department
- ✓ Medical Admissions Unit
- ✓ Paediatric observation unit
- ✓ Surgical admissions ward
- ✓ Acute admissions ward
- ✓ Acute GP Service
- ✓ Minor Injuries Unit
- ✓ Urgent Care Centre
- ✓ Ambulance Service
- ✓ NHS 111
- ✓ Out of hours service

- To update our strategy for achieving interoperability so that we have a clear roadmap for the next phase

7 System impact

- People and practitioners have timely access to information
- Increased clinical effectiveness
- Improved flow with people following pathways appropriate for their care plans
- Increased efficiency in service provision

Enabling change

Championing quality

Staff satisfaction

Cross cutting

We monitor the results of the NHS Staff Survey and review sector benchmarks. We include an indicator in the workforce section of the provider contract that seeks assurance that providers have initiatives in place that seek to improve staff health and well-being. The table below shows overall staff engagement scores across our main providers.

Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged

Overall Engagement Scores	2011	2012	2013	2014	2014 Sector Ranking	Latest Average for Sector
RCHT	3.31	3.39	3.45	3.34	Lowest 20%	3.74
CFT	3.57	3.66	3.70	3.60	Lowest 20%	3.72
PCH	3.65	3.67	3.75		PCH did not partake	3.75

A system-wide workforce group has identified a range of factors that impact on the workforce.

Our Living Well prototype trial is including experience of practitioners and volunteers within its outcomes framework so we will have a good understanding of the impact on staff satisfaction of our new model of integrated care.

NHS Kernow has commissioned an external review of its own staff and member engagement involving stakeholder interviews and staff focus groups as well as surveys of staff and members, findings will enhance the current staff and member engagement plan.

Actions 2015/16

- Action in relation to provider staff survey results and action plans will follow from our monthly contract clinical review meetings
- Implement recommendations from the evaluation of the *Living Well* prototype
- Participate in the national staff survey
- Implement the recommendations from the external review
- Build on the achievements of the gold healthy workplace award

❼ System impact

- Improved engagement
- Practitioners will have confidence in working in integrated care teams, contributing to innovation

Enabling change

Supporting the whole of the change programme

Championing quality

Improving patient experience

We use a range of methods to measure patient experience and to influence improvements . All the local services have now introduced Family and Friends Test measure and we are working with them to ensure high response rates and incremental increase in satisfaction scores. We set out our ambition for improving experience of our of hours primary care in our 5 year strategic plan.

Actions we will take to ensure we understand patients' experience

- Contract monitor complaints and information from the Patient Advice and Liaison Service
- Listen to people's stories
- Attend events to pick up feedback from people who may not normally come in contact with health services
- Go to representative groups to discuss patient experience amongst people who share protected characteristics

Improving experience of out of hours primary care

- How we will improve the GP out of hours service is set out in the better value section of this Plan

Ensuring that all the NHS Constitution patient rights and commitments given to patients are met

- All providers are contracted to meet the requirements of the NHS Constitution and we expect them to publicise this to people
- We have identified performance improvement as a clear priority for 2015/16 within out change programme to take action to achieve the standards in the NHS Constitution

Meeting the requirements of the Caldicott review that are relevant to patients

- We have protocols in place for information sharing to ensure appropriate balance between protection of patient information and improving patient care. This includes joint funding and complaints processes.

7

System impact

- Improve the quality of care delivered to patients and support to carers
- Improve access of services to patients and carers
- Actively engage with patient groups and learn from their experience to refine current services and design future services.

Enabling change

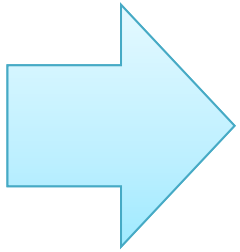
Supporting the whole of the change programme

Championing quality

Improving patient safety

To improve patient safety we will

- Work with partners on reviewing whole systems safety impact when the unscheduled care system is in escalated operational status
- Measure and review improvements in the four harms identified within the safety thermometer.
- Review information from providers relating to patient safety, provided in response to our local quality indicators and National Reporting and Learning System organisational reports.
- Through clinically focussed contract review meetings engage with providers about the level of incidence and severity of harms reported and the improvement initiatives undertaken in each of the main harm areas.
- Hold bi monthly Serious Incident Assurance meetings to review in detail and seek assurance of process and learning from provider and clinical commissioning group serious incidents.
- Disseminate the learning from serious incidents via a newsletter to staff and GP practices
- Support care homes in their delivery of care to clients by developing further Operating Standards that address potential harm areas such as falls and end of life care
- Lead and steer the Cornwall Quality Care Collaborative, supporting the five work streams in identifying and achieving outcomes that will support improvements in patient safety and increase capability
- Measure and review improvements to the national and local CQUINs
- Continue whole system focus on infection prevention and control with an emphasis on improving antibiotic prescribing
- National CQUINs have been included in the relevant contracts for the care of patients with acute kidney injury and the identification and early treatment of sepsis



7 System impact

- Reduced number of care homes going into safeguarding
- Reduced cost associated with poor quality and failure demand
- Service capacity released from managing the impact of poor quality
- Improved patient outcomes and experience
- Improved staff morale and experience

Enabling change

Supporting the whole of the change programme

Championing quality

Improving quality of care – clinical standards for seven day working

This includes implementing five of the ten clinical standards for seven day working described by the NHS Service, Seven days a week Forum. These are being built into the contract with the Royal Cornwall Hospital for 2015/16. The remaining five will be spread across all providers and we will ask for service development plans for them for 2016/17.

To improve quality of care in 2015/16 we will

- Implement Clinical Standard No. 2 for seven day working i.e. all emergency admissions have a thorough clinical assessment by a suitable consultant within 14 hours of arrival at the hospital
- Implement Clinical Standard No. 3 for seven day working i.e. all emergency in-patients assessed for complex or on-going needs within 14 hours by a multi-professional team plus an integrated management plan, date and criteria for discharge and medicines reconciliation within 24 hours
- Implement Clinical Standard No. 4 for seven day working i.e. handovers led by a senior decision maker, standardised handover processes and multi-professional participation
- Implement Clinical Standard No. 5 for seven day working i.e. hospital in-patients have seven day access to diagnostic tests
- Implement Clinical Standard No. 8 for seven day working i.e. patients on high dependency areas seen and reviewed by a consultant twice daily and every 24 hours when transferred to a general ward, including maximising continuity of care

System impact

- Hospitals should meet patient and public expectations by providing a consistent service seven days a week for urgent and emergency care pathways
- Improve mortality rates by removing the variation in staffing levels, the absence in senior decision makers of consultant level and experience, ensure diagnostic services are available
- Minimise the length of stay in hospital
- Reduction in re-admission rates
- Improvements to patient and carer experience

Enabling change

Supporting the whole of the change programme

Championing quality

Compassion in practice

The following actions are being taken to ensure that local provider plans are delivering against the six action areas of Compassion in Practice implementation plans and that the 6 Cs are being rolled out across all staff. All the local services have now introduced Family and Friends Test measure and we are working with them to ensure high response rates.

Implementing compassion in practice in 2015/16

1 – Helping people to stay independent, Maximising well-being and improved health outcomes is central to our Pioneer *Living Well* work

2- Working with people to provide a positive experience of care

- We will monitor the Family and Friends test results
- Work with stakeholders to look at other sources of feedback and use this to influence change e.g STREAM
- Work with providers to support them to improve people's experience of care with a particular focus on care homes in the Care Collaborative

3- Delivering high quality care and measuring impact

We will work with providers to collect data on the quality of the care and the information will be used to provide assurance to the Governing Body and support providers to affect the change.

4- Building and strengthening leadership

- We will continue to train and develop staff at all levels of the organisation to promote compassionate and effective leadership
- We will engage with staff and stakeholders to gauge their views on organisational culture and act on the feedback

5-Ensuring we have the right staff with the right skills in the right place

- We will work with stakeholders to ensure we have the right staff in place and to plan for future workforce requirements
- We will work with providers to monitor Safer Staffing levels to ensure patients are cared for in a safe, effective and compassionate environment

Action Area 6 – Supporting positive staff experience

- We will engage with our staff using a variety of means such as focus groups, staff bulletin, staff surveys
- We will promote the staff rights and pledges in the NHS Constitution
- We will ensure that staff have access to up to date policies and procedures and support mechanisms

7

System impact

- People are less dependent on health and social care services
- Maintaining a high quality of care and support
- Influencing culture across organisations

Enabling change

Supporting the whole of the change programme

Championing quality

Safeguarding

We will continue to maintain a focus on the safety of vulnerable adults and children. We will commission services that promote and protect individual human rights, independence and well-being.

To safeguard adults

- Secure assurance from commissioned providers that any adult thought to be at risk of abuse or neglect is kept safe.
- Secure assurance that they are effectively safeguarded against abuse, neglect, discrimination, embarrassment, or poor, compassionless treatment.
- Continue to build on existing relationships to work in active partnership with the local authority and the Local Safeguarding Adult Boards and we will contribute to multi-agency agendas such as the Multi-Agency Public Protection; the Domestic Violence and Prevent agenda.
- Work with neighbouring commissioners to develop a supporting Safeguarding lead Health Forum as a health focussed sub group of the Area Team.
- Focus on a proactive approach to commissioning and contracting of individual placements. Contracts will include the Multiagency Safeguarding Adults Commissioning Protocol and will be monitored via quality assurance/triangulation process and we will run in depth reviews of safeguarding processes for all providers.
- Continue to collaborate with the Safeguarding Adults Board to ensure the quality of multiagency or bespoke packages of training.

To safeguard children

- Continue to support the work of the multi-agency referral unit to identify children and young people in need of safeguarding and protection.
- Work in close collaboration with partner agencies and continue to ensure that all services commissioned for children and young people are age appropriate and sensitive to their specific needs.
- Ensure all national requirements for the safeguarding of children and young people are implemented across the health community.

7

System impact

- Vulnerable people are protected from abuse and neglect
- Everyone is treated with dignity and respect

Enabling change

Supporting the whole of the change programme

Championing quality

Responding to Francis, Berwick and Winterbourne

We will work together with the Devon and Torbay Health and Wellbeing Boards and with providers to ensure that the recommendations made in *Transforming Care: A national response to Winterbourne View Hospital* are implemented and ensure a dramatic reduction in hospital placements for people with learning disabilities and autism and people in NHS funded care who have a mental health condition or challenging behaviours. We continue to have a comparatively low rate of out of area non-secure in-patient admissions with two individuals currently commissioned.

- Our 'Francis' working group will embed actions and further develop our response to the Francis report recommendations
- We continue to commission community based services specifically for people who are perceived as having "challenging behaviour" and are seen as part of the Winterbourne View cohort.
- 2015/16 plans are to consolidate the strategy for joint working with the local authority and NHS care providers to provide local housing and care
- NHS Kernow has a stated strategy to commission in-patient specialist learning disability beds in Cornwall and to avoid out of area admissions where at all possible
- We have the patient at the heart of everything that we do – our approved engagement, inclusion and patient experience strategy describes ways in which we can gather intelligence (and use it) and ways in which people can become (and are) involved in service design and monitoring.
- We network with our local and regional colleagues to encourage best practice and the most effective triangulation or sharing of headline information in order to drive up quality.
- We seek to collect patient experience information on both the individual and the collective level and work to be inclusive when we engage
- Our Dignity in Care champions go into wards and check that people are treated with dignity and respect - this is fed back to the provider the same day. If there are any issues this is followed up by a report and the provider attends the next meeting of the assessors to provide assurance that they have made the required changes.

7

System impact

- A safe and effective healthcare and well being system
- Improved outcomes for people
- Preventing avoidable admission to hospital
- Ensuring that people's experience is heard and acted upon

Enabling change

Supporting the whole of the change programme

Championing quality

Quality premium

NHS England provides additional funding as a reward for achieving improvements in quality, known as the 'quality premium'. It is additional to the main financial allocation.

It rewards clinical commissioning groups for improving the quality of services they commission and for associated improvements in health outcomes and reducing inequalities.

It is based on a number of different measures that are set each year. Five are national requirements and we are allowed to set one local outcome and measure.

If achieved in full it could provide an estimated additional £2.7m in funding, which can be used to secure improvement in

- the quality of health services; or
- the outcomes achieved from the provision of health services; or
- reducing inequalities between patients in terms of their ability to access health services or the outcomes achieved.

As well as achieving targets set for these measures, there are also certain conditions that have to be met for the reward to be allocated including:-

'The total quality premium payment for a CCG will be reduced if its providers do not meet the NHS Constitution rights or pledges for patients in relation to (a) maximum 18-week waits from referral to treatment, (b) maximum four-hour waits in A&E departments, (c) maximum 14-day wait from a urgent GP referral for suspected cancer, and (d) maximum 8-minute responses for Category A red 1 ambulance calls. '

The results we are seeking from quality improvements during 2015/16 that will attract a quality premium	% of quality premium	Reward if achieved in full (£000s)
People lose fewer years of life due to causes amenable to healthcare	10%	£270
Reduce delayed transfers of care which are an NHS responsibility and Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays	30%	£811
Improve the waiting time in the emergency department at the Royal Cornwall Hospital for patients diagnosed with a mental health condition	30%	£811
Improve antibiotic prescribing in primary and secondary care	10%	£270
Reducing alcohol related admissions and emergency admissions of children with lower respiratory tract infections	20%	£540

Enabling change

Supporting the whole of the change programme

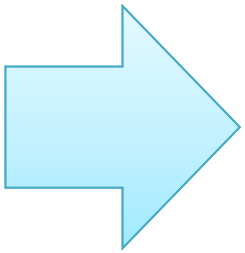
Transforming Commissioning

With NHS England, Councils and neighbouring Clinical Commissioning Groups

During 2014/15 we embarked upon an ambitious programme to identify opportunities for integrating commissioning: with NHS England for primary care, with the Councils, and with neighbouring Clinical Commissioning Groups. We will test new models of commissioning. We already work very closely with NEW Devon Clinical Commissioning Group on the contract with the Plymouth Hospitals Trust. We are working with the Area Team on reviews of Personal Medical Service agreements and opportunities for developing primary care.

Actions in 2015/16

- Consulting with GPs on the options for commissioning of primary care
- Supporting practices on the Productive General Practice programme to share their learning with other practices
- Strengthening opportunities for joint working with other Clinical Commissioning Groups, especially for NHS 111, 999 and driving out better value.
- Trial new models for commissioning, such as capitation and outcome based incentivised contracts and alliance models – moving towards more outcome-based commissioning and contracting
- Supporting NHS England on the procurement of Walk-in centre services
- Working with the Council on the Children's services review, intermediate care, home care, care homes and voluntary and community sector commissioning
- Working with Public Health colleagues to establish joint intelligence, evidence and shared engagement



7 System impact

- Health and social care commissioning is increasingly aligned to benefit service users and providers
- Opportunities to share resources enhanced
- Pooling of budgets reduces transactions costs
- Alignment of processes and systems to reduce avoidable delays in personalised commissioning
- Combined strength to help shape the market and support provider development
- Stronger local and political accountability

Enabling change

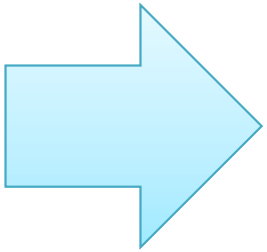
Transforming how we commission cross cutting services

How we commission services

Cross cutting

Actions in 2015/16

- Testing Integrated Personal Commissioning as part of the national programme
- Re-procuring children's community health and well-being services to ensure that from April 2016 there is an integrated specialist and targeted service in place that is aligned to the Councils' commissioned services.
- Joint commissioning for Special Educational Needs and Disabilities starting with a review of policies around joint packages of care
- Delivering the first phase of integrating commission processes with Social Care and developing collaborative commissioning with NHS England for Primary Care
- Transforming how we commission home care and care homes, supporting providers in the delivery of the standards within the Cornwall Quality Care Collaborative
- Development of an ageless carers strategy for Cornwall, in partnership with Cornwall Council
- Working towards developing Multispecialty Community Providers with local devolved capitated budgets (testing with East Cornwall using indicative budgets in 2015/16)



7 System impact

- Commissioning of complex care for individuals is more person centred, delivering better outcomes for people
- Triple aims for children's services set up for delivery
- Streamlined commissioning processes between health and social care , increasing management capacity to cope with reduced management budgets.
- Improved capacity, capability and quality of services in care homes, and for care at home service providers.
- Carers are supported better to fulfil the vital role they provide.

Enabling change

Supporting the whole of the change programme

Organisational Health (NHS Kernow)

Maintaining a strong organisation to deliver the Operating Plan

NHS Kernow strives for continuous improvement as an organisation with good governance, patient and public involvement, delivery of statutory functions and duties; working effectively in partnership and comprehensive commissioning support functions.

Actions in 2015/16

A well-led organisation

- Delivery of our Human Resources strategy
- Further develop collaboration with other Clinical Commissioning Groups
- Further develop collaboration with Cornwall Council and the Council of the Isles of Scilly
- Further develop the role of the Patient Reference Group

Finance

- Develop and implement a financial recovery plan
- Financial modelling

Performance: delivery of commitments and improved outcomes

- Improve change management by development of a Programme Management Office function
- Improve business processes
- Cost-effective procurement and management of contracts

Planning

- Participate in the refresh of the Health and Well-being Strategy
- Review of NHS Kernow's five year Strategic Plan
- Production of the 2016/17 Operating Plan
- Develop and implement the IPC commissioning cycle
- Develop collaboration with the South West AHSN and PenCLAHRC
- Work with partners to further develop sharing of intelligence and information and improve use of business intelligence in long and short-term planning

Whole system alignment

During 2014/15 effort has been put into strengthening the governance and strategic alignment arrangements both within NHS Kernow itself, and between partner NHS, Social Care and voluntary and community sector organisations. Two main strands have been developed to drive alignment and collaboration across commissioning and service provision.

- Commissioning is coordinated by a **Joint Strategic Executive** between NHS Kernow and Cornwall Council, to which other commissioners such as NHS England and the Council of the Isles of Scilly are engaged.
- Provision and performance delivery is coordinated via the **Systems Resilience group.**

Both report into the Cornwall Health and Well Being Board.

The Joint Strategic Executive is chaired by the lead director in Cornwall Council and involves senior officers from health and social care commissioning. This is an important element supporting both immediate operational commissioning for people in the care system, and for identifying opportunities for integrating commissioning functions between health and social care. We have further developed our joint arrangements by creating two **Integrated Commissioning Boards** feeding into the Joint Strategic Executive**.** One for children's services and the other for adults. They drive alignment for critical areas of shared purpose, such as children's services, care homes, personal budgets, intermediate care and continuing healthcare.

The Systems Resilience Group has two functions

- Improving operational flow and performance;
- strategic alignment and transformation.

Comprised of Chief Executive Officers and Directors from both commissioner and provider organisations across health, social care and the voluntary sector, it drives engagement across the care system. Feeding into part 1 of the Group's meeting, **weekly Chief Officer** meetings occur to keep a grip, at the most senior level, of operational performance. This is informed by the daily operational level group, through escalation reporting. To deliver the required improvements in operational flow and performance, a programme structure and governance architecture has been established, geared around the key findings of the **Emergency Care Intensive Support Team** following their assessment of our emergency care system.

During times of operational pressure, NHS Kernow leads the implementation of a command and control process in line with NHS England South Escalation framework, involving all partners from health and social care. The Systems Resilience Group is responsible for ensuring such processes are fit for purpose, responding to changes in needs, and involve the right organisations and people.

Other Clinical Commissioning Groups

We share service providers with five neighbouring Groups; NEW Devon, South Devon and Torbay; Somerset and Dorset. To support collaborative working we meet regularly at a Board to share issues and improvement work, with facilitation from the SW Academic Health Science Network. Aligned and collaborative commissioning arrangements are in place for specific services, such as acute services in Plymouth, NHS 111 and the 999 emergency services. Further opportunities for aligned or joint commissioning are being explored.

8 Governance

Governance within NHS Kernow

With NHS Kernow, we are evolving our operational and strategic management arrangements to reflect the demands of the system and national direction of travel.

The **Governing Body** is still ultimately accountable for decisions made by NHS Kernow, but delegates certain powers through 5 sub-committees:

- Governance and Assurance;
- Audit;
- Finance, Performance and Quality; and
- Remuneration.

Each sub-committee includes executive officers and clinical or lay members of the Governing Body, with reporting of minutes, decisions and escalation direct through the chair to the Governing Body.

In addition, a Procurement Committee meets as required to oversee procurement strategy and progression through procurement gateways, providing assurance to the Governing Body, and guidance to procurement teams.

Within the **Executive function**, regular groups drive the key elements of our operational plan. These include:

- Executive Management Team (Weekly) - for oversight of operations, QIPP and transformation;
- Delivering Better Value Executive Task Group (weekly) – for oversight of Delivering Better Value work streams;

Within each directorate, regular team meetings and operational fora support the delivery of commissioning and business support functions.

Delivering Better Value (QIPP)

Each theme is led by an Executive Director, accountable to the Executive Management Team for its scope and success. A Governing Body clinical lead is also assigned, ensuring both strong clinical leadership and direct accountability to the Governing Body. Delivering Better Value links with operational performance and longer term strategy and transformation, as outlined in this operational plan. The Executive leads report weekly to the Executive Management Team on issues requiring escalation, and monthly into the FP&Q Committee.

In developing the plan, we have also held regular working sessions with the Governing Body.

Teams have been allocated to each of the Delivering Better Value themes with a named member of the team responsible for each scheme.

The 2015/16 programme was launched in May by bringing all teams together for a shared understanding of the overall strategy and the contribution of the projects to it; to understand the support now available from the Programme Management Office; and to enable sharing of best practice and issues that need resolving. A second event will be held in June.

A similar process is being used with finance and project leads from providers to further develop collaboration with providers and ensure alignment with Cost Improvement Plans.

The Programme Management Office has developed a risk stratification criteria and methodology that will be applied to each scheme. It will also produce a regular highlight report for the Executive Task Group of performance against key milestones for the overall programme.

Locality engagement

Each member GP Practice has a mandated GP who is part of 1 of 10 **locality commissioning boards** across Cornwall and the Isles of Scilly.

Each locality Board has a GP Locality Lead who as well as chairing the locality commissioning board, also represents this locality at the **Network Leadership Group .**

The Network Leadership Group acts both as a communication cascade to member practices for the Clinical Commissioning Group and as a vital clinical reference group for testing provider and commissioner plans, developing QIPP ideas and helping resolve operational and strategic problems.

This plan has been informed by the locality plans developed through the Network Leadership Group and presented to the Group during its development.

Clinician Engagement - Further driving clinician engagement, we have created the **Clinical Oversight Group**, chaired by a Governing Body clinical member, to engage clinicians from across our provider partners.

The Clinical Oversight Group sits between the providers and our Governing Body, and whilst is has no decision making powers, it provides another vital opportunity for local clinicians to influence the Governing Body, and for NHS Kernow and provider partners to seek clinician support for insight.

Local alignment

At the local level we are introducing *Living Well* Boards that have representation from health, social care and the voluntary sector and, in Penwith, the Police.

These could become steering groups for tactical control of Integrated Care teams.

Patient Engagement

To drive engagement of patients, carers and the public in our plan, we are investing in our **Patient Reference Group**. This is formed from members of the **Patient Participation Groups** – there is a Patient Participation Group for each GP Practice across Cornwall and the Isles of Scilly.

We are supporting the Patient Reference Group with presentation from the Executive Team and our Engagement Team, and are developing the group to both test and challenge issues and opportunities, and act as a communication cascade to the Patient Participation Groups.

This plan has been developed with input from the Patient Reference Group and will be cascaded to Patient Participation Groups by representatives.

Localities engage with their Patient Participation Groups in a variety of ways. For example, East Cornwall Patient Participation Groups have formed an umbrella group, the chair of which is the patient representative on the Locality Group providing a link between the two.

Patient representatives are involved in our major work streams, they played a vital part, for example, in the recent procurement of GP out of hours services.