HEALTHY PEOPLE
living healthy lives
in healthy communities

NHS
Northern, Eastern and Western Devon
Clinical Commissioning Group

Integrated, personal and sustainable: Community services for the 21st Century

A Strategic Vision for Transforming Community Services

Purpose

In this document we set out our strategic vision for Transforming Community Services. This document explains the the context for this strategy and so there is detailed explanation about the issues that are influencing are the vision for future service delivery. We have also set out a detailed description of how services will be delivered in the future.

We will be producing a summary document ahead of the Governing Body meeting on September 04 2014. This will include all of the key elements of our vision for community services.

If you want more information on how services will be delivered in the three locality areas within our CCG, Northern, Eastern and Western Devon, these Locality Proposal documents are due to be published on September 17 2014. We will be describing our procurement strategy within the Case for Change document that is to be discussed at our Governing Body meeting on September 04 2014.

This Strategic Framework and the other documents set out above will all be available on the CCG's website (http://www.newdevonccg.nhs.uk/involve/100055)

Contents

Introduction to the Strategic Framework

This document sets the scene for strategy, design and delivery of community services in the Northern Eastern and Western Devon Clinical Commissioning Group's (the CCG) area.

This final Strategic Framework has been completed following 15 months of working with stakeholders and clinicians to develop a vision for the future of Community Services within the NEW Devon CCG geographic footprint. The results of this extensive co-production phase are documented in this Strategic Framework through the proposed service delivery models.

This document also reflects the responses that we received during the eight week period of engagement on the draft Framework that was published in May 2014. During this time we received over 250 responses reflecting the views of over 2,000 people.

Purpose of the Strategic Framework

In sections one and two we describe the national and local policy that has informed the discussions that we have been having with key stakeholders during the production of our strategy. We also describe the important local envionmental factors that have been considered, including demographic change and financial challenges. Finally, these sections set out the principles and priorities that have been identified during the development of this Framework with key stakeholders.

We have split the services within this Framework into four distinct categories to enable us to design care solutions that best meet the needs of the populations that will access those services. The scope of these categories is set out within Section 1, with the strategic direction for each category being described within Section 3. These four categories are:

- Preventive and personalised support
- Pathways for people with complex health needs
- Urgent care in the community
- Community specialty services

Summary of the vision

We are faced with significant challenges in the NHS. This represents an opportunity for innovative service redesign to ensure that services provide safe, high quality care in an effective and efficient manner, but which are also sustainable for future generations.

Our vision is that care is provided closer to home, away from acute hospitals wherever it is clinically safe to do so,and that the service is effective and efficient, and represents value for money. We will achieve this by making services easier to access where they cross acute and community service boundaries and provide greater levels of preventative care to help people self-manage their conditions. We will standardise urgent care services so that they are easy to access and consistent, and increase the level of integration both within health care but also with social care providers.

We are aware that communities can be wary of service change. We have, and will continue to engage with our communities and will ensure that their views are reflected in the design of services for the future. Furthermore, we will not move care closer to home until the necessary services are in place to support patients.

Other core documentation

This Strategic Framework sets out the overarching CCG strategy for the future of community services and we are planning for full implementation from April 2016. The implementation of this Framework will be specified in a series of locality focussed and CCG wide documents.

Each Locality is developing its response to this Strategic Framwork. These documents set out how Complex Care services will be commissioned locally, and how and where these services will be provided in the future. The CCG is developing CCG-wide strategies for Urgent Care Services, Preventative and Personalised Support and Specialty Services. The specifications for these services will be discussed fully with key stakeholders prior to the implementation approach being signed off by the Governing Body.

The Locality and CCG wide documentation will all be available on the CCG's website (http://www.newdevonccg.nhs.uk/involve/100055) once they have been completed. This will be updated throughout the design and implementation phases.

In addition to this Strategic Framework, the CCG will also be producing a summary document that sets out the key points from this Framework, and the vision for the future of community services in a short easy to read version. This document will be made available at the Governing Body meeting on September 04 2014 and also on the CCG's website.

Next steps and further engagement opportunities

Following the approval of this Strategic Framework on September 04 2014, the localities will publish their proposals for the delivery of community services within their areas. These Locality documents are due to be published on September 17 2014 and will be subject to a 12 week period of stakeholder engagement before they go to the CCG's Governing Body in January 2015.

We would welcome your thoughts and views on the proposals for service delivery set out in these docuements, and encourage challenge as to whether these are in line with the vision, principles and priorities of this Strategic Framework, and whether they best meet the needs of the local populations.

Section 1: Scene Setting

Introduction to the Strategic Framework

This document sets the scene for strategy, design and delivery of community services within the Northern Eastern and Western Devon Clinical Commissioning Group's (the CCG) area.

What are community services?
Community services are those general health and integrated health and care services that take place at home or nearby in local care settings. They include nursing; multi-disciplinary teams to help people with complex needs remain at home or return home from hospital sooner; and a range of clinical and other services in community hospitals and local care centres. Within NEW Devon there are 19 community hospitals which have been developed with support from local communities and leagues of friends. Many of these buildings are now not considered to be appropriate for delivering modern healthcare. We will work with local populations to redesign the services that are provided from these location to improve the quality of care available to local populations.

It is built on the views of members of the public, councillors and other public representatives, charity and voluntary groups, clinicians and healthcare leaders – and represents the combined insights of thousands of people living and working in the area.

The role community services can play in improving healthcare is understood – but not yet fully realised. Their position in the heart of communities means that these services are ideally placed in or close to patient's homes to help them remain well and independent for as long as possible; but although NHS policy has been shifting towards this for some time, and there are innovative examples, we have not yet released their full potential.

Addressing this is an early priority for the CCG – because it will bring real and tangible benefits for patients. In May 2013, only a month after our organisation was established, doctors and nurses working in the CCG began to develop the strategy, principles and which services they services would be needed. In doing so, they placed real importance on community services within the NHS and wider social care system, recognising that they were particularly important for individuals, carers families and communities in our largely rural county. It was also important to consider community services as a foundation for bringing about a more effective, efficient and financially sustainable system of healthcare.

We are aware that communities are often wary of service change. We have, and will continue to engage with our communities and will ensure that their views are reflected in the design of services for the future. This will include any difficult conversations that may be required about changes to the future model of service delivery.

Over the last few years, there have been significant changes in the way the NHS is run. Healthcare commissioning organisations have been reorganised, there have

been changes in national policy – against a background of increasing financial pressure on commissioners and providers alike.

In July last year NHS England published '*The NHS Belongs to its People: a Call to Action'*, a document that asked staff, public and politicians to help the NHS meet future healthcare demand and tackle a funding gap predicted to grow to £30 billion nationwide by 2021 if services do not change.

Given this we are putting a greater emphasis on commissioning services that aim to prevent ill health, are well integrated with social care and other services, and work in tandem with GPs and other primary care services; something that will be made easier when CCGs are given joint responsibility– alongside NHS England – later this year. It is essential that these services offer value for money while providing health care in the most efficient way possible.

When we achieve what is set out in this document we will have a system that offers prevention, early intervention and support to remain at home where possible, with access to quality clinical care in hospital settings.

All in all this is an exciting time for community services. Although there are challenges ahead, and some of the conversations we need to have will not be easy, the CCG will ensure a strong, resilient, modern, role for community services within the future NHS.

Programme Scope

Community services are those general health and integrated health and care services that take place at home or nearby in local care settings. They include nursing; multi-disciplinary teams to help people with complex needs remain at home or return home from hospital sooner; and a range of clinical and other services in community hospitals and local care centres. The document describes how these services will be commissioned in the future, including the development of new services. Mental Health, Primary Care and Children's services are not in the scope of this review, however, the integration of these services with wider community services is recognised and will be a core part of the implementation of this Framework.

A word on the format

The document is split into the four areas shown in the table below. Each of these areas details a tailored approach to best meet the health needs of the population and deliver quality, effective and efficient care.

Now that the strategic direction for each of these areas is set out, work to achieve our objectives will begin immediately through:

- Developing early (and specific) proposals for the design of services in Northern, Eastern and Western localities for implementation by 2015/16.
- Developing medium to longer term proposals for transformation of community services in readiness for contract awards from 2015/16 onwards.

Category	Service
Preventive and personalised support	Community services designed to help people who are older, frail or otherwise have complex health needs to remain well, support them to recover and enable them to have choice and control of their own care through a new model and design of services.
Pathways for people with complex health needs	Range of community hospital and community services to support people with complex health needs such as multiple long term conditions, frailty or disability with a new co-ordinated pathway design from pro-active care through crisis responses and to ongoing care.
Urgent care in the community	Urgent minor injury and illness services to a new design that will achieve consistent, quality, resilient and networked urgent care in line with the requirements of the recent Keogh report. This new system design aims to listen to, see or treat people in the right setting.
Community specialty services	A range of specialist community services that support people who may be vulnerable and whose conditions or needs require more specialist input from professional in podiatry, bladder and bowel care, specialist nursing and others.

Many people use general community healthcare services – not all of whom are able to use services in the way that the majority of people can. The strategy recognises this and seeks to ensure that people who are vulnerable, disabled or have specific needs have fair and equal access to care and support. Community services of the future will be expected to be fully aware of the needs of people with mental health problems, learning disabilities, who are older, who are perhaps carers, or are children, and the many others who may need support.

Planning for future design of community services will take into account the mixed rural and urban nature of the geography, demographic pressures, and considerations such as rural isolation, transport links and access to services for individuals and carers. Future planning will take into account a range of strategies including:

- Health and wellbeing strategies for Devon[1] and Plymouth[2].
- Mental health strategy
- Older people's mental health strategy
- Carers strategy
- Learning disability Strategy
- Continuing Healthcare and End Of Life

Many of the community services included in this document are directly linked to the strategies above. Right now the way the services interact are not as effective as they could be and we will work with these services to identify barriers to effective cross

[1] http://www.devonhealthandwellbeing.org.uk/strategies/
[2] www.plymouth.gov.uk/healthandwellbeingboard

profession/team/organisation working. We will also develop service design plans and specifications so that greater integration of service provision comes as standard.

Developing the framework

This framework was developed through co-production with people who have wished to become involved. The approach produced a wealth of insights and understanding that we otherwise may not have come across. Doing it this way enables us to design community services that are far more relevant to people who live, work, and visit our area.

What is co-production?
Co-production is a way of working where decision-makers and the public/stakeholders, or service providers and users, work together to create a decision or a service which works for them all. The approach is value-driven and built on the principle that those who are affected by a service are best placed to help design it.

Since the programme started just over a year we have:

- Listened to views of patients, carers and communities and those who represent them, recognising the importance of reaching diverse communities;
- Listened and worked with key stakeholders and clinical and system leaders involved in health and social care commissioning and provision; and
- Reviewed needs, evidence, a wealth of policy information and other details relevant to community services;

In the main, doctors and other clinicians and professionals led the work with our communities, ensuring that they could hear first hand what was being said. They then incorporated the views into this document.

The following are direct quotes from what we heard and sum up the general observations. We heard that people want:

- ‘Healthcare that does not stop at the boundaries’ [of organisations or geography]
- Services that ‘see me as a person - not as a condition’;
- Services that ‘keep increasing the ambition…for patients and communities’
- Services that are ‘safe and secure…with future proofing in mind’.

There was overall consistency of the general message, as well as some very specific issues that we will address. Themes were consistent with our vision of *Healthy People, Living Healthy Lives, in Healthy Communities.*

Based on this, we have created six strategic priorities to underpin this framework (see table a below).

There was a shared understanding of the need for change particularly from the aspect of patients and carers. We are developing new care models focused on prevention and wellbeing, as well as strengthening care at home, while reviewing

other services which would need to change. The importance of engaging communities for sustainable health, wellbeing and care was clearly emphasised.

Table a: Community services priorities

There was a very clear message that patients wished to see a service based on the seamless delivery of treatment across providers, geographies and clinical pathways.

What is seamless treatment?
Seamless delivery not only provides a better experience for the patient, but also provides better clinical outcomes. Seamless treatment means that clinical handover between staff at every stage of the process is safe and effective.

This strategic framework echoes the intention to create seamless care pathways as one of the key drivers for change.

In total we have reached more than 4000 people - 2000 directly involved before proposals and plans were developed and a further 275 pieces of feedback from individuals and those representing large stakeholder groups. This has given a good understanding of what is important to people locally(including clinical staff providing services) and has informed not only this document and subsequent implementation and contract specification but also wider strategies such as the CCG's draft five year strategic plans. The full engagement report can be found on the CCG's website[3].

[3] http://www.newdevonccg.nhs.uk/involve/community-services/101039

Responding to national policy

The Francis[4] and Keogh[5] reports emphasise the importance of quality and well delivered, designed and commissioned services that place the patient at the centre. Achieving this is increasingly complex as people are living longer, often at home with multiple illnesses and/or diseases. Our commitment is to ensure that services are provided to support people living longer lives and remaining as independent as possible.

What are the Francis report findings?

The review was commissioned following the failings of mid-Staffordshire Foundation NHS Trust. The report considered why the serious problems at the Trust, including poor quality care, failures in leadership and staff shortages)were not identified and acted on sooner, and what should be done to prevent it happening again in future. The review identified that although there were significant failings at Board level, responsibility for delivering high quality care should be the responsibility of staff throughout the NHS. In particular the following recommendations were made:

- Commissioners of services must ensure that those services are well provided and are provided safely.
- A single regulator for financial and quality aspects
- Implementation of the Duty of Candour
– organisations are required to be open, honest and truthful when things go wrong
- Only registered people should care for patients
- Fit and proper person test for those in charge of organisations

What are the findings of the Keogh report into quality?

The review was commissioned by the NHS to review the quality of care and treatment provided by those NHS trusts and NHS foundation trusts that are persistent outliers on when looking at the level of unexpected deaths in their services. The key messages were that most deaths happen in an emergency so it is crucial to get those services right, especially at weekends and during the night when other services are often not currently available. It is also key to ensure that service provision for the elderly is effective both within and outside of the hospital setting. Finally, it is crucial that excellent staff are recruited and retained by organisations.

These national policies mean that resources (money and people) will be deployed differently, with some traditional models that no longer meet the rigour or need being replaced.

NHS England's document '*The NHS Belongs to the People; a Call to Action:*'[6] sets out that to support higher numbers of people living longer with more complex conditions, to deal with increasing costs of care when funding says the same (also called flat funding) or even falls in real terms, and to respond to the rising expectations of quality, the NHS needs to embrace new ways of working. This includes the themes already touched upon; commissioning for prevention, rethinking

[4] http://www.midstaffspublicinquiry.com/report
[5] http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf
[6] http://www.england.nhs.uk/2013/07/11/call-to-action/

models of care for people with complex needs, improving flows of patients, and focusing on people and care rather than buildings and systems. All of this applies to community services.

- The *Call to Action* also highlights the emerging role of GP practices as an 'organising unit' for care in the future, emphasising the importance of comprehensive local arrangements. This is now being advanced through the planned co-commissioning of primary care by CCGs and NHS England.
- The importance of integrated health and wellbeing, integrated commissioning and integrated delivery of services has been cemented through the Better Care Fund. This is a pooled budget for health and social care which will be used as a catalyst for improving services and ensuring value for money, governed through Health and Wellbeing Boards.
- The rising focus on giving people greater choice and control over their care – and greater personalisation (with the further expansion of personal health budgets for people with long term conditions in 2015/16, and the new 'year of care' approach to long term conditions support which sets foundations for greater integration around individuals.

What is the Better Care Fund and what is it trying to achieve?
The Better Care Fund has been set up to improve outcomes for the public, provide better value for money, and ensure services as more sustainable. It means health and social care services must work together to meet individuals' needs. The Government will introduce a £3.8 billion pooled budget for health and social care services, shared between the NHS and local authorities, to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people. The NHS will make available a further £200 million in 2014-15 to accelerate this transformation.

What are health and wellbeing boards and what do they do?
The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. Health and wellbeing board members collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way. As a result, patients and the public will experience more joined-up services from the NHS and local councils in the future. There are two boards in the NEW Devon CCG area – one for each of the Devon County and Plymouth City council areas.

What are personal health budgets and what do they do?
A personal health budget is an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team. The vision for personal health budgets is to enable people with long term conditions and disabilities to have greater choice, flexibility and control over the health care and support they receive.

What is the new 'year of care' approach and its aims?

The Year of Care is about improving care for people with long-term conditions in the NHS. It is about putting people with Long Term Conditions such as diabetes firmly in the driving seat of their care, and supports them to self-manage. By moving the treatment and payment of care from an episodic basis to holistic approach it gives providers the funding and incentives to put patients more control of their care and treatment.

The role of community services in transforming care

In February 2014 the King's Fund, a leading national think tank, reported on how community services can be used to transform care (*Community Services: How They Can Transform Care*[7]). The report noted that fundamental and comprehensive change to services is needed to improve the effectiveness of the whole system. It also highlighted the importance of integrating services and ensuring that there were good links between primary care, hospital and community services.

The report says that significant numbers of patients occupying hospital beds could be cared for in other settings '...but only if suitable services are available and can be accessed easily'. It also advised that community services needed to be closely connected to other parts of the health and social care system within the same area (a 'natural geography') if they were to be a major driving force for improving community health. Furthermore community service provision needed to be involved in the key decisions at an earlier stage in a patient's journey through the system. The report sets out 7 key components for change:

- Simplify services and remove unnecessary complexity.
- Wrap (extended) multidisciplinary services around groups of practices.
- Use these services to build multi-disciplinary care teams for people with complex needs.
- Support these teams with new models of specialist input.
- Develop teams and services to provide support to patients (as alternative to hospital stay).
- Build information, infrastructure, ways of working, commissioning to support this.
- Reach out into the wider community to improve prevention, support isolated people, create healthy communities.

Local reviews and evidence

We have taken into consideration a range of local partnerships relevant to community services including Health and Wellbeing strategies, joint (NHS and social care) strategies for key care groups, our own draft five year strategic plan – together with the drive towards integration of health and social care.

"A review carried out by the Devon health overview and scrutiny committee, a group of councillors whose role it is to scrutinise the local health services, stated that they believed that the NHS should not be unduly constrained by an historical model, and should look beyond 'bricks and mortar' with patients and communities at the heart of future service change."

[7] http://www.kingsfund.org.uk/publications/community-services

There has also been a range of focused work specifically looking at evidence for care at home and exploring new models for delivery and this found that in many cases hospital is not the best place for patients to receive care; that the speed and quality of recovery from illness is often enhanced in familiar surroundings.
A public health evidence review conducted in 2013[8] indicated that when compared with inpatient care, care delivered at home can: be as safe and effective; achieve similar or reduced mortality; result in similar levels of readmissions; have fewer people needing residential care and deliver increased patient satisfaction. The review in identifying the benefits of home care highlighted the importance of selecting the right patients to be treated at home based on clinical and cost effectiveness of the treatment.

We will, of course, continue to provide care in hospitals but we will do so only where it offers the best outcome for patients based on clinical need, availability of other services and financial implications.

Planning for population change

Northern, eastern and western Devon, covering as it does cities such as Plymouth and Exeter, moorland villages, larger towns and villages is characterised by a large and dispersed rural geography with a small number of urban centres.

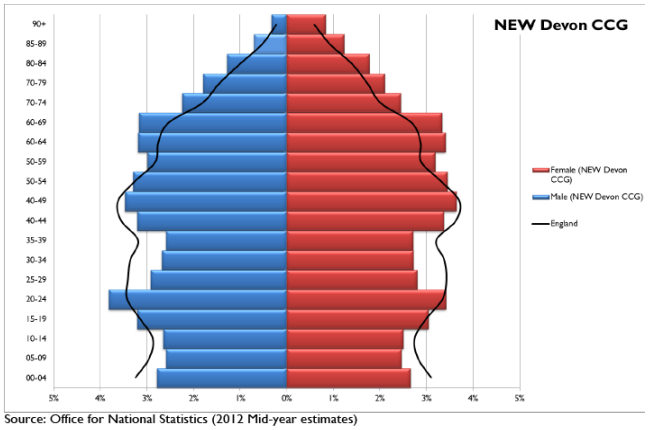
In terms of local administration, the CCG spans two upper tier local authority boundaries, Devon and Plymouth. It operates in three geographical localities to maintain commissioning relevant to the needs and priorities in local communities.

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

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

The proportions of older adults are already higher than England and rising. By 2021, the population in NEW Devon is expected to grow by 6% with a 9% rise in 60-74 year olds and a further 26% increase (over 22000 people) in the 75 and overs'.

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



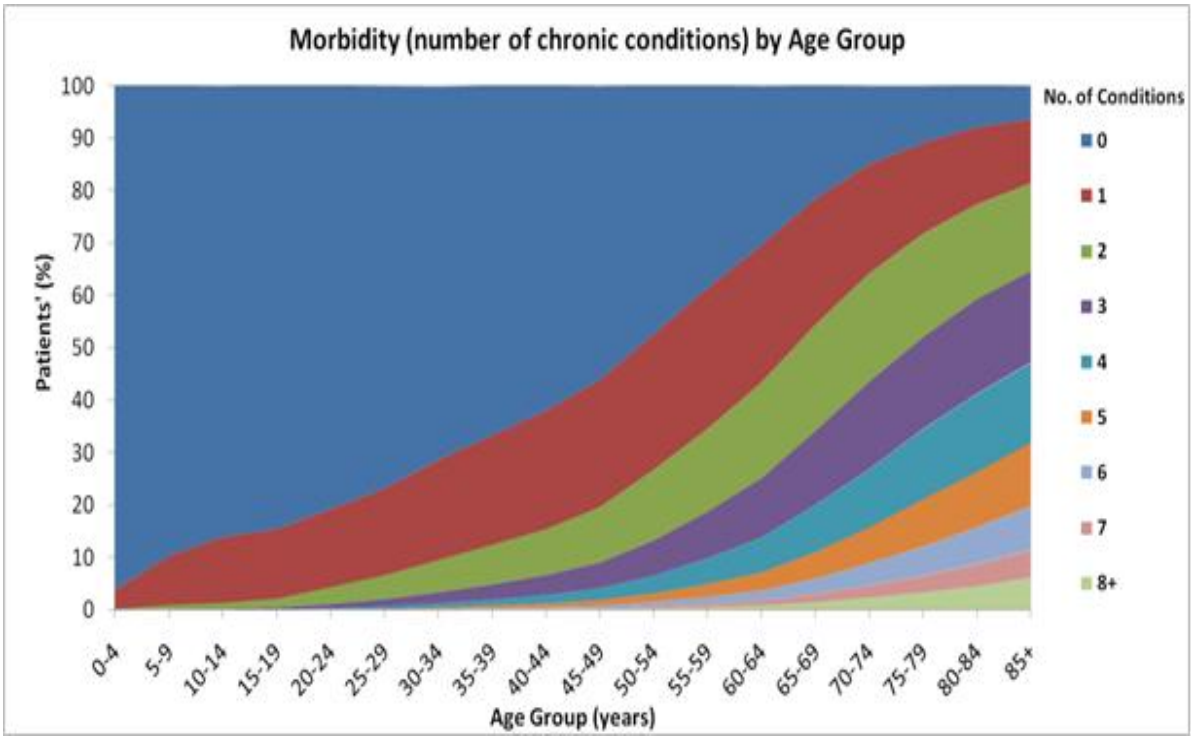
Source: Office for National Statistics (2012 Mid-year estimates)

By 2021, the population in NEW Devon is expected to grow by 6%, by 2021 there will be a 9% rise in 60-74 year olds in Devon. By 2021 there will be a 26% rise in the number of people aged 75 or over in Devon. These percentage increases are

[8] Devon County Council, 'Joint Health and Wellbeing Strategy 2013-2016 http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2014/05/Devon-Joint-Health-and-Wellbeing-Strategy-2013-to-2016.pdf

greater in some sub-localities which provide significant challenges when designing future service provision.

Overall, health indicators and life expectancy are better than the national average but this masks the gaps that exist in relation to deprivation and health inequalities. Population statistics across wide areas average out variation and we will focus in on smaller geographies to take this, and the mix of urban and rural factors, into account. The impact of new housing and communities is also of importance.



As people age they have increasing complexity of health need and frailty affecting the pattern of services required. At the age of 35, only 10% of the population will suffer from two or more chronic conditions, such as asthma, depression or dementia for example. This increases to 50% by the age of 60 and 80% for those over 85. For those aged over 75, 50% of people will have 3 or more chronic conditions, and 10% will have 5 or more. Increased levels of co-morbidity represent a greater challenge to providing safe high quality healthcare.

At the age of 35, only 10% of the population will suffer from two or more chronic conditions. The population that suffer from two or more chronic conditions increases to 50% by the age of 60 and 80% for those over 85. For those aged over 75, 50% of people will have 3 or more chronic conditions, and 10% will have 5 or more.

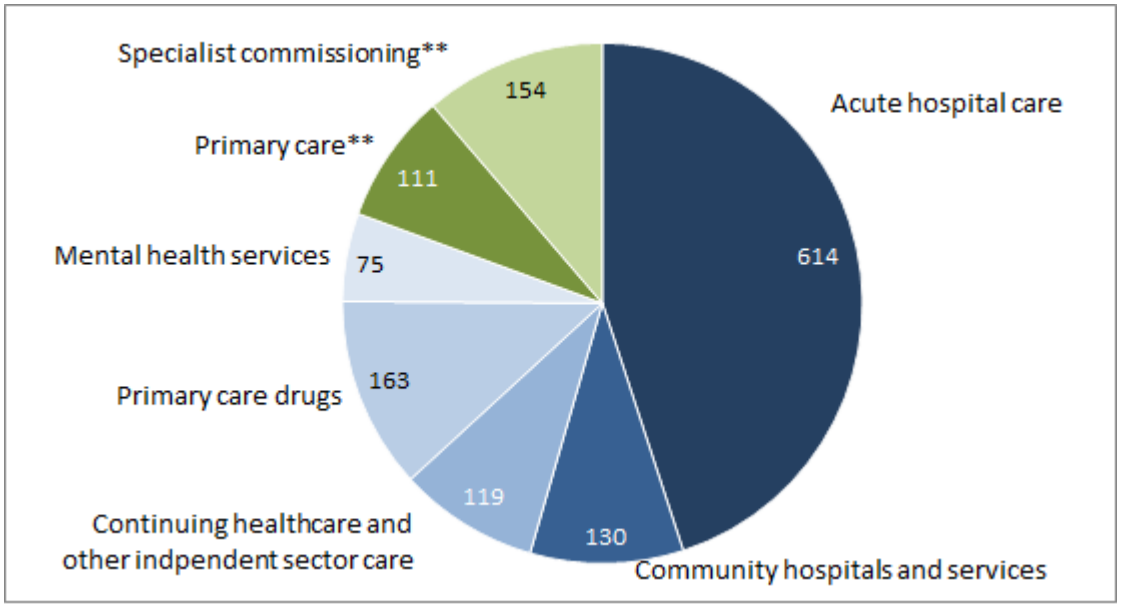
The current pattern of how services are being used suggests things are changing. Fewer people are going into hospital and more people are being cared for at home. We know acute healthcare demand is set to rise, linked to the age profile of the population, so we need to act now to design community services for the future taking both patient and carer needs carefully into account.

The financial position: An overview of resources

Commissioning community services accounts for £130 million of our £1.1 billion budget (shown in blue below). This pays for the current supply of services including community nursing, complex care, community hospitals/local care centres and specialist community services. This equates to spend on community services of £144.44 per head of population, or £356k per day.

Other organisations commission healthcare too. NHS England (shown in green below) commissions primary care (eg. GP services) for example and local authorities have a key role in working with us to provide integrated care so the Clinical Commissioning Group spend, although a substantial part, does not reflect the whole picture.

NHS NEW Devon Clinical Commissioning Group area Healthcare Spend 2013/14. £million



** These services are commissioned by NHS England for the population of NEW Devon CCG and are not included in the commissioning budget of £1.1bn. The total spend in these areas is £265m.

A Challenged Health Economy

In February 2014, our area was highlighted as one of eleven challenged health economies by Monitor, NHS England, and the NHS Trust Development Authority. As a result PricewaterhouseCoopers has been working with both service commissioners and providers within Devon to develop an integrated five-year plan. The response to these challenges will be called *NHS Futures: Transforming Care in Devon and Plymouth.*

Although we are focused on commissioning a community model, the financial outlook for all providers of NHS services in the medium term is that a minimum efficiency requirement of 4 per cent (£5.2m circa per annum for community services) is likely to be needed to deal with growing costs and demands on those services.

Given these financial and operational pressures, the CCG is in a position of having to make changes not only to improve the quality and efficiency of services, but also

to ensure that we can invest in the future. Our strategy to achieve clinically enhanced inpatient care when needed and otherwise to focus on sustaining more people at home and out of hospital will bring greater financial flexibility than can be achieved in traditional bed-based models.

"This will not only improve services for people but will also enable better targeting of the money to where it can bring most benefit."

An effective community system

We see community services as key to delivering more sustainable care, supporting the priorities for out-of-hospital care, and making every penny count.

We will shift from a pattern of services that have developed over time, to a commissioned set of community services that provide for current and expected health needs, promote quality, efficiency and effectiveness and stand the test of time.

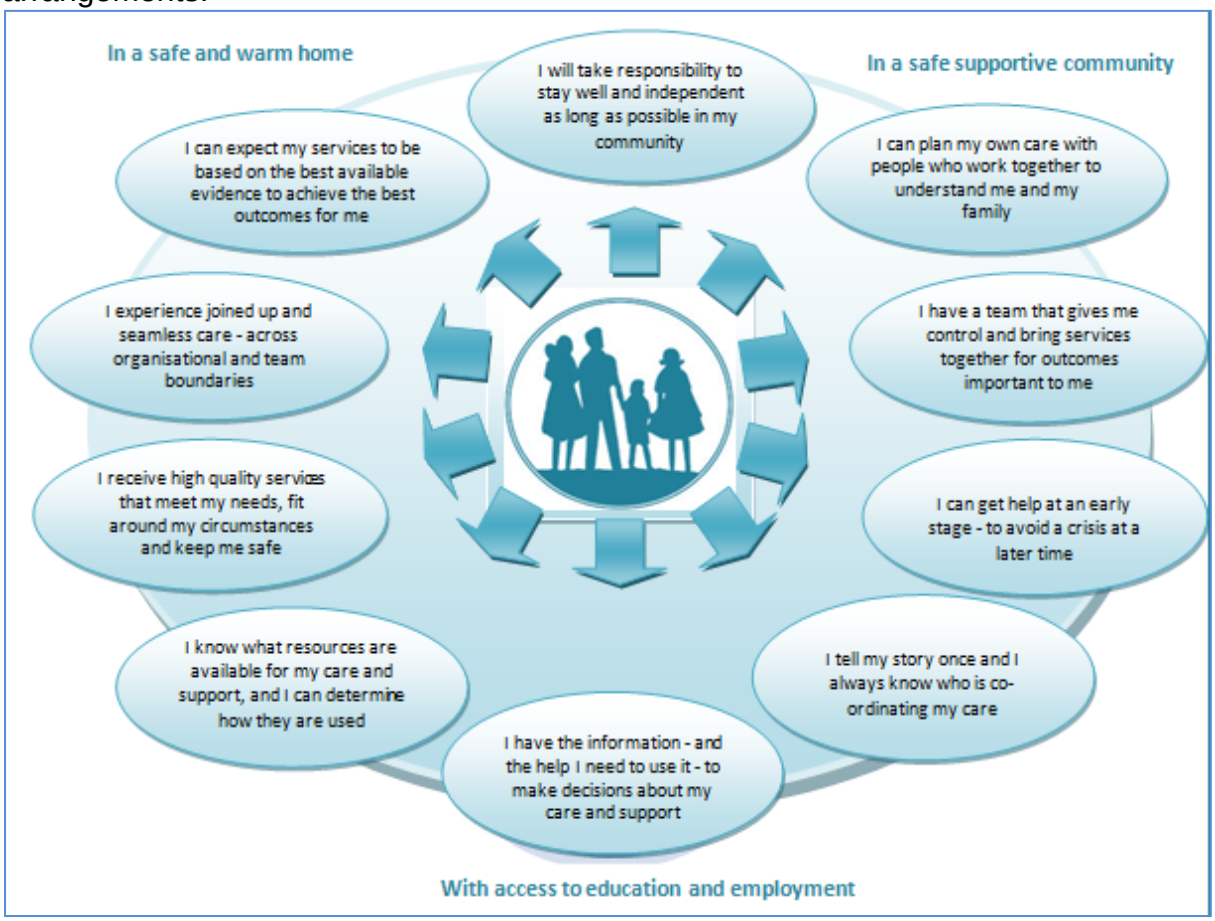
Section 2: Building services based on experiences, quality, clinical outcomes and priorities

A community system based on experiences

The CCG developed a large stakeholder reference group at the start of this programme. Based on the six strategic priorities, the reference group provided feedback that enabled ten commissioning principles to be developed. These 10 principles form the basis of the case for change.

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

These principles were then turned into what we've called 'I statements' which we will use to guide planning and decision making on the strategy and delivery arrangements.



A community system based on quality

Quality is the guiding principle for all of our work and is at the heart of any change within community services. Quality comes in many guises but for this programme it essentially means ensuring that the pace of change and the development of pathways are seamless and are demonstrated by the delivery of local, safe, effective and responsive services which provide real benefits to people in terms of their care.

We see community care services as a 'golden thread' that binds seamless and high quality pathways of care together. Involving communities in defining what *high quality means to them* means care providers can effectively reflect the experiences and outcomes that are important.

We continue to take into account the need to balance quality with access to care. As standards rise and requirements such as staff to patient ratios increase, accompanied by the reality that services where bed numbers or activity is lower, it can become increasingly difficult to maintain staff availability and/or competence, resulting in short-term changes to services. We want to make strategic decisions that ensure long-term stability of service.

During the development of this framework, we collected many examples of how organisational boundaries and patient transfers between organisations can cause disruption to patient pathways. These include different patient booking systems, inconsistent methods for recording and sharing patient clinical notes, and communication delays between organisations that result in slower patient transfer.

What is a patient pathway?
The "patient pathway" is the route that a patient will take from their first contact with an NHS member of staff (usually their GP), through referral, to the completion of their treatment. It also covers the period from entry into a hospital or a Treatment Centre, until the patient leaves.

In our constant strive for quality it will be important to seek to eliminate or minimise the impact of these barriers. We will enable true collaboration across health and social care providers so that care is organised around the patient and not the profession, department or organisation, with quality care throughout.

A community system based on outcomes

As community services are designed, commissioned and specified we will put a greater focus on outcomes.

What are outcomes?
Outcomes, or the results of care, can be at an individual, service, or population level. As we shift to an approach based on patient pathways, clarity of outcome for the combined set of services in any given pathway will be central to future service design.

National outcomes

The NHS, adult social services and public health have set clear outcomes for patients and the population. Due to the important role that community services play in good health and wellbeing, it is important that their contribution in adult social care and public health is understood. As this work progresses it will be important to consider how pathways and services will contribute to these outcomes.

Health and Wellbeing Board and Clinical Commissioning Group Outcomes

NHS Outcomes

- Preventing people from dying early
- Enhancing quality of life for people with long term conditions
- Helping people recover from episodes of illness
- Ensuring a positive experience of care
- Care in a safe environment and protecting people from avoidable harm

Public Health Outcomes

- Improving the wider determinants of health
- Health protection
- Health improvement
- Healthcare public health and preventing premature mortality

Adult Social Care Outcomes

- Enhancing quality of life for people with care and support needs
- Delaying and reducing the need for care and support
- Ensuring people have a positive experience of care
- Safeguarding people who are vulnerable and protecting them from avoidable harm

In addition to the outcomes above, the strategic priorities and measures set by Joint Strategic Needs Assessments, Health and Wellbeing Strategies and local Health and Wellbeing Boards in Devon and Plymouth will be at the centre of any future plans. In particular, community services need to address health inequalities and play their role in achieving integrated outcomes with social care.

The primary measure of this in the Better Care Fund is the reduction in the level of total emergency admissions. The following sub-measures are also included when assessing the success of the fund:

- Delayed transfers of care
- Effectiveness of reablement
- Admissions to residential and nursing care
- Patient and service user experience
- Dementia diagnosis rates (local measure)

A community system based on priorities

The six strategic priorities based on discussion with stakeholders (outlined on p4) reflect the need for strategic shifts in the way we commission services, deploy resources, and design care to deliver the vision, principles, quality and outcomes described above.

Help people to stay well

From a primary focus on caring we would expect the emphasis to move towards prevention, self-management and early help recognising the importance of information and positive approaches in particular helping older people remain well where possible.

Our pathway design for adults with complex needs addresses this including the important role of community services in promoting wellbeing.

Integrate care

Services that are co-ordinated and integrated and that remove and minimise organisational boundaries should be a central feature for future services. The importance of services being wrapped around individuals and their families has been stressed time and again.

Our work with local authorities to strengthen integration is progressing rapidly. In addition this strategic framework emphasises the importance of integration of other services.

Personalise support

Personalisation, choice and control over areas such as personal health budgets, information, education and self-management support are all important. Personalisation is much more than personal health budgets and we need to develop a model of care that is designed for individuals.

We have tested views in a number of discussions and as a result this strategic framework increases the emphasis on flexible approaches to supporting individuals.

Co-ordinate pathways

The importance of pathway based approaches to care with co-ordination through prevention to crisis and ongoing care has been identified time and again, with a particular emphasis based on the natural flows of patients.

In addition to addressing the role of prevention, the work on pathways includes responses to crisis and ongoing care and evaluation.

Think carer think family

The key role of carers and the need to support carers' health and wellbeing in addition to that of patients and the population, to achieve mainstream services that are carer aware are especially important as more services are focused in people's homes and in the community.

The important learning from carers is central to implementation of the strategic framework and the Carers Strategy work and continued links will guide community services.

Home as the first choice

The growing understanding of the need to shift the emphasis to fewer beds but a greater number of more personalised and responsive care packages at home is now indicating a clear impetus to achieve this at the earliest opportunity.

Getting the right balance of care is central to this strategic framework and will be the subject of ongoing engagement in both the planning and evaluation of services.

Section 3: Pathways for the future

Pathway design

In this section we set out the direction for preventive and personalised support; a pathway for adults with complex needs; and urgent care in the community; and the next steps for specialty community services. In each section we detail the national policy that has informed the strategic direction set out in this Framework.

We have heard that patients want services to be unaffected by organisational or geographic boundaries. In response to this, we are designing service specifications to help patients to flow through the health and care system in a way that is streamlined, co-ordinated and, crucially, designed around them.

What is a service specification?

A service specification is a document that contains a description of what a commissioner requires from a service. It is a working tool for the Provider to use to structure how they will deliver the service, and it is a document for the commissioner to measure the quality of the service, hold the provider to account and move towards the desired outcomes set out in strategic documents.

This focuses on three areas:

- Keeping you well and maintaining your independence (proactive and preventive care)
- Responding to crisis (responding rapidly and safely in a crisis)
- Getting you well again (rehabilitation, ongoing support and end of life care)

Moving to a care pathway approach will reduce variation in the way services are delivered, generating a better experience for patients while increasing safety by reducing clinical handovers between different providers.

What is a care pathway approach?

A Care Pathway is a structured approach to care delivery that clearly describes the journey an individual is likely to take when moving through the Care System.

The purpose of a clearly specified Care Pathway is to ensure that each individual receives the most appropriate care and treatment within clearly agreed timeframes; and in the least restrictive environments.

Preventive and personalised support

Community health and integrated health and care services are ideally placed to tailor care and support services for the communities they serve; helping to harness the

power of communities in maintaining their own health and wellbeing while mobilising other community assets to support people to live well and at home.

What are community assets and how might we use them?
Community assets are land and buildings owned or managed by community organisations. These assets cover a wide spectrum and include town halls, community centres, sports facilities, affordable housing and libraries.

Our Vision

- To make 'every contact with the NHS count', embedding preventive and personalised support into day-to-day activity.
- Introduce or develop proactive, ongoing care services through a shift in resources to new prevention and personalisation initiatives.
- Establish a model of care that is designed with personal health budgets in mind giving greater choice and flexibility for patients to take charge of their own wellbeing.
- To develop and use a flexible pattern of delivery that is wider than health and social care, building on partnerships and the voluntary sector, recognising that the NHS does not have all the answers

The policy direction

The need to shift emphasis from a system that spends most of its time dealing with ill health towards one that actively promotes prevention, first signalled by Wanless in 2002[9] (and again in 2007), is being driven by the NHS England Call to Action.

'Commissioning for Prevention' emphasises high impact prevention programmes designed to reduce acute capacity in the medium term, not only for admissions but also appointments.

Main findings of Wanless
This report by the former NatWest bank chairman, Derek Wanless, was on improving public health and reducing health inequalities in England. Wanless urged the government to develop a more coherent strategy to reduce preventable illness caused by unhealthy behaviour such as smoking and physical inactivity.

Community services have a role to play, particularly in supporting people with long term conditions and co-morbidities (more than one condition affecting health and wellbeing) at an earlier stage to deliver more relevant care. The NHS commissioning guide for self-management support and shared decision making for long-term conditions emphasises the need for a fundamental shift to help people manage life with their condition, harnessing the power of the wider community in doing so.

2015/16 has been identified as the NHS' Year of Care [10]. This focuses on delivering more personalised care for those with long-term conditions.

[9] Securing Our Future Health - http://www.yearofcare.co.uk/sites/default/files/images/Wanless.pdf
[10] http://www.yearofcare.co.uk/

Approximately 30 per cent of the population live with one or more long-term condition and that they account for nearly 85 per cent of the total NHS spend.

Research, in Wanless, has found that if patients manage their own healthcare provision, they are able to reduce the level of their hospital admissions and increase their quality of life.

By engaging key stakeholders and providers, working with patients and developing care pathways that are seamless across boundaries, the CCG will implement significant changes for those living with a long-term condition.

The CCG will continue the process of allocating personal health budgets to those receiving continuing healthcare funding as well as identifying those patients with long-term conditions who might benefit from such an approach.

The current pattern of care

In general, community services resources are targeted towards delivery of care, although a wider role in relation to wellbeing is part and parcel of integrated teams.

There is on-going work between the CCG and the local authorities to increase the level of personalisation that is available to individuals. Personal health budgets are a relatively new initiative in health, but there is strong and successful local authority experience in this area for adult social care. The CCG is also in the early stages of planning health and wellbeing hubs which will consolidate the provision of health and social care services into one location.

What are health and wellbeing hubs?
Integrated hubs that bring together health (including mental health) and social care with the voluntary and commercial sector to provide services for the community in a much more joined up way than has previously been possible. Currently hubs are being developed in Budleigh Salterton and Moretonhampstead. These hubs may not contain inpatient beds, but will have a range of clinical services to enable a range of services to be provided to patients that would otherwise be provided in acute hospitals.

How we will enhance preventive and personalised support

Keeping people well and maintaining their independence is a key part of the overall aim for adults with complex needs and multi-disciplinary teams work with community and voluntary sector partners to ensure this. But with rising numbers of older people – and therefore a higher prevalence of complex need - we will design services and care pathways to reflect the additional frailty, cognitive impairment and social isolation that many more people may face in the future.

The service redesign work will focus on those who are assessed as at risk of admission to hospital or care home, deterioration of health and wellbeing or health inequalities. In particular, we will:

- Change the way buildings are used, with some community hospitals hubs for health and wellbeing - rather than traditional inpatient units. We will design

these with communities to bring together a range of prevention, wellbeing and care services.

- Develop personalised care planning for people with complex needs and their carers to include prevention, self-management and appropriate support plans designed to help people maintain their independence and avoid crises.
- Establish by 2016 a commissioning and delivery framework so that we can create a 'menu' of quality-assured potential service providers, offering bespoke packages of support so that individuals can have more control and choice (incl. use of personal health budgets)
- Build on existing targeted services that support individuals at higher risk of admission through information, self-management and named clinical leadership of their care and support.
- Explore opportunities afforded by technology to provide preventive and personalised support, bringing this into the mainstream processes of support where the benefits of such an approach are clear
- Develop a series of pilot schemes for people with long-term conditions to assess the success of personal health budgets in helping to enhance the quality of their lives through self-commissioning healthcare.

Outcomes and benefits for patients

This model would play a part towards the following outcomes:

NHS and Social Care Outcomes	Enhancing quality of life for people with long term conditions Enhancing quality of life for people with care and support needs Helping people recover from episodes of illness Delaying and reducing the need for care and support
Better Care Fund Outcomes	Reducing emergency admissions to hospital Reducing delayed discharge from hospital Effectiveness of reablement

Additional benefits for patients and carers expected are:

- ✓ More influence and control over the support and care received through a personalised model that enables individuals to integrate their service provision.
- ✓ Access to tools and techniques to manage life with complex needs, and plans and support to avoid a crisis and where possible remain well and at home.
- ✓ Access to a new style of health and wellbeing hub in a number of locations, designed with complex needs in mind. These will provide a range of health, wellbeing and social activities and support for local communities, which in part will decrease the risk of social isolation often experienced by people living alone.
- ✓ Increased support for patients and their carers living with multiple long-term conditions through closer work with the community and voluntary sector.

This model is likely to be achieved in different ways to meet the needs of the community. Service provision in some locations e.g. the urban centres of Plymouth and Exeter may look different to those provided in other locations.

Delivering the transformation

To achieve this model, our intention is that from 2015/16 and beyond we will move from a system that is quite prescriptive in what services can be used – to one that increasingly prioritises personalised and preventive support, putting more power into the hands of the individual to make to choices .We have already begun to prepare for this and now will begin to:

- Change existing services to release resources from current provision to generate the capacity to commission the model described.
- Work with patients, carers and healthcare professionals to help individuals to commission services based on a shared understanding of the risks involved.
- Design and implement clear governance arrangements for the development of a market in prevention, personalisation and proactive care services over time
- Develop flexible contractual approaches to enable bespoke preventive and self-care solutions.
- Develop quality safeguards to ensure that care provided is effective, efficient and safe.

To make a real difference we recognise that we must harness the power of local communities; encouraging the charitable and voluntary sector, local businesses, community partners such as the police, fire and rescue services and local councils is pivotal in community engagement and wellbeing. It is essential that we work in partnership with the local Health and Wellbeing Boards to deliver this.

Pathways for people with complex needs

With more people living with multiple long term conditions and complex needs, it is essential to design the right model of care and treatment. The elements involved in care – and indeed the organisations and individuals providing this – are part of one system; they are interdependent. A patient pathway approach will reduce or avoid the fragmentation and gaps in care sometimes experienced – and improve outcomes. By coordinating services, patients will experience a more effective and efficient service that provides higher quality care and better clinical outcomes.

Our Vision

- A model of care focused on co-ordinated and integrated pathways throughout from pro-active care, through crisis responses and to ongoing care.
- Proactive preventive support as part of this pathway to help keep people well and maintain their independence.
- Planned specialist-led integrated multi-professional health and social care teams to provide support in a crisis to help people remain well at home with less time in hospital.
- Multi-disciplinary rehabilitation, ongoing and end of life care where required, that is effective and responsive to need.
- Services are provided to support people living longer lives and remaining as independent and as close to home as possible for as long as this offers the most effective care solution.

The policy direction

'The NHS Belongs to the people; a Call to Action' states that the current fragmented health and care system is not meeting the needs of older people. Older people are most likely to suffer problems with co-ordination of care and delays in transitions between services. The report sets out a framework and tools to help local service leaders to bring about whole system changes identifying nine components of care for attention:

- Healthy, active ageing and supporting independence
- Living well with simple or stable long-term conditions
- Living well with complex co-morbidities, dementia and frailty
- Rapid support close to home in times of crisis
- Good acute hospital care when needed
- Good discharge planning and post-discharge support
- Good rehabilitation and reablement after acute illness or injury
- High-quality nursing and residential care for those who need it
- Choice, control and support end of life

NHS England has published guidance on an integrated pathway for frail older people[11] highlighting the value of skilled community services and design of care around whole pathways and co-ordinated multi-disciplinary teams. Examples of a wider view are also included within the guidance such as the role of the community and voluntary sector in 'welcome home' support from hospital as part of a pathway of care.

"20-30 per cent of emergency admissions to hospital could have been avoided if appropriate alternative forms of care had been available or if care had been managed better in the period leading up to admission." "For acute care in Devon, between 18 per cent and 29 per cent said they were fit for discharge." "In community hospitals between 34 per cent and 40 per cent said they were fit for discharge." [12]

The current pattern of services

The current pattern of service delivery includes integrated health and social care teams in most of the area – but not all. There are some examples of good links with the voluntary sector but at present whole system multi-disciplinary teams are not widespread. There are examples in Devon of excellent joint health and social care working, including pilots such as hospital at home scheme in East Devon where specialist clinicians are part of the service. There are community nursing and therapy services although numbers, allocations and roles do vary across the area. There are on-going developments in Plymouth to integrate service delivery between the local authority and community healthcare provider.

How we will enhance services for individuals with complex needs

Integrated and clinically enhanced community services are essential in shifting care from busy acute hospitals into community settings so that where it is safe and

[11] http://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf

[12] The estimate comes from a range of equity audits by Devon County Council's public health department. These can be found here: http://www.devonhealthandwellbeing.org.uk/library/hea/

appropriate, people can remain at or near home. Rapid clinical opinions, access to tests and diagnostics, as well as joined up health and social care all have a part to play. Getting the balance and mix of services right, and making this work effectively, will enable people to receive the right care and support in the right place at the right time.

In addition to commissioning preventative and personalised services, described in the previous section, our pathway builds on the strengths of current services;

- Creating a model of service that offers a realistic alternative to hospital stays by both preventing admission and reducing length of stay with more effective community interventions (for example community diabetic services), and early and specialist-led assessment when needed.
- Clinically-led teams linked to general practices that have access to the full range of skills and services across the whole care pathway to help people receive the care they need outside of the hospital environment
- A smaller number of strategically located enhanced community hospitals, offering clinical assessment, inpatient care, ambulatory care and diagnostics to enable more people requiring hospital appointments or admission to receive this in the community.

What is ambulatory care?
Ambulatory care is a personal health care consultation, treatment, or intervention using advanced medical technology or procedures delivered on an outpatient basis. This would include moving more surgery to a day case basis where it is clinically safe and effective to do so.

- A consistent approach to supporting people living in care homes when they need healthcare to help them to remain there rather than them being moved or admitted to hospital.
- Being clear in service specifications of the need for coordination of the pathway with mental health expertise, particularly in the care of older people with dementia and other mental health illnesses who require physical healthcare.
- Similarly, being clear in service specifications of the need for coordination of the pathway with end of life expertise, recognising the role that hospices will have in developing end of life responses.

This model reflects national direction and will strengthen community services to meet the needs of the local population. Initial examples of hospital at home, the development of local clinics, and the use of technology to reach out to people all support this approach. In our area, review of evidence by public health teams has confirmed the clear benefits of care at home whilst recognising that in the design of these services proposals will have to be impact assessed in relation to cost effectiveness.

Outcomes and benefits for patients

This model would play a part towards the following outcomes:

NHS and Social Care Outcomes	Enhancing quality of life for people with long term conditions Enhancing quality of life for people with care and support needs Helping people recover from episodes of illness Delaying and reducing the need for care and support Ensuring a positive experience of care
Better Care Fund Outcomes	Reducing emergency admissions to hospital Reducing delayed discharge from hospital Effectiveness of reablement Patient service user experience Admissions to residential and nursing care

Additional benefits for individuals, families and communities would include:

- ✓ Knowing that community and home based care is centred on people and not simply their conditions, bringing expertise and co-ordination so that pathways - from proactive care to support in a crisis and ongoing care - are seamless and effective.
- ✓ Access to clinically led and integrated care so that home based care is quality, safe, comprehensive and value for money, connecting the whole system around individuals and their carer's.
- ✓ Local access to community inpatient, diagnostic and outpatient services that offer consistent, high quality and resilient healthcare services that enable care to be provided closer to home
- ✓ Freeing up of facilities and resources to positively enable new models of service designed with people with complex needs in mind such as the innovative new health and wellbeing hubs being developed in Budleigh and Moretonhampstead.

Delivering the transformation

We will commission joined up care that follows patient flows within a natural geography (the path patients take through local services) if we are to maximise shifts in care from acute to community settings and design the system for out of hospital care. The influence of this pathway approach is that specialist physicians and primary care expertise would be at the heart of the community services.

Decisions about which organisations will provide these services will set out in a case for change that will be finalised in November 2014.

We are working with professionals and the public in a number of communities to design the way forward together and we will build on this to enable the consolidation of inpatient services into fewer inpatient units freeing up the resources to genuinely enhance care and support at home.

Urgent care in the community

Urgent care in community settings needs to be a high quality, consistent, and resilient service which can be and is used as a first choice for routine urgent care. As

part of a wider network of expertise it needs to be designed so that the majority of patients can be seen, treated and their care completed in a single attendance. It also needs to be designed so that patients understand which part of the system they access depending on their health needs.

What is urgent care?
Urgent care is for patients who have medical problems that cannot wait, but that can't be managed by their GP (e.g. because they are closed) or which don't really need a visit to an Accident & Emergency department. Urgent care services are provided in a range of settings including walk in centres, minor injury units and out of hours GP and dentistry services.

The policy direction

The national Keogh report[13] (*High quality care for all, now and for future generations: Transforming urgent and emergency care services in England)* outlines the following guiding principles for urgent and emergency care in England and outlines a system that:

- Provides consistently high quality and safe care, across all seven days of the week;
- Is simple and guides good, informed choices by patients, their carers and clinicians;
- Provides access to the right care in the right place, by those with the right skills, the first time; and
- Is efficient and effective in the delivery of care and services for patients.

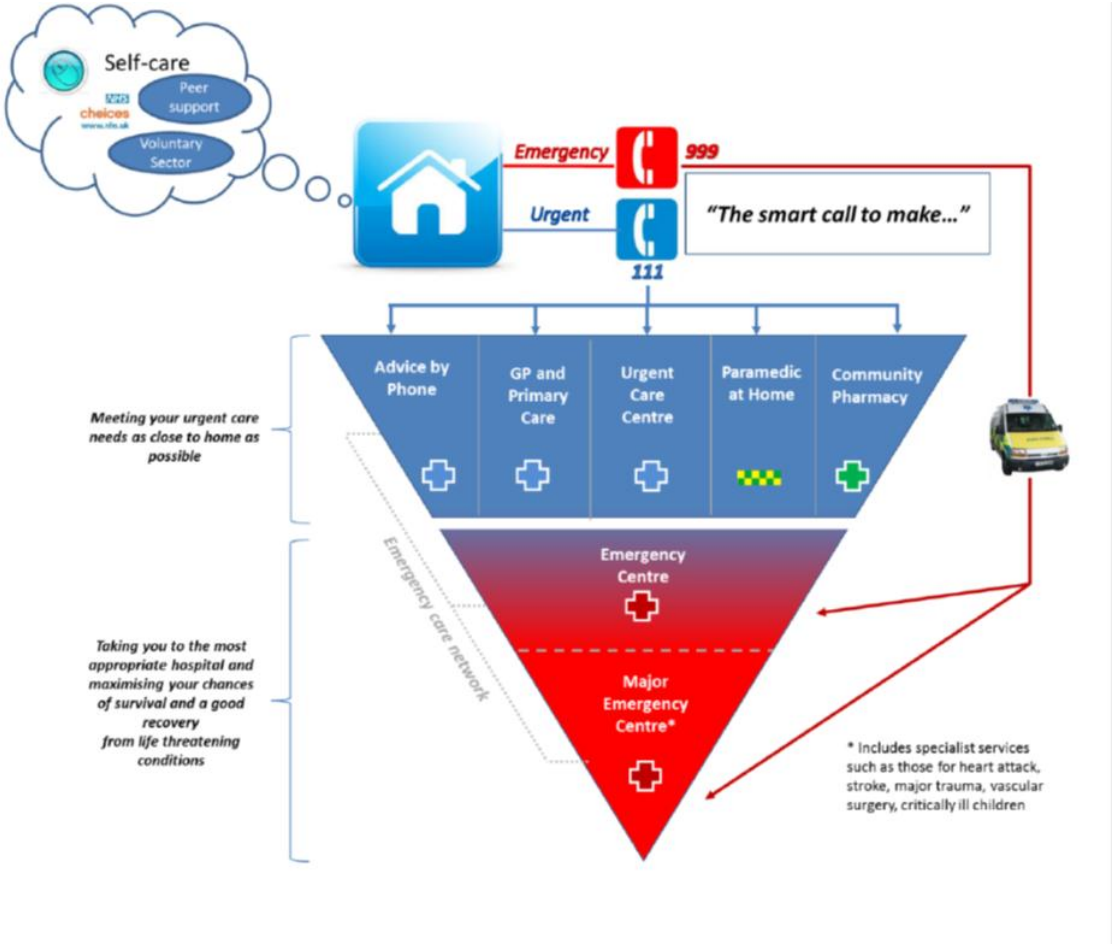
The CCG has adopted the same principles to guide the work it is undertaking as part of emergency and urgent care service provision. The diagram below is taken from the work, being developed nationally and describes the urgent and emergency care needs for patients.

The highly rural nature of our area requires the models proposed in the Keogh review to be adapted to meet local needs.

We are thinking creatively about how services are provided; particularly where it may be possible to ‘take services to people’ rather than expecting everyone to attend centres. This also brings with it excellent opportunities to consider how services can be more aligned so we ensure that the right clinician is available to meet an individual’s needs irrespective of which service they contacted.

We are also considering how other opportunities that were highlighted through discussions with stakeholders are used, in particular pharmacies and primary care (dentistry, medical and optical services.

[13] http://www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf



The picture in Devon – the current pattern of services

Urgent care services are provided by Accident and Emergency centres at acute hospital sites, two walk-in centres, twelve standalone minor injury units, and GP Out of Hours services.

The scope of these services, their activity, opening times and access to them is varied across the units. The range of symptoms which can be treated is different too and this makes it difficult for patients to be clear as to which service to use, when. This can result in patients defaulting to already busy accident and emergency departments.

The variation, as well as differing access levels, means the current model is difficult to sustain. Between January 2014 and March 2014, access of Minor Injury Units varied between an average attendance of 0.5 people per day to 34.7 people a day depending on location. Maintaining the expertise and skills base of clinicians for the full scope of urgent care requires regular exposure and experience which is difficult where use of services is low. A review by Devon County Council Health and Wellbeing Scrutiny Task Group in 2012 emphasised the need to balance convenience of access with quality standards and the need for greater consistency of service than is presently available.

NHS 111 has been operational since September 2013 in Devon. It has had an impact on the dynamics of urgent care and the routing of patients to different

services or treatment options. We need to be sure we commission the right levels of service and work with the providers of the NHS 111 service to ensure that people are directed to the right services.

What is NHS 111?
NHS 111 is a new service that's being introduced to make it easier for you to access local NHS healthcare services in England. You can call 111 when you need medical help fast but it's not a 999 emergency. NHS 111 is a fast and easy way to get the right help, whatever the time.

For example if you need medical help fast but it's not a 999 emergency, you think you need to go to A&E or need another NHS urgent care service, you don't know who to call or you don't have a GP to call, or you need health information or reassurance about what to do next.

In looking at community aspects of urgent care, it is important to also consider the following urgent care services:

- Primary care treatment centres.
- Acute hospital emergency departments
- Urgent care home visiting services

We will ensure that patients will have the best response to meet their needs, which will also result in a better use of resources. We will also ensure that there is a clear link with urgent care services commissioned by NHS England, such as those in primary care, to further streamline the provision of services.

How we will enhance urgent care services in the community

In response to the national policy and local requirements, we will develop an urgent care system that:

- Promotes prevention
- Takes services to patients by using technology and home visits
- Develop urgent care centres where it is affordable and makes sense to do so clinically
- Adapt the models outlined in the Keogh review so that they meet the needs of our largely rural area
- Aligns urgent care services with primary care and out-of-hour's services including sharing the same site where possible. Urgent care services will have access to a greater range of diagnostic equipment, including x-ray.
- Improves the coordination of services to meet the patient's needs.
- Places senior clinical leadership within the urgent and emergency care network, ensuring more joined up care.
- Implements shared information technology protocols and governance for the most effective care, enabling us to share records so that the patient can be confident that the person treating them knows as much about them as possible.

This model will replace the current pattern of minor injury and walk-in services with a smaller number of high quality urgent care centres accompanied by outreach support in more rural areas through a network. It will link to, and support, developing primary care urgent care services to offer routine support.

Further work is needed to fully ensure that demand on services is managed effectively and does not simply increase. It will also be necessary to ensure that urgent care centres meet the necessary rigour in meeting needs and quality, efficiency and effectiveness standards. This is equally as important for the urgent care services provided by GPs and other primary care practitioners.

This model is already being tested in Tiverton and was developed in response to what the community asked for. The learning from this will inform future planning for urgent care centres in the rest of Devon, where we are currently exploring other opportunities for tests of change.

Outcomes and benefits for patients

The revised urgent care services structure will deliver the following benefits to patients:

- Give people access to a high standard of care and treatment wherever you live in Northern, Eastern and Western Devon.
- The urgent care system will be much easier to understand across the CCG area.
- Away from existing urgent care sites, care will be provided closer to home and patients will be seen, treated and cared for in one visit – unless the problem is too severe or complicated to do so.
- Recognition of the role of prevention in urgent care to avoid repeat attendances where possible through a positive approach to future care planning and patient and public information and education.
- Knowing that the person providing treatment is part of a much wider network of expertise that can be accessed should it be necessary to support needs and care.

Specialty services in the community

Community specialty services are typified as services that take place in clinics or home. They particularly support people who may be vulnerable due to their age or illness/condition and require more specialist input. Working with patients in the community and linking with all parts of the health and care system, these services have an extremely important role to play.

It is important these services are taken into account in this community service programme. Although there have been reviews of some of these services over time we have identified the benefits of an extended period of co-production particularly designed to look at the delivery of services in more depth.

What services are included?

Specialty services include: podiatry; tissue viability; musculo-skeletal physiotherapy; bladder, bowel and pelvic floor services; specialist nursing such as cardiac nursing, and others.

Speciality services also have some common features.

- They are generally for patients who are often vulnerable due to age, long-term health conditions or following an episode of ill health.
- Some speciality services are used by small numbers of people with complex needs and working in a networked approach with other specialty, acute, primary and community services is essential to make the best use of the resources available.
- The ethos of promoting and maintaining health and wellbeing is important in these services and most have established education strategies and support arrangements to reduce the impact of risk behaviours on the individuals themselves and others.

Listening to people as part of a review

The CCG is undertaking a review of these services by working with professionals, commissioners, clinicians and patient and public representatives. This will allow us to properly consider current and future needs, the opportunities and challenges ahead, and the relevant policy frameworks as a basis for proposing the strategic direction and future pathways for these services.

The review will determine if the current model is the most efficient and effective way to deliver services and develop service specifications for those services where it is felt that service enhancements can be made.
Once this has been completed, we will refresh this particular element of the strategy; setting out how each of the elements will be commissioned in the future and determining detailed commissioning direction as necessary.

Section 4: Next steps

Strategic Development

This strategic framework sets the foundations for the design and delivery of community services for the next five years. It is a live document and will take into account the rapid pace of development in health and social care. As such it will be reviewed and updated at key milestones.

Over the coming months we will talk to key stakeholders and communities to develop how this Framework for the future will be delivered. This will result in locality proposals being developed and approved prior to implementation during 2015.

We recognise that the services currently being delivered will not be those that are in place at the start of the next contract period. This is due to change being required now to help make the system more efficient and effective for patients. We will develop these elements at the same time as developing our locality wide plans for the future during the period to October 2015. These include:

- Developing the Health and Wellbeing Hubs in Budleigh Salterton and Moretonhampstead Hospitals.
- Progressing plans for the integration of health and social care service delivery in Plymouth and continuing to further develop joint working and integration in Devon.
- Progressing plans for the role of community services in achieving the outcomes described in the Better Care Fund.
- Work with Healthwatch to develop a delivery and monitoring model for the priorities, principles and 'I' statements set out in this Strategic Framework.
- Develop and finalise locality proposals; involving and consulting with communities to set locality blueprints for the future.
- Develop process to ensure longer term sustainable delivery of care is achieved including how people can be engaged as we specify and procure services.

We will also be working to set out our commissioning intentions in relation to the four categories set out in this framework for the 2015/16 planning round which starts later in the autumn of 2014.

We will keep people up to date through locality engagement, our website, and other means to ensure involvement in the ongoing development and implementation of this Framework.